SUPPORTING WHOLE CHILD HEALTH IN NC: Priority behavioral health initiatives

Charlene Wong, MD MSHP
Assistant Secretary for Children and Families
NC Psychiatric Association Annual Meeting
October 1, 2022

We need to offer services further upstream to build resiliency, invest in coordinated systems of care that make mental health services easy to access, where and when they are needed and to reduce the stigma around accessing these services.

We will work to ensure that North Carolina’s children grow up safe, healthy and thriving in nurturing and resilient families and communities. Investing in families and children’s healthy development builds more resilient, better educational outcomes and, in the long term, a stronger society.

We will work to strengthen the workforce that supports early learning, health and wellness by delivering services to North Carolina. And we will take action to be an equitable workplace that lives its values and ensure that all people have the opportunity to be fully included members of their communities.

These priorities and our work across the department are grounded in whole-person health, driven by equity, and responsive to the lessons learned responding to the greatest health crisis in more than a generation.
Child & Family Well-Being

ALL CHILDREN HAVE THE OPPORTUNITY TO DEVELOP TO THEIR FULL POTENTIAL AND THRIVE

- Recovering stronger from COVID-19
- Focusing on the whole child and the whole family
- Encouraging needed and comprehensive investments in children and families

Child & Family Well-Being

Child behavioral health
Bring together programs and data to support children’s behavioral health needs in their communities

Child welfare
Strengthen the services and supports available across NC for our most vulnerable children and families

Nutritional insecurity for children & families
Increase access to heathy, nutritious food through innovative strategies

Maternal & infant health
Equitably improve women’s health and birth outcomes
AGENDA

Children's Behavioral Health by the Numbers: COVID's impact in the US and in NC

A New Division that Supports Whole Child Health in North Carolina: Division of Child & Family Well-Being

Priority Child Behavioral Health Initiatives
1. School behavioral health to meet children where they are and support our educators
2. Child behavioral health data dashboard to increase accountability and promote equitable access

A Pilot Model for Medicaid-insured Children: NC Integrated Care for Kids

CRUCIAL FACTORS AND ELEMENTS THAT IMPACT YOUTH BEHAVIORAL HEALTH

FIGURE 1

Factors that can shape the mental health of young people

Social and economic inequalities, discrimination, racism, migration, media and technology, popular culture, government policies

Neighborhood safety, access to green spaces, healthy food, housing, health care, pollution, natural disasters, climate change

Relationships with peers, teachers, and mentors; faith community; school climate, academic pressure, community support

Relationships with parents, caregivers, and siblings: family mental health, financial stability, domestic violence, trauma

Age, genetics, race, ethnicity, gender, sexual orientation, disability, beliefs, knowledge, attitudes, coping skills

### THE PANDEMIC INCREASED THE STRESS FELT BY FAMILIES

- **1/3** of adults with children are struggling to pay their usual expenses like food, rent, health care and transportation.
- **1/5** of renters living with children reported that they are not caught up on rent.
- **1/8** of adults living with children report their household does not have enough food to eat.

Black and brown families and women disproportionately feel the strain of the pandemic.

Financial hardship has long-term consequences for the healthy development of children.

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**The Pandemic Increased the Stress Felt by Families**

- **Work disruption**
  - Lack of high-quality, affordable child care can make it difficult for parents—especially single mothers—to work.
  - **7.6 million** adults had someone in their household who took paid or unpaid leave, left their job, lost their job or did not look for a job in the last month because of disrupted child care arrangements.

