Healthy: Pre-Read for Workgroup Meeting #1

October 22nd ECAP Workgroup Meeting

Overview

This document contains:

- Data to report out on the ECAP 2025 targets and sub-targets for each of the two goals
- A summary of the strengths and weaknesses (identified at the launch meeting) to meet the ECAP goals
- An early childhood services inventory and summary of relevant cross-agency taskforces that already exist in Durham related to the Healthy goals

We will use this information in the October 22nd workgroup meeting to:

- Discuss the data and take an equity approach to our data analysis
- Discuss our Durham-specific ECAP sub-targets
- Identify the highest-priority needs in Durham that need to be addressed in order to meet these goals, as well as the primary assets and community strengths that will help us meet our goals

Questions to keep in mind:

- Equity Lens to the Data:
    - What do you notice when you look at the data? Anything surprising, confusing, unclear?
    - What disparities do you see and what do you think is causing those?
    - Whose experiences are not represented or might be misrepresented in the data?
    - How does the data align with your direct experience?
    - Whose perspective is needed to understand the data?
- Durham-specific 2025 Targets and Sub-Targets?
    - Should our 2025 target here in Durham be the same as the state's?
        - If not, how should we determine what it should be?
    - What will we be able to accomplish in Durham? Should 2025 be the goalpost?
    - How does COVID-19 impact our sub-targets?
- Needs:
    - What other challenges are there in Durham preventing us from meeting the ECAP goals?
- Assets:
    - What other strengths are there in Durham that can help us meet the ECAP goals?
    - How might we more intentionally consider the community-based assets here in Durham?
- In summary:
    - After reviewing this document, what are the areas of greatest need that you see? Greatest strengths?
    - What reports, research, or recommendations have you found that you think will be important for us to consider as we brainstorm strategies to reach the ECAP goals?
    - What approaches should we take to bring other perspectives, especially those of people experiencing the problem, into the conversation?

Table of Contents

Executive Summary

GOAL 1: HEALTHY BABIES				
TARGET	**SHORT DESCRIPTION**	**METRIC**	**NC**	**DURHAM**
2025 Target	Infant Mortality Racial Disparity Ratio	Infant Mortality Disparity Between African American and White Infants	2.5x *2013-17*	3.1x *2013-17*
Sub-Target 1	Infant Mortality Rates	Infant Mortality Rate out of 1,000 Live Births	7.1 *2013-17*	6.4 *2013-17*
		Black Infant Mortality Rate out of 1,000 Live Births	12.7 *2013-17*	11.9 *2013-17*
		Hispanic Infant Mortality Rate out of 1,000 Live Births	5.7 *2013-17*	-
		White Infant Mortality Rate out of 1,000 Live Births	5.3 *2013-17*	3.8 *2013-17*
Sub-Target 2	Low Birth Weight	Percent of Babies Born at a Low Birth Weight (<2,500g)	9.2% *2014-18*	8.8% *2014-18*
		Percent of Black Babies Born at a Low Birth Weight (<2,500g)	14.1% *2016*	-
		Percent of Hispanic Babies Born at a Low Birth Weight (<2,500g)	7.4% *2016*	-
		Percent of White Babies Born at a Low Birth Weight (<2,500g)	7.6% *2016*	-
Sub-Target 3	Pregnancy Intendedness	Percent of New Mothers Indicating Their Pregnancy was Intended	56.9% *2016*	-
Sub-Target 4	Women's Preventive Health Visits	Percent of Women Aged 18 - 44 Who Had a Routine Checkup in the Past Year, 2017	26.3% *2017*	-
Sub-Target 5	Breastfeeding	Percent of Infants in Ever Breastfed	84.9% *2015*	74.64% *2018-19 (WIC)*
		Percent of Infants Breastfed at 6 Months	58.8% *2015*	31.43% *2018-19 (WIC)*
Sub-Target 6	Poverty	Percent of Families with Children Aged 0 - 8 Living at or Below 200% of the Federal Poverty Level	52.4% *2016*	-

GOAL 2: PREVENTIVE HEALTH SERVICES				
TARGET	**SHORT DESCRIPTION**	**METRIC**	**NC**	**DURHAM**
2025 Target	Regular Well-Child Visits	Percent of Children Aged 0 – 15 Months Enrolled in Medicaid and Health Choice Who Receive Regular Well-Child Visits	62.5% *2017*	63.6% *2017*
		Percent of Children Ages 3 – 6 Years Enrolled in Medicaid and Health Choice Who Receive Regular Well-Child Visits	69.9% *2017*	68.8% *2017*
Sub-Target 1	Health Insurance	Percent of Children Aged 0-8 Years without Health Insurance	4.3% *2016*	-
		Percent of Heads of Household with Children 0-8 without Health Insurance	19.8% *2016*	-
Sub-Target 2	Immunizations	Percent of 19 – 35 Month-Old Children Who Are Up-To-Date on Immunizations – Combination 6	73.6% *2017*	-
		Percent of 19 – 35 Month-Old Children Who Are Up-To-Date on Immunizations – Combination 7	70.9% *2017*	-
Sub-Target 3	Annual Dental Services	Percent of Children <1 year old Enrolled in Medicaid Receiving at Least One Dental Service by a Dentist	3.6% *2017*	-
		Percent of Children Ages 1-2 Enrolled in Medicaid Receiving at Least One Dental Service by a Dentist	30% *2017*	-
		Percent of Children Ages 3-5 Enrolled in Medicaid Receiving at Least One Dental Service by a Dentist	58.8% *2017*	-
		Percent of Children Ages 6-9 Enrolled in Medicaid Receiving at Least One Dental Service by a Dentist	70% *2017*	-
Sub-Target 4	Dental Varnishings	Percent of Children Enrolled in Medicaid or Health Choice Receiving 4 or More Varnishings by 42 Months of Age	45.8% *2018*	-
Sub-Target 5	Lead Screening	Percent of Children Ages 1 and 2 Receiving Lead Screening	56.6% *2018*	48.4% *2018*
		Percent of Children Enrolled in Medicaid Receiving Lead Screening by 2nd Birthday	60% *2017*	-
Sub-Target 6	Poverty	Percent of Families with Children Aged 0 - 8 Living at or Below 200% of the Federal Poverty Level	52.4% *2016*	-

Detailed Data Review

GOAL 1 | GOAL 2

Goal 1: Healthy Babies

COMMITMENT: Babies across North Carolina from all backgrounds will have a healthy start in their first year of life.

2025 TARGET: By 2025, decrease the statewide infant mortality disparity ratio from 2.5 to 1.92, according to data provided by the State Center for Health Statistics.[9]

SUB-TARGETS:

1. **Infant mortality rates, disaggregated by race and ethnicity**
   - DATA SOURCE: State Center for Health Statistics (SCHS), Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS)
   - TREND BY 2025: Decreasing

   For more details, visit the interactive NC Early Childhood Action Plan Data Dashboard

2. **Percent of babies born at a low birth weight (<2,500g), disaggregated by race and ethnicity**
   - DATA SOURCE: State Center for Health Statistics (SCHS), Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS)
   - TREND BY 2025: Decreasing

3. **Percent of mothers indicating their pregnancy was intended**
   - DATA SOURCE: Pregnancy Risk Assessment Monitoring System (PRAMS), State Center for Health Statistics (SCHS), Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS)
   - TREND BY 2025: Increasing

4. **Percent of women ages 18-44 years with preventive health visit in last year**
   - DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), State Center for Health Statistics (SCHS), Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS)
   - TREND BY 2025: Increasing

5. **Percent of infants breastfed:**
   - **Ever breastfed**
   - **Breastfed at 6 months-old**
   - DATA SOURCE: National Immunization Survey, Centers for Disease Control and Prevention
   - TREND BY 2025: Increasing

6. **Percent of families living at or below 200% of the federal poverty level**
   - DATA SOURCE: American Community Survey (ACS), U.S. Census Bureau
   - TREND BY 2025: Decreasing

DATA AVAILABILITY

		Can this sub-target be reported at the County Level with the ECAP data source?	Does the ECAP County Data Report Provide County-Level Data?	Can we get this data at the County-Level?
2025 Target	Infant Morality Racial Disparity Ratio	Yes	Yes	Yes
Sub-Target 1	Infant Mortality Rates	Yes	Yes	Yes
Sub-Target 2	Low Birth Weight	Yes	Yes	Yes
Sub-Target 3	Pregnancy Intendedness	No	No	To Be Determined
Sub-Target 4	Women's Preventive Health Visits	No	No	To Be Determined
Sub-Target 5	Breastfeeding	No	No	WIC Family Connects
Sub-Target 6	Poverty	Yes	No	Similar Metrics

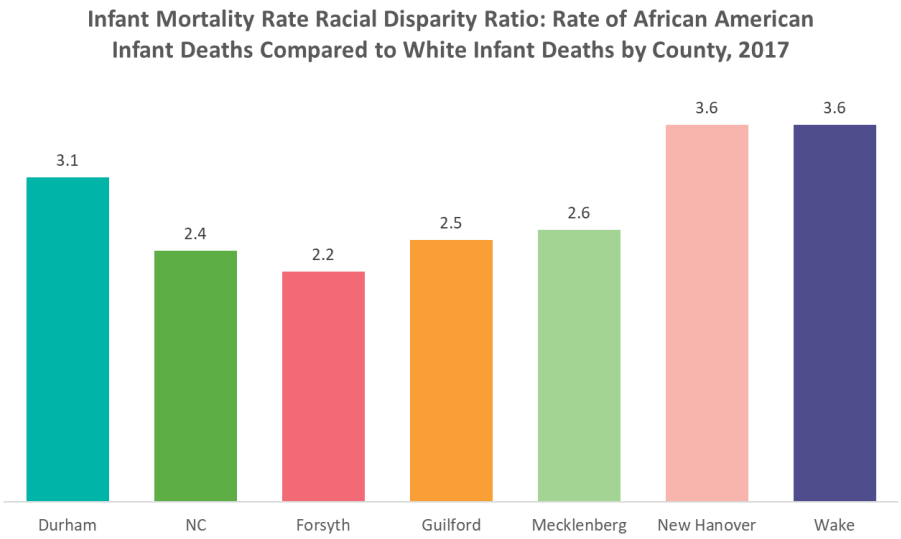
DATA REVIEW: HOW ARE WE DOING AS A COUNTY ON THE TARGETS AND SUB-TARGETS FOR GOAL 1?

2025 TARGET: ***Decrease the statewide infant mortality disparity ratio from 2.5 to 1.92, according to data provided by the State Center for Health Statistics.***

The infant mortality disparity ratio is not only a key indicator of infant and maternal health, but also used more broadly to indicate societal health, poverty levels, racial disparities, and the availability and quality of health services in a community.[1]

The leading causes of infant mortality in North Carolina are preterm birth and low birth weight, birth defects, Sudden Unexpected Infant Death (SUID), maternal complication of pregnancy, labor, and delivery, and other perinatal conditions. The infant mortality rate is directly impacted by social factors like poverty and racism, which contribute to the risk factors above, and to other behavioral and health risk factors, like education, tobacco use, obesity, and access to medical care before and during pregnancy.[2]

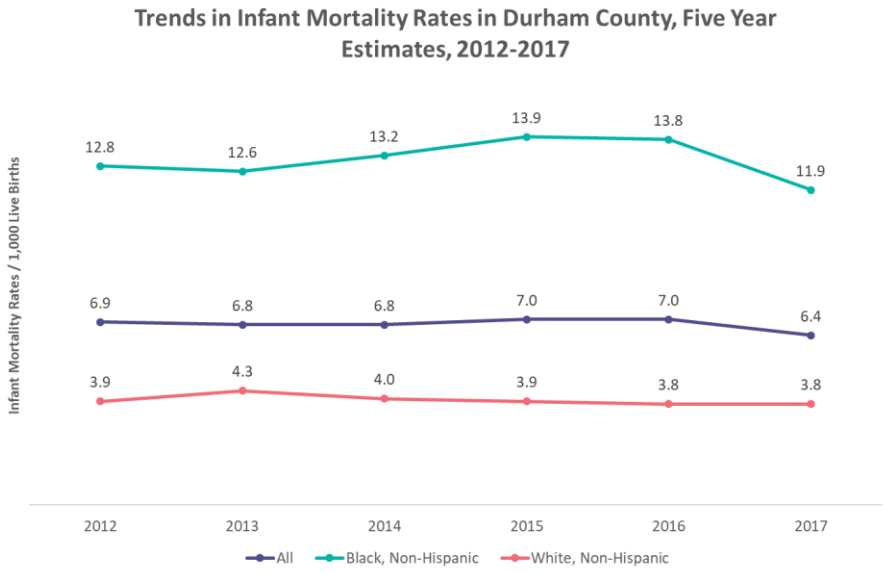
[1] "North Carolina Early Childhood Action Plan." NCDHHS, February 2019.
[2] "North Carolina Early Childhood Action Plan." NCDHHS, February 2019.



Source: State Center for Health Statistics (SCHS), Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS). Early Childhood Action Plan Durham County Data Report, 2019.

For decades, racial and ethnic disparities across the state have remained intractably high.[3] Black Infants in Durham die at more than three times the rate of white infants, higher than the state average and many comparable counties.