- **Lack of access to paid leave**
  - The majority of **low-wage workers** have **no paid sick leave or paid family and medical leave.**

[69%](#) **No access to paid sick leave**
[95%](#) **No access to paid family and medical leave**

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MORE CHILDREN EXPERIENCED WORSENING MENTAL HEALTH DURING COVID

Share of Parents Reporting Worsening Mental Health For Their Children Ages 5-12, October-November 2020

Overall Worsening of Mental or Emotional Health

- Overall Worsening: 22.1%
- Elevated Symptoms of Depression: 4.4%
- Elevated Symptoms of Anxiety: 6.3%
- Elevated Symptoms of Psychological Stress: 9.2%


THE COVID-19 PANDEMIC WORSEned AN ALREADY GROWING CHALLENGE FOR YOUTH

National Trends

- 37% Experienced poor mental health during COVID-19
- 44% Experienced persistent feelings of sadness or hopelessness during the past 12 months

Females & LGBTQ+ youth experienced worse mental health threats during COVID-19

North Carolina Trends

- ~3,600+ NC children have lost a parent/caregiver to COVID-19
- 46% ↑ in youth with 1+ major depressive episode during pandemic (2020-21)
- Rate of children discharged from emergency departments with a behavioral health condition increased by ~70% during the pandemic

IMPACT OF COVID-19 ON ADOLESCENT BEHAVIORAL HEALTH: A SYSTEMATIC REVIEW

- 16 quantitative studies conducted in 2019-2021 with 40,076 participants.
- Globally, adolescents of varying backgrounds experience higher rates of anxiety, depression and stress due to the pandemic.
- Adolescents also have had a higher frequency of using alcohol and cannabis during COVID-19.

**HOWEVER ...**
- Social support
- Positive coping skills
- Home quarantining
- Parent-child discussions

Seem to positively impact adolescent mental health during this crisis period

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SUICIDE ATTEMPTS AMONG ADOLESCENTS ARE RISING

- In 2020, the proportion of mental health-related emergency department (ED) visits among adolescents aged 12-17 years increased 31% compared to 2019.
- In May 2020, ED visits for suspected suicide attempts began to increase among adolescents aged 12-17.
- From February 21 to March 20, 2021, ED visits for suspected suicide attempt increased among both girls and boys aged 12-17, with the increase among girls substantially higher.

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NC DATA ON YOUTH SUICIDE FROM THE CHILD FATALITY TASK FORCE

- The suicide rate for 2020 was the highest in more than a decade
- Suicide was the leading cause of death for youth ages 10 to 14 years of age and third leading cause of death for teens ages 15 to 17 years
- There were 56 youth suicides in NC with firearms being the lethal means used in 31 of those deaths
- There were almost 550 hospitalizations and over 2700 emergency room visits for self-inflicted injury among youth ages 10 to 17 years

MANY CHILDREN WITH A MENTAL HEALTH DIAGNOSIS ARE NOT RECEIVING CARE

Figure. Prevalence of Mental Health Disorders and Mental Health Care Use Among US Youth

YOUTH ACCESS TO MENTAL HEALTH CARE RANKINGS

2018

2022


Mental Health America – Ranking the States (2022): https://mhanational.org/issues/2022/ranking-states

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FAR TOO FEW CHILD AND ADOLESCENT PSYCHIATRISTS IN NORTH CAROLINA

• 1 in 6 children in NC have a behavioral health disorder and numbers are increasing
• Lack of access to care means clinicians serving youth are inordinately tasked with supporting children with behavioral health concerns
  • 61/100 counties have 0 child and adolescent psychiatrists (CAPs)
  • 288 CAPs in all of NC
• 6,000 clinicians prescribed psychotropic medications to children in NC with Medicaid coverage
  • Very few prescribing clinicians have adequate mental health training.

Health Professional Shortage Areas: Primary Care, by County, 2022 - North Carolina

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CHILDREN’S BEHAVIORAL HEALTH ISSUES AND CARE ARE COSTLY

- Children with mental health conditions or emotional problems are more likely to:
  - Use special education services
  - Repeat grades
  - Perform poorly on standardized tests
  ... and are less likely to complete secondary education
  (Currie & Stabile, 2006; Fletcher & Wolfe, 2008)

- Untreated mental health problems can also result in:
  - Lower grades
  - Substance use
  - Other risky behaviors (Busch, Golberstein, & Meara, 2014)

- Poor health and economic outcomes in adulthood are correlated with childhood onset of mental health disorders (Currie, 2009)

- Poor mental health in childhood tends to lead to worse overall consequences than those stemming from other childhood health problems (Case, Fertig, and Paxson 2005)

$247B
Estimated annual cost of child and adolescent mental health disorders
based primarily on the direct costs to individuals/families.