SUB-TARGET 1: ***Decrease infant mortality rates, disaggregated by race and ethnicity.***



Source: State Center for Health Statistics (SCHS), Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS). Early Childhood Action Plan Durham County Data Report, 2019.

Black infant mortality remains significantly higher than the overall rate of infant mortality and the rate of white infant mortality.

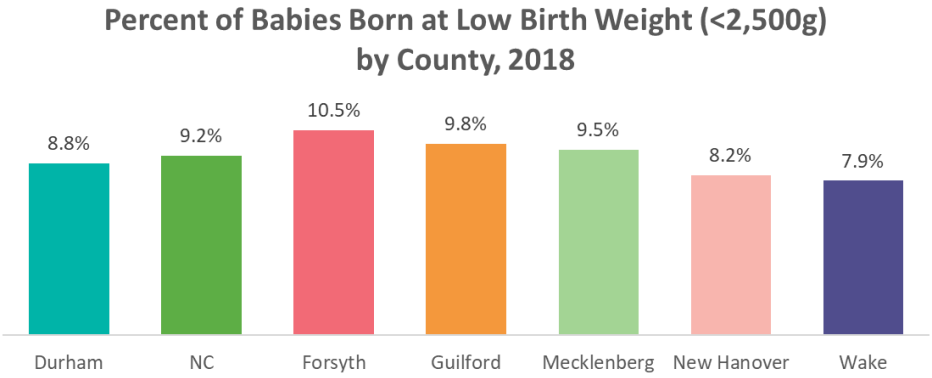
It is important to note that the ECAP Durham County data report did not disaggregate data for Hispanic infant mortality. While not calculated as a moving average as the other data (and therefore not directly comparable to the current available data), the most recent data on Hispanic infant mortality in Durham reveals that the rate is 8.9 (Hispanic infant mortalities per 1,000 live births).[4]

[3] "North Carolina Early Childhood Action Plan." NCDHHS, February 2019.

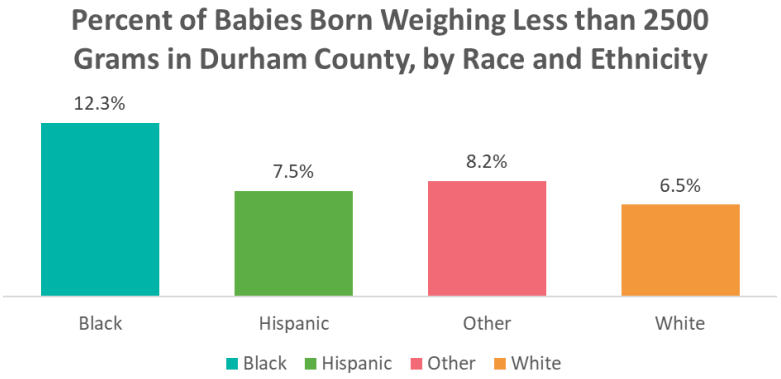
[4] "2018 North Carolina Infant Mortality Report, Table 1." State Center for Health Statistics (SCHS), Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS). 2018.

SUB-TARGET 2: ***Decrease the percent of babies born at a low birth weight (<2,500g), disaggregated by race and ethnicity.***

Babies who are born weighing less than 2,500 grams (5.5 pounds) are at a greater risk for physical and developmental problems than infants born at a normal weight. Children who are born at a low birth weight are at higher risk for long-term illness or disability and are more likely to be enrolled in special education classes or to repeat a grade.[5]



Source: State Center for Health Statistics (SCHS), Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS). Early Childhood Action Plan Durham County Data Report, 2019.



Source: North Carolina Department of Health and Human Services, State Center for Health Statistics: North Carolina Live Birth Data. Accessed via North Carolina Early Childhood Foundation.

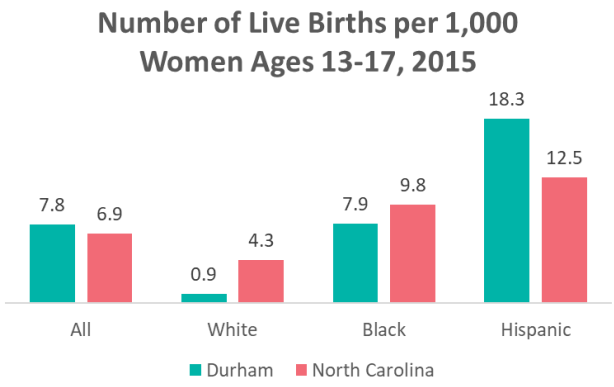
Babies born in Durham are less likely to be born at low birth weight (8.8 percent) than the statewide average (9.2 percent). However, there are significant racial disparities. 12.3 percent of Black babies are born at low birth weight, while only 6.5 percent of white babies are.

National research has shown that babies born to Black mothers – regardless of the mother's socio-economic status and education status – are more likely to be born at low birth weight.[6] One contributing factor is that impacts of systemic racism contribute to a higher allostatic load for families of color, especially Black families. This is known as toxic stress or weathering, and can put women at higher risk for worse pregnancy outcomes.[7]

[5] "Measures of Success Data for Supporting Regional Coordination and Collaboration by Leveraging ESSA North Carolina State Consultant Meeting." Pathways to Grade Level Reading. North Carolina Early Childhood Foundation, February 2020.
[6] Reeves, Richard and Matthew, Dayna Bowen. "6 Charts Showing Race Gaps Within the American Middle Class." Brookings. October 2016.
[7] Geronimus, A.T. "The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations." Ethn Dis. 1992 Summer;2(3):207-21. PMID: 1467758.

SUB-TARGET 3: *Increase the percent of mothers indicating that their pregnancy was intended.*

The ECAP measures this using the Pregnancy Risk Assessment Monitoring System (PRAMS), but the sample size is too small to report at the County Level.



While not all teenage pregnancies are unintended, the vast majority (82 percent) are unplanned.[8] In Durham County, 10.3 out of 1,000 teen girls ages 15-17 give birth.[9] Teen pregnancy rates differ dramatically by race and ethnicity.

Source: "State of Durham County's Young Children." Duke Center for Child and Family Policy and Durham County, 2017.

SUB-TARGET 4: *Increase the percent of women ages 18-44 years with preventive health visit in the last year.*

The ECAP measures this using the Behavioral Risk Factor Surveillance System (BRFSS), but the sample size is too small to report at the County Level.

While not the exact ECAP measure, the following data are tracked at the county level. However, they are focused on prenatal care, not all preventive health visits for women.