OTHER COSTS:
Linkage to ...
- Delinquent behavior (Busch et al., 2014)
- Poorer academic outcomes for classmates (Aizer, 2008)
- Addiction and crime in adulthood
  (Currie & Stabile, 2009; Fergusson, Horwood, & Riddler, 2007)


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BUILDING ON THE DEPARTMENT’S VISION FOR CHILDREN & FAMILIES

Children are healthy and thrive in safe, stable and nurturing families, schools and communities

NC Department of Health and Human Services

Click to add text

BUILDING A STRONGER, MORE INTEGRATED NCDHHS
**STRATEGIC GOAL – IMPROVE CHILD AND FAMILY WELL-BEING**

**Key Objective:** Build a strong infrastructure to increase access to child and family well-being services.

**Key Strategies:**
- Establish a Division of Child and Family Well-Being to maximize services and outcomes for children and their families, including all child nutrition programs, prevention services for children from birth to 21, children’s mental health services, and early intervention programs.
- Build a data and analysis infrastructure across child-serving sectors to identify gaps and inequities in service provision and well-being outcomes to ensure the most effective deployment of federal, state, and local resources.
- Increase access to children’s mental health services by expanding mental health services in primary care, schools, and specialty care.

**WHY?**

The Division of Child and Family Well-Being will prioritize the coordination of behavioral health, physical health, social, and nutrition programs to support whole-person care to meet the escalating needs of children and families. Strategies include:

- **Enhancing how children and families access programs that support their well-being:** Coordination across programs serving children and families allows more families to access programs across mental, social, and health services. An early area of work will be making it easier for families to enroll in the nutrition programs in the Division (e.g., WIC and FNS/SNAP).

- **Coordinating increased investments to improve child health and well-being:** The investments will be informed by data with a focus on closing equity gaps in child well-being. An early focus will be maximizing the impact of the federal American Rescue Plan funds to address inequities in child well-being, including increasing access to youth mental health services.

- **Getting upstream of the behavioral health crisis:** DCFW is part of DHHS’s collective commitment to building innovative, coordinated, and whole-person centered systems that recognize that physical, behavioral, and social health are interdependent and that preventing the onset of health issues is the best way to support children thriving.
PROGRAMS IN THE DIVISION OF CHILD AND FAMILY WELL-BEING

**Food and Nutrition Services:** North Carolina’s Supplemental Nutrition Assistance Program (SNAP)

**Community Nutrition Services:** North Carolina’s Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Child & Adult Care Food Program (CACFP)

**Early Intervention:** North Carolina Early Intervention/Infant-Toddler Program (ITP) provides supports and services to children birth to 3 with developmental delays or established conditions

**Whole Child Health:**
- **Child Behavioral Health** programs support school & community mental health services for children and youth, such as system of care, children with complex needs, coordination with schools on mental health services, pediatric mental health care access program, and behavioral health supports and coordination for DSS-involved youth
- **Children and Youth** health and prevention services, such as school health promotion, home visiting and Triple P programs, nurse consultation, supports for children and youth with special health care needs, genetics and newborn screening, care management for at-risk children, and more

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FEELING CLOSE TO PEOPLE AT SCHOOL PROVIDES CRITICAL PROTECTION FOR STUDENTS

<table>
<thead>
<tr>
<th>Students who felt close to people at school</th>
<th>Students who didn’t feel close to people at school</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced persistent feelings of sadness or hopelessness during the past 12 months</td>
<td>35%</td>
</tr>
<tr>
<td>Seriously considered attempting suicide during the past year</td>
<td>14%</td>
</tr>
<tr>
<td>Attempted suicide during the past year</td>
<td>6%</td>
</tr>
</tbody>
</table>

For more information, visit cdc.gov/nchstp/newsroom

LEVERAGING COVID FLEXIBILITIES TO OFFER BEHAVIORAL HEALTH SUPPORTS IN SCHOOLS

North Carolina public schools can opt-in to new funding opportunities to support school-based mental and behavioral health initiatives at no cost to K-12 schools through the CDC’s Reopening Schools grant. Schools must be participating in our COVID testing program to be eligible for these behavioral health supports.