- 71.3 percent of pregnant women received early prenatal care in 2018[10]
- 6.7 percent of births with very late or no prenatal care in 2018[11]
- There are racial disparities in prenatal care in the first trimester. As of 2015, 77 percent of white women in Durham received prenatal care in their first trimester, while 62 percent and 59 percent of Black and Hispanic received early care, respectively.[12]

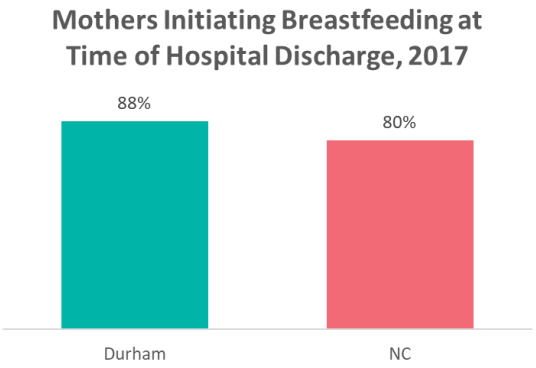
[8] "Unintended Pregnancy Among Young People in the United States: Dismantling Structural Barriers to Prevention." Advocates for Youth, November 2011.
[9] "Durham County: 2020 NC Data Card." NC Child, NC Pathways to Grade-Level Reading whole-child Measure of Success. March 2020.
[10] "Durham County: 2020 NC Data Card." NC Child, NC Pathways to Grade-Level Reading whole-child Measure of Success. March 2020.
[11] "Percent of Births with Very Late or No Prenatal Care." Kids Count Data Center. The Annie E. Casey Foundation, 2018.
[12] "State of Durham County's Young Children." Duke Center for Child and Family Policy and Durham County, 2017.

SUB-TARGET 5: ***Increase the percent of infants breasted: Ever breastfed; Breastfed at 6 months-old.***

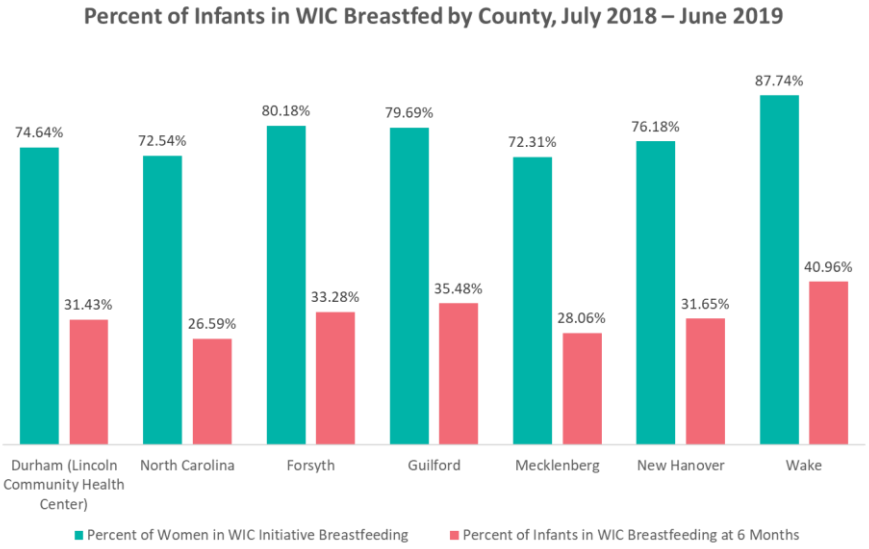
The American Academy of Pediatrics recommends that infants be exclusively breastfed for the first six months of a baby's life due to the health benefits the mother and the baby.[13]

The ECAP measures this using the National Immunization Survey, but the sample size is too small to report at the County Level.

There are, however, several other data sources reporting on breastfeeding data in Durham County. According to the State of Durham County's Young Children report released in 2017, Durham's breastfeeding initiation rate (88 percent) is higher than the state (80 percent).[14]



Source: "State of Durham County's Young Children." Duke Center for Child and Family Policy and Durham County, 2017.



The only longitudinal breastfeeding data available at 6 months at the county-level is for women receiving WIC. Historically, WIC participants are more likely to experience barriers to breastfeeding than non-WIC participants, and therefore typically have lower breastfeeding rates than the population of new mothers at large.

Source for Initiating Breastfeeding: "FY21 Agreement Addenda Section III: WIC Deliverable #3A: Breastfeeding Promotion and Support—Breastfeeding Initiation." North Carolina Department of Health and Human Services (NCDHHS), Division of Public Health (DPH), Women, Infants and Children (WIC).

Source for Breastfeeding at 6 Months: "FY21 Agreement Addenda Section III: WIC Deliverable #3C: Breastfeeding Promotion and Support—Breastfeeding Duration at 6 Months." North Carolina Department of Health and Human Services (NCDHHS), Division of Public Health (DPH), Women, Infants and Children (WIC).

The other source of longitudinal data is through Family Connects home visits post-partum. Since January 2020, at the time of the Family Connects home visit, 63 percent of mothers were exclusively

[13] Eidelman AI, Schanler RJ, Johnston M, et al. "Breastfeeding and the use of human milk." Pediatrics. 2012;129(3):827-841.
[14] "State of Durham County's Young Children." Duke Center for Child and Family Policy and Durham County, 2017.

breastfeeding, 9 percent were feeding with formula only, and 23 percent were feeding with a combination of breastmilk and formula.[15]

SUB-TARGET 6: *Decrease the percent of families living at or below 200% of the federal poverty level.*

It is very clear that a household's income has a direct impact on so many of the other targets that the ECAP measures. It is often lifted up of one of the root causes of various health and educational outcomes. The Durham county data report did not provide this information at the county-level, however there are similar data points from other sources:

- 46 percent of Durham County's young children aged 0-6 live below 200 percent of the federal poverty level.[16]
- More than a quarter of Durham's young children (26 percent) live in a home where the head of household's income is at or below poverty level.[17]
- Poverty rates have stark racial disparities: 37 percent of young children aged 0-8 who are Black and 36 percent who are Hispanic live in homes at or below poverty level; whereas only 8 percent of young white children in Durham live in poverty.[18]

[15] Family Connects. Duke Center for Child and Family Policy. Data Request for Durham Early Childhood Action Plan Needs and Assets Assessment, October 2020.
[16] "Measures of Success Data for Supporting Regional Coordination and Collaboration by Leveraging ESSA North Carolina State Consultant Meeting." Pathways to Grade Level Reading. North Carolina Early Childhood Foundation, February 2020.
[17] "State of Durham County's Young Children." Duke Center for Child and Family Policy and Durham County, 2017.
[18] "State of Durham County's Young Children." Duke Center for Child and Family Policy and Durham County, 2017.

Detailed Data Review

GOAL 1 | **GOAL 2**

Goal 2: Preventive Health Services

COMMITMENT: Babies, toddlers, young children, and their families will have regular, ongoing access to high-quality health services.