- **Funding to support School Health Advisory Councils** that are based at the school district level. SHACs can choose activities that will benefit their local district that align with the WSCC model, including partnerships that support behavioral health services and professional development.

- **The North Carolina Psychiatric Access Line (NC-PAL)** provides telephonic consultation and education programs on child behavioral health. Selected schools will receive behavioral health educational consultation and training for school staff.

- **System of Care (SOC) Training** for schools will cover how to work with local behavioral health partners to engage families, transition plan for students, and be effective in the changing NC Medicaid landscape as we transition to Medicaid Managed Care.
NC Department of Health and Human Services is receiving $5 million of GEER funds to expand Youth Mental Health First Aid (MHFA) training.

Youth MHFA training teaches adults who work with youth, including teachers and school staff, how to identify and support youth ages 12-18 who are experiencing mental health and substance use challenges and how to help in crisis situations.

WHAT MENTAL HEALTH FIRST AID COVERS:
- Common signs and symptoms of mental health challenges in this age group, including anxiety, depression, eating disorders and attention deficit hyperactive disorder (ADHD)
- Common signs and symptoms of substance use challenges
- How to interact with a child or adolescent in crisis
- How to connect the youth with help
- Expanded content on trauma, substance use, self-care and the impact of social media and bullying
LANDSCAPE: EARLY INSIGHTS ON SCHOOL-BASED BEHAVIORAL HEALTH

- **Child/youth behavioral health is a shared priority**, which can be seen in increased state support and investments in school mental health (e.g., social/emotional learning programs)

- **Strong partnerships** to address school-based behavioral health exist throughout state and community levels (e.g., cross-sector partnerships addressing suicide prevention among youth)

- Emphasis on **trauma** and **resiliency** in many projects with opportunities to expand existing work in school settings

- **Multi-Tiered System of Supports (MTSS)** framework: Great foundation to build upon for addressing youth mental health in schools

- **System of Care**: Community-based services and supports to meet the needs of children involved with multiple systems is also an initiative to build upon

WHOLE SCHOOL, WHOLE COMMUNITY, WHOLE CHILD (WSCC) MODEL

- CDC’s framework for addressing health in schools

- Adopted by the North Carolina State Board of Education

- Emphasizes
  - **Student-centered**
  - Role of **community** in supporting school
  - **Connections** between health and academic achievement
  - Importance of **evidence-based** school policies and practices

[https://www.cdc.gov/healthyschools/wscc/index.htm](https://www.cdc.gov/healthyschools/wscc/index.htm)
WHY WE NEED CHILD BEHAVIORAL HEALTH DASHBOARD

To help us achieve our vision that all children are healthy and thrive in nurturing families, schools, and communities

- Brings together data from various systems that is currently siloed
- Visibility into what’s happening with children with behavioral health needs across the state in various systems
- Greater shared accountability for stakeholders and the general public
- Identify gaps in service, access, and inequities
- Targeted interventions and solutions
- Track outcomes

CHILD BEHAVIORAL HEALTH DATA DASHBOARD

- A cross-Divisional team at NCDHHS has met weekly and convened in work groups to complete this work
- Multiple external partners have engaged in these efforts, such as academic research partners, families, providers, and more
- Launch a NC child behavioral health data dashboard that provides a statewide snapshot of data and trends by early 2023
- Automate the data feeds into the dashboard
- Add new prioritized metrics to the data dashboard
METRICS PRIORITIZED BY CROSS-DIVISIONAL & EXTERNAL STAKEHOLDER GROUPS

<table>
<thead>
<tr>
<th>Metric (Data Source)</th>
<th>Child Population M = Medicaid Pop</th>
<th>Foster Care Population</th>
</tr>
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<tbody>
<tr>
<td>% children who are “flourishing” (Nat. Survey Child Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of children with ADHD diagnosis (Medicaid)</td>
<td>✓ M</td>
<td>✓</td>
</tr>
<tr>
<td># of children with depression diagnosis (Medicaid)</td>
<td>✓ M</td>
<td>✓</td>
</tr>
<tr>
<td># of children with SUD diagnosis (Medicaid)</td>
<td>✓ M</td>
<td>✓</td>
</tr>
<tr>
<td># of substance-affected infants (Plan of Safe Care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency department utilization for behavioral health (Medicaid)</td>
<td>✓ M</td>
<td>✓</td>
</tr>
<tr>
<td>Suicide attempts resulting in ED visit (NC DETECT)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mobile Crisis Utilization (counts, later cost) (Medicaid)</td>
<td>✓ M</td>
<td>✓</td>
</tr>
<tr>
<td>PRTF utilization (counts, later costs) (Medicaid)</td>
<td>✓ M</td>
<td>✓</td>
</tr>
<tr>
<td>Inpatient psychiatric care utilization (counts, later costs) (Medicaid)</td>
<td>✓ M</td>
<td>✓</td>
</tr>
</tbody>
</table>

School Behavioral Health

% high schoolers and % of middle schoolers feeling sad or hopeless in last 12 months (YRBS)

Early Childhood

% babies born with low and very low birth weight (Vital Statistics)

% children who had 6 well-child visits with a primary care practitioner (PCP) during their first 30 months of life (Medicaid)

% of deliveries that had a postpartum visit on or between 21 and 56 days after delivery (Medicaid)

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Children and Families Involved with Child Welfare or at High Risk for Child Welfare Involvement Require the Right Set of Supports

The multi-sector Transformation Team convened by DHHS includes representation from the below DHHS divisions and external stakeholders.
We Developed a Common Vision Statement, Mission Statement, and Guiding Principles

**Vision:** Every child grows up in their own safe, nurturing family and community with the opportunity to achieve their full potential.

**Mission:** North Carolina’s child- and family-serving systems act collaboratively to provide equitable access to strength-based supports and protection to children experiencing or at imminent risk of harm, and their families.

**Guiding Principles:**
1. Keep children and families at the center of all policies and processes.
2. Take bold action to dismantle and counter the effects of structural racism to create more equitable child- and family-serving systems.
3. Promote stability by keeping families together safely whenever possible, minimizing placement changes, and preserving children’s natural support networks.
4. Engage families with cultural humility, ensure their voices are heard, and learn from their lived experience.
5. Recognize and embrace the family unit in its many forms.
6. Respect the rights and autonomy of families.
7. Earn trust, be transparent, assign responsibility, and hold ourselves accountable.
8. Ensure consistency and seamless coordination across child- and family-serving agencies.
9. Value relative caregivers, foster parents, and the child- and family-serving workforce and enable them to fulfill their vital roles.

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**STRENGTHENING THE SERVICE ARRAY FOR CHILDREN WITH THE MOST COMPLEX BEHAVIORAL NEEDS**

The Coordinated Action Plan Outlines 13 Strategies to Pursue as a Starting Point

<table>
<thead>
<tr>
<th>Expand treatment services that prevent children from being removed from their homes or experiencing multiple placements</th>
<th>Connect children to expanded care placement options more quickly</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expand High-Fidelity Wraparound Services Pilots Statewide</td>
<td>• Establish Placement First Pilots</td>
</tr>
<tr>
<td>• Launch START Substance Use Treatment Pilots in 10 Counties</td>
<td>• Establish Crisis, Inpatient and Residential Bed Tracking and Crisis Referral System</td>
</tr>
<tr>
<td>• Expand MORES Mobile Crisis Intervention Teams Statewide</td>
<td>• Establish Emergency Respite Pilots for Caregivers</td>
</tr>
<tr>
<td>• Strengthen Care Coordination for Children and Youth in DSS Care and for Former Foster Youth</td>
<td>• Build Professional Foster Parenting Programs</td>
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<tr>
<td>• Expand the NC-PAL Program Statewide</td>
<td>• Strengthen the NCDHHS Rapid Response Team (RRT)</td>
</tr>
<tr>
<td>• Implement the “988” Statewide Crisis Hotline</td>
<td>• Develop a Plan to Increase Supply of Appropriate Treatment and Residential Placements for Children Needing Behavioral Health Services</td>
</tr>
</tbody>
</table>