2025 TARGET: By 2025, increase the percentage of North Carolina's young children enrolled in Medicaid and Health Choice who receive regular well-child visits as part of a healthcare delivery process that provides comprehensive, patient-centered, accessible, quality care as recommended for certain age groups, according to data provided through NC Medicaid and HEDIS measures.[18]

- For children ages 0-15 months, increase from 63.9% to 68.7%.
- For children ages 3-6 years, increase from 69.8% to 78.5%.

SUB-TARGETS:

For more details, visit the interactive NC Early Childhood Action Plan Data Dashboard

1. **Percent of individuals with health insurance**
   - **Children aged 0-8 years**
   - **Heads of household with young children**

   DATA SOURCE: American Community Survey (ACS), U.S. Census Bureau

   TREND BY 2025: Increasing

2. **Percent of 19–35-month-old children who are up-to-date on immunizations**
   - **Combination 6: 4 or more doses of DTaP, 3 or more doses of Polio, 1 or more doses of MMR, Hib full series (3 or 4 doses, depending on product type received), 3 or more doses of HepB, and 1 or more doses of Varicella**
   - **Combination 7: 4 or more doses of DTaP, 3 or more doses of Polio, 1 or more doses of MMR, Hib full series (3 or 4 doses, depending on product type received), 3 or more doses of HepB, 1 or more doses of Varicella, and 4 or more doses of PCV**

   DATA SOURCE: National Immunization Survey

   TREND BY 2025: Increasing

3. **Percent of children enrolled in Medicaid or Health Choice aged 0-9 who had at least one dental service during the year:**
   - **Age <1 year**
   - **Ages 1-2 years**
   - **Ages 3-5 years**
   - **Ages 6-9 years**

   DATA SOURCE: Dental Quality Alliance Utilization of Services Measures, NC Medicaid

   TREND BY 2025: Increasing

4. **Percent of children receiving 4 or more varnishings by 42 months of age**

   DATA SOURCE: NC Medicaid

   TREND BY 2025: Increasing

5. **Percent of children ages 1 and 2 years receiving lead screening**

   DATA SOURCE: NCLEAD Surveillance System, Children's Environmental Health, Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS)

   TREND BY 2025: Increasing

6. **Percent of families living at or below 200% of the federal poverty level**

   DATA SOURCE: American Community Survey (ACS), U.S. Census Bureau

   TREND BY 2025: Decreasing

DATA AVAILABILITY

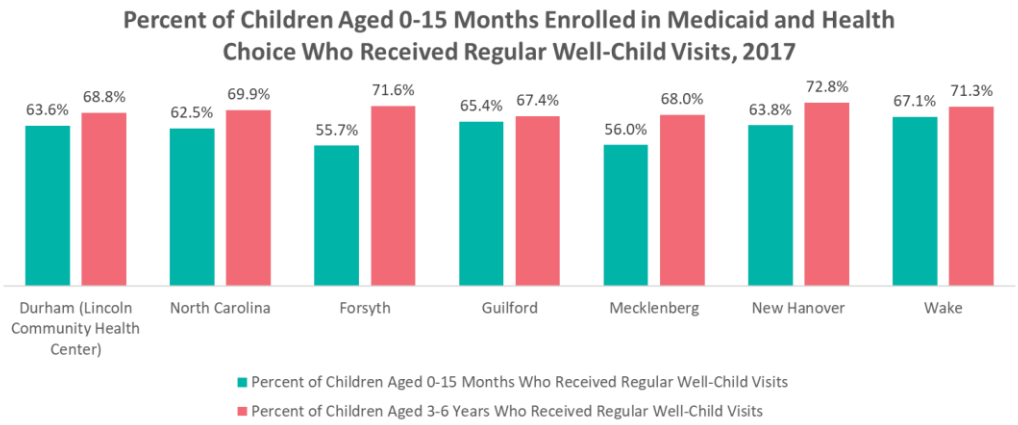
		Can this sub-target be reported at the County Level with the ECAP data source?	Does the ECAP County Data Report Provide County-Level Data?	Can we get this data at the County-Level?
2025 Target	Regular Well-Child Visits	Yes	Yes	Yes
Sub-Target 1	Health Insurance	Yes	No	Similar Metrics
Sub-Target 2	Up-To-Date on Immunizations	No	No	No
Sub-Target 3	Annual Dental Services	Yes	No	*Would require a Medicaid request*
Sub-Target 4	Dental Varnishings	Yes	No	*Would require a Medicaid request*
Sub-Target 5	Lead Screening	Yes	Yes	Yes
Sub-Target 6	Poverty	Yes	No	Similar Metrics

DATA REVIEW: HOW ARE WE DOING AS A COUNTY ON THE TARGETS AND SUB-TARGETS FOR GOAL 2?

2025 TARGET: ***Increase the percentage of North Carolina's young children enrolled in Medicaid and Health Choice who receive regular well-child visits: For children ages 0-16 months, increase from 63.9% to 68.7%; For children ages 3-6 years, increase from 69.8% to 78.5%.***

Timely health check-ups are essential to support the optimal health and well-being of babies and young children in Durham. During well-child visits, healthcare professionals provide preventive care, such as immunizations, lead screenings, and other developmental and social-emotional screenings, to identify health concerns as early as possible. Parents also have a chance to talk through their concerns, get information, guidance and advice about their child's health and development, and get connected to the right services for their child.[19]

[19] "North Carolina Early Childhood Action Plan." NCDHHS, February 2019.



Source: NC Medicaid, Healthcare Effectiveness Data and Information Set (HEDIS). Early Childhood Action Plan Durham County Data Report, 2019.

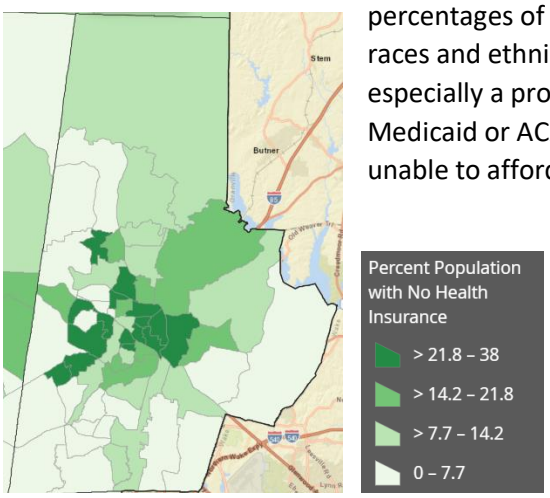
Durham is on par with the state and other counties on this sub-target.

SUB-TARGET 1: *Increase the percent of individuals with health insurance: Children aged 0-8 years; Heads of household with young children.*

The data to report on this sub-target was not included in the Durham County Data Report, however we have a several similar metrics at the county level.

According to the 2019 American Community Survey 1-Year Estimates, 94.57 percent of children under age 6 in Durham County have health insurance.[20]

However, about 15.1% of the adult population in Durham aged 18-64 years lack health insurance.[21] About 1 in 4 are parents.[22] This map identifies the census tracts that are hot spots where larger percentages of the community lack health insurance. While people of all races and ethnicities are affected by lack of access to insurance, this is especially a problem for undocumented adults, who do not qualify for Medicaid or ACA insurance and are more likely to be low-income and unable to afford to purchase private insurance.[23]



Source: NC State Center for Health Statistics, North Carolina Social Determinants of Health by Regions.

[20] "Health Insurance Coverage Status by Sex by Age." United States Census Bureau. 2019: American Community Survey 1-Year Estimates Detailed Tables. TableID: B27001.
[21] "Uninsured Population by Age Group in North Carolina." Kids Count Data Center. The Annie E. Casey Foundation, 2018.
[22] "Durham County: 2020 NC Data Card." NC Child, NC Pathways to Grade-Level Reading whole-child Measure of Success. March 2020.
[23] Artiga, Samantha and Diaz, Maria. "Health Coverage and Care of Undocumented Immigrants." Kaiser Family Foundation. July 2019.

SUB-TARGET 2: *Increase the percent of 19-35-month-old children who are up-to-date on immunizations: Combination 6; Combination 7.*

The ECAP measures this using the National Immunization Survey, but the sample size is too small to report at the County Level. There has also been concern that immunization rates have dropped because of the pandemic and the perceived risk of virus transmission at doctors' offices. [24]

SUB-TARGET 3: *Percent of children enrolled in Medicaid or Health Choice aged 0-9 who had at least one dental service during the year: Age <1 year, Ages 1-2 years, Ages 3-5 years, Ages 6-9 years.*

The data to report on this sub-target was not included in the Durham County Data Report.

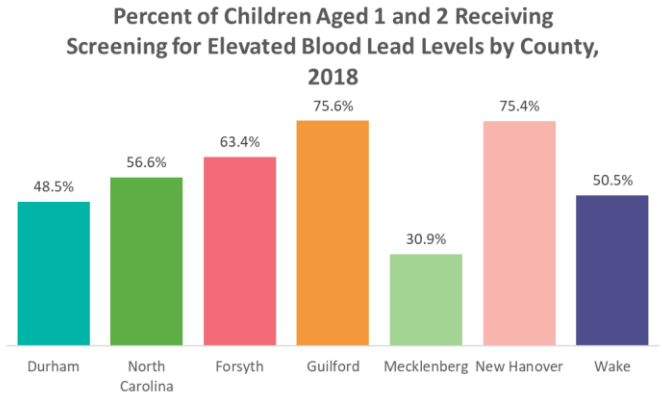
As of 2015-16, 21 percent of children had untreated tooth decay.[25] Untreated dental problems can lead to secondary physical illness, delay overall development, compromise school attendance and performance, and interfere with psycho-social functioning.[26]

SUB-TARGET 4: *Increase the percent of children receiving 4 or more varnishings by 42 months of age.*

The data to report on this sub-target was not included in the Durham County Data Report.

SUB-TARGET 5: *Increase the percent of children ages 1 and 2 years receiving lead screening.*

Lead poisoning is a major environmental health concern and we have an opportunity to ensure children grow up in homes free from lead exposure. Children ages six and younger are more vulnerable to lead exposure as their nervous system is still developing, their bodies absorb four to five times as much ingested lead as adults from a given source, and they are more likely to expose themselves by putting their hands and other objects in their mouths.[27]



Lead poisoning disproportionately impacts children of color and children from low-income families who are more likely to live in substandard housing and polluted communities with higher risk of lead exposure.[28] Children should be screened at ages 1 and 2 at their well-child visit or the first time they enter the healthcare system.

Source: NCLEAD Surveillance System, NC Childhood Blood Lead Surveillance System,

[24] Bramer et al. "Decline in Child Vaccination Coverage During the COVID-19 Pandemic." Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report, 69(20): 630-31. May 2020.
[25] "Measures of Success Data for Supporting Regional Coordination and Collaboration by Leveraging ESSA North Carolina State Consultant Meeting." Pathways to Grade Level Reading. North Carolina Early Childhood Foundation, February 2020.
[26] "Measures of Success Data for Supporting Regional Coordination and Collaboration by Leveraging ESSA North Carolina State Consultant Meeting." Pathways to Grade Level Reading. North Carolina Early Childhood Foundation, February 2020.
[27] "Preventing Lead Poisoning in Young Children: Chapter 2." Centers for Disease Control and Prevention. Accessed October 2020.
[28] "Learn about Lead." United States Environmental Protection Agency. Accessed October 2020.

Children's Environmental Health, Division of Public Health (DPH), NC Department of Health and Human Services (NCDHHS). 2018.

SUB-TARGET 6: *Decrease the percent of families living at or below 200% of the federal poverty level.*

It is very clear that a household's income has a direct impact on so many of the other targets that the ECAP measures. It is often lifted up of one of the root causes of various health and educational outcomes. The Durham county data report did not provide this information at the county-level, however there are similar data points from other sources:

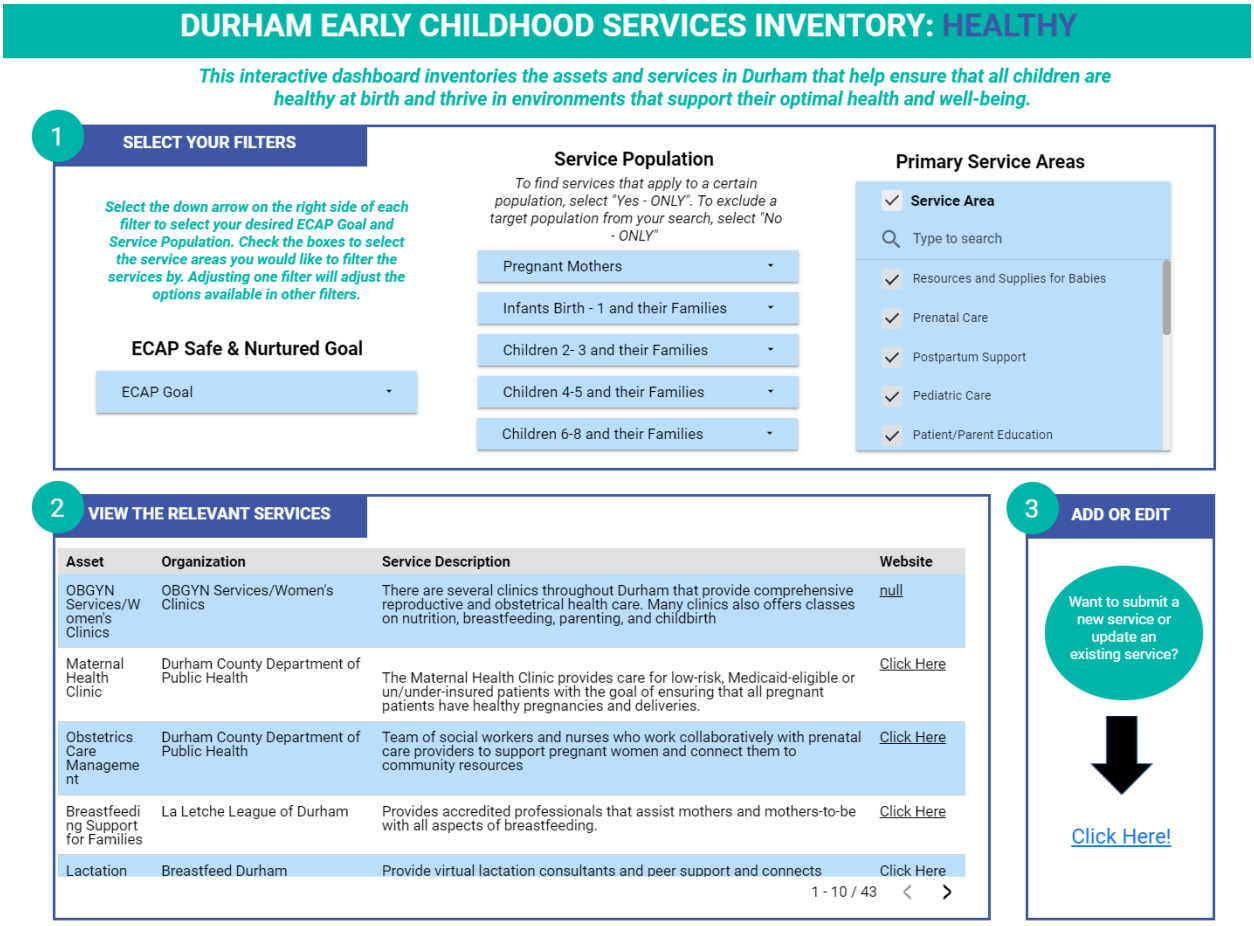
- 46 percent of Durham County's young children aged 0-6 live below 200 percent of the federal poverty level.[29]
- More than a quarter of Durham's young children (26 percent) live in a home where the head of household's income is at or below poverty level.[30]
- Poverty rates have stark racial disparities: 37 percent of young children aged 0-8 who are Black and 36 percent who are Hispanic live in homes at or below poverty level; whereas only 8 percent of young white children in Durham live in poverty.[31]

[29] "Measures of Success Data for Supporting Regional Coordination and Collaboration by Leveraging ESSA North Carolina State Consultant Meeting." Pathways to Grade Level Reading. North Carolina Early Childhood Foundation, February 2020.
[30] "State of Durham County's Young Children." Duke Center for Child and Family Policy and Durham County, 2017.
[31] "State of Durham County's Young Children." Duke Center for Child and Family Policy and Durham County, 2017.

Durham Early Childhood Services and Assets

WHAT SERVICES AND ASSETS ARE ALREADY AVAILABLE IN DURHAM COUNTY TO MEET THE ECAP GOALS?

Visit the early childhood services inventory to explore services in Durham helping to ensure children in Durham are healthy at birth and thrive in environments that support their optimal health and well-being.



The ECAP Healthy has representatives from the following taskforces which are also working to ensure children in Durham grow up healthy. The workgroup should consider how these groups might play a role in setting targets and strategies.

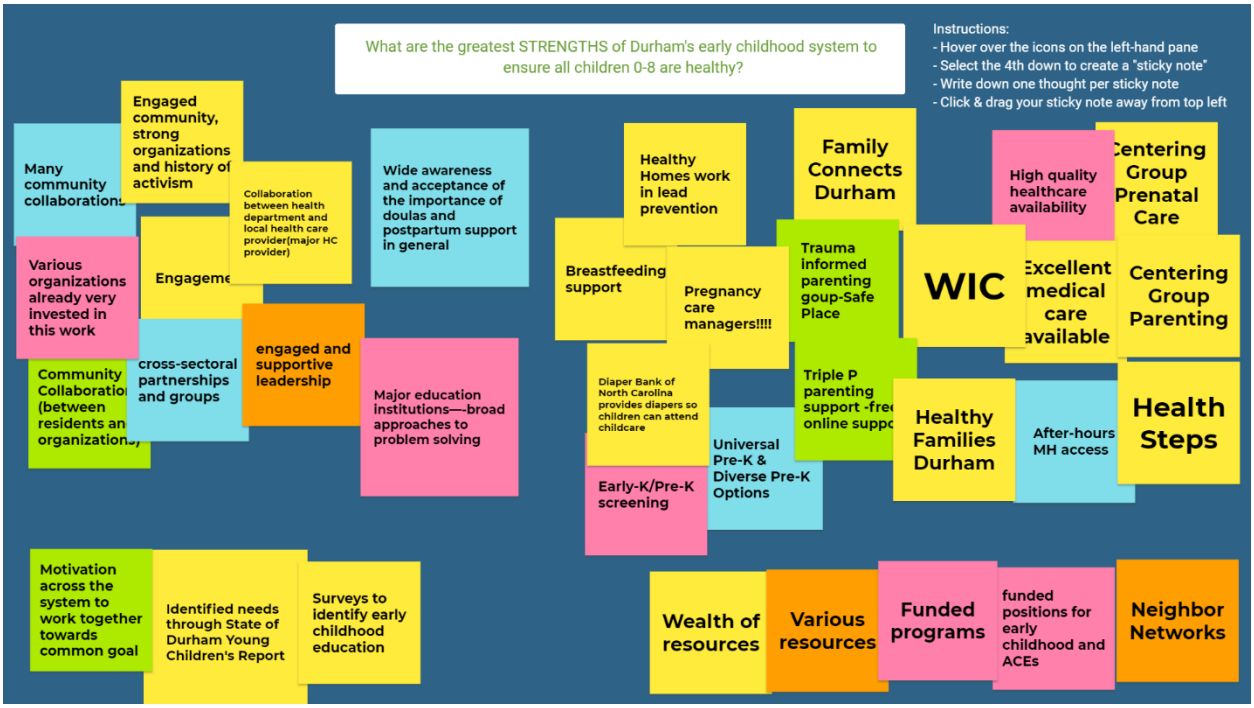
Taskforce	Mission	Goals
Born in Durham Healthy for Life (BIDHFL)	Reduce perinatal health inequities in Durham.	• Support Durham's Community Health Assessment Goals • Reduce Perinatal Health Inequities • Support the NC Perinatal Health Strategic Plan • Organize Durham's Communities around Perinatal Health • Be an inclusive organization focused on perinatal health
ICO4MCH	Implement evidence-based strategies that are proven to lower infant mortality rates, improve birth outcomes and improve the overall health status of children ages birth to five.	• **Improve birth outcomes:** Teach people about the different types of birth control methods and work to help make sure everyone is able to get the type of birth control and family planning services that they want when they want them. • **Reduce infant mortality:** Help people quit smoking and using tobacco products. • **Improve the health status of children ages 0-5 in Durham:** Partner with Durham Connects, now Family Connects.
Partnership for a Healthy Durham	The Partnership for a Healthy Durham is a coalition of local organizations and community members with the goal of collaboratively improving the physical, mental, and social health and well-being of Durham's residents.	• **Improve access to care**: Increate uninsured and underinsured residents' awareness about affordable healthcare options and resources; increase number of patient navigators; facilitate racial equity training opportunities for patient care teams in Durham County; normalize/destigmatize HIV prevention and treatment. • **Communications:** Coordinate community resources; survey the community and providers about communication preferences; partner with Alliance to relaunch the Network of Care resource website. • **Obesity, Diabetes, and Food Access**: Increase access to healthy foods, increase physical activity, and coordinate chronic disease education resources in Durham County.
Latino Health Roundtable	The Latino Health Roundtable is an inter-agency collaborative effort to improve in the Hispanic/Latino community in Durham County, North Carolina.	

Triangle Black Maternal Wellness Council	Address racial disparities in maternal health by elevating the expertise and scaling the innovative solutions of those closest to the issue - Black birthing people, parents, and birth workers.	• Highlight the work of those who are tackling maternal and infant health issues head on • Spearhead innovative, community-sourced and evidence-based solutions to make the Triangle a place where Black families will thrive
NC InCK	The North Carolina Integrated Care for Kids Model (NC InCK) is designed to build and support the infrastructure needed to integrate health and human services for Medicaid and CHIP-enrolled beneficiaries.	• **More holistically assess the needs of children:** Integrate data on health, social and guardian needs; assign a "need" level to each child based on these factors; update level over time as need changes • **Coordinate services across sectors for kids with high needs:** Assign a service integration consultant to facilitate cross-sector coordination; develop a cross-sector shared action plan; identify a single point of contact for each child • **Design new ways to paying for care and outcomes:** Develop alternative payment models that focus on improving child health and reducing costs of care; link payments to more meaningful measures of children's health and social outcomes

Summary of Strengths and Weaknesses

WHAT ARE THE STRENGTHS AND WEAKNESSES OF DURHAM COUNTY'S EARLY CHILDHOOD SYSTEM TO MEET THE ECAP GOALS?

STRENGTHS of Durham's early childhood system to ensure all children 0-8 are healthy	WEAKNESSES of Durham's early childhood system to ensure all children 0-8 are healthy
• Community activism, engagement and networks of support • Engaged and supportive leadership • Good sense of the needs • High-quality healthcare • Strength of academic institutions • Strong cross-agency collaboration • Strong early childhood education and screening • Strong organizations and services • Support of doulas and post-partum networks of support • Well-resourced	• Adverse Childhood Experiences • Culturally incompetent care, racial bias in service delivery, dismissive of concerns of BIPOC birthing people • Difficult to navigate services • Issues with access to healthcare due to immigration status • Lack of BIPOC leaders and service providers • Lack of coordination and communication between services • Lack of mental healthcare • Lack of transportation to reach services • Language barriers • Not enough focus on the systems that cause inequities • Persistent racial disparities in health outcomes • Unaffordable healthcare / access to insurance • Understaffed and under-resourced • Undervalued community assets and lack of intentional community engagement


What are the greatest STRENGTHS of Durham's early childhood system to ensure all children 0-8 are healthy?
Instructions:
- Hover over the icons on the left-hand pane
- Select the 4th down to create a "sticky note"
- Write down one thought per sticky note
- Click & drag your sticky note away from top left
Many community collaboration
Engaged community, strong organizations and history of activism
Collaboration between health department and local health care provider(major HC provider)
Wide awareness and acceptance of the importance of doulas and postpartum support in general
Various organizations already very invested in this work
Engageme
Community Collaborati (between residents an organization
cross-sectoral partnerships and groups
engaged and supportive leadership
Major education institutions—broad approaches to problem solving
Healthy Homes work in lead prevention
Family Connects Durham
High quality healthcare availability
Centering Group Prenatal Care
Breastfeeding support
Pregnancy care managers!!!!
Trauma informed parenting goup-Safe Place
WIC
Excellent medical care available
Centering Group Parenting
Diaper Bank of North Carolina provides diapers so children can attend childcare
Triple P parenting support -free online suppo
Healthy Families Durham
After-hours MH access
Health Steps
Universal Pre-K & Diverse Pre-K Options
Early-K/Pre-K screening
Motivation across the system to work together towards common goal
Identified needs through State of Durham Young Children's Report
Surveys to identify early childhood education
Wealth of resources
Various resources
Funded programs
funded positions for early childhood and ACEs
Neighbor Networks


Instructions:
Mental Health barriers and lack of services to assist that concern.
providers & case managers overworked
could do more to value help/suggestions from the community
Lack of intentional community engagement and outreach
Communication problems
Lack of continuity and coordination across service types
Cost of/access to health insurance
Accessibility
The cost of living and lack of housing that is affordable for all
Access to basic needs
Too many barriers for people to access basic needs.
lack of awareness about what exists
not centering the voices of those most affect
Little to no support for BIPOC organizations doing work within their own communi
Addressing concerns before pregnancy and during.
gaps in eligibility
Lack of manpower
Culturally competer care
Understanding the cultural differences of the families we serve
The difficulty of navigating the system
Food insecurities
Families need access to diapers so children can attend childcare. Without from home, many children cannot go to daycare.
Lack of flexibility within a system.
Lack of funding
Overlapping services and requirements
Education
transportation barriers
The demand/need for services and resources far outweighs the availability
Difficulty in navigating services
lack of awareness
Existing systems do not work.
lack of peer support/navigators
Difficult to navigate
Misunderstanding of what services are providing
Transportation
Disparities
Communi violence (traumatic impact)
Qualitative research within diverse communities
Coordination
implicit bias
Limitations based on immigration status
language barriers
Deep disparities in health outcomes in African American and Latinx communities
Not much progress (YET) on addressing racial disparities in maternal and infant mortality
adverse and traumatic experiences with healthcare systems and providers
Too much blame on parents, and not enough blame on the system for creating these inequalities.
need more providers and decision makers that reflect the population served
discomfort accessing resources due to immigration status
Language barriers