FIVE WAYS MEDICAID EXPANSION HELPS CHILDREN AND FAMILIES

Healthier parents = healthier children

Protects families from medical debt

Closes the disparity gap for BIPOC families

More kids are covered and have access to care

Behavioral health coverage for adults and children

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**A Pilot Model for Medicaid-insured Children**: NC Integrated Care for Kids
NC InCK: Brief Overview

- Children who will be served by NC InCK: All Medicaid and CHIP-insured children in this 5-county area
  - Birth to age 20
  - Regardless of where they receive medical care
  - ~95,000 children overall

- Funding: A 7-year, $16M grant from CMS to:

  Duke
  THE UNIVERSITY OF NORTH CAROLINA at CHAPEL HILL
  NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Phased Launch began on January 1st, 2022

Three Key Strategies to Integrate Care for Children in NC InCK

1. Understand Needs
   - More holistically understand the needs of children and youth

2. Support and Bridge Services
   - Integrate services across sectors for children and youth who could benefit from additional support

3. Focus Health Care Investments
   - Find ways to invest resources into what matters most for children, youth, and families
Children's health and health care data drive their risk stratification and services. Cross-sector data informs child-specific risk stratification and elevates additional children for more integrated supports.


Health care providers are paid predominantly fee-for-service. Innovative incentives and payment models facilitate resources and flexibility to support more whole child care approaches.

Current State in NC

NC InCK's Intervention

Understanding a Child's Needs

Integrating Services

Investing in What Matters

Behavioral Health and NC InCK
How NC InCK Supports Integrated Behavioral Health Care

1. UNDERSTAND NEEDS
   Mental Health utilization for both youth and guardian included in data algorithm prioritizing families for outreach

2. SUPPORT AND BRIDGE SERVICES
   Care Managers trained in supporting Behavioral Health needs of children, work with families for a minimum of one-year to support mental health and cross-sector needs

3. FOCUS HEALTH CARE INVESTMENTS
   New payment model includes screening for clinical depression and follow-up as incentivized measure

Overview: NC InCK & Behavioral Health

<table>
<thead>
<tr>
<th>Key Goals</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve rates of:</td>
<td>Within Primary Care settings:</td>
</tr>
<tr>
<td>• Adolescent depression screening with f/u plan</td>
<td>• Screening for depression and f/u plan incentivized in NC InCK APM</td>
</tr>
<tr>
<td>• Engagement in first line psychosocial care for youth prescribed antipsychotics</td>
<td>• Promotion of NC PAL program and offering of enhanced pediatric mental health training (REACH PPP)</td>
</tr>
<tr>
<td>• 7 and 30-day f/u for youth after hospitalization for MI</td>
<td>• Supporting Collaborative Care through development of cross-practice Learning Collaborative</td>
</tr>
<tr>
<td>Increase cross-sector support for children and youth facing behavioral health challenges</td>
<td>Outside of Primary Care settings:</td>
</tr>
<tr>
<td>Enhance delivery of mobile crisis response and alternative crisis services.</td>
<td>• Educating Care Managers on supporting youth mental health</td>
</tr>
<tr>
<td></td>
<td>• Supporting schools in implementing behavioral health trainings and services</td>
</tr>
<tr>
<td></td>
<td>• Promoting centralized mobile crisis hotline</td>
</tr>
<tr>
<td></td>
<td>• Delivering pediatric mental health training to first responders</td>
</tr>
<tr>
<td></td>
<td>• Advocating for improved data collection &amp; reporting on crisis utilization and outcomes</td>
</tr>
</tbody>
</table>

Work informed by an InCK Behavioral Health Workgroup comprised of LME/MCO, Health System, & NC DHHS Leadership
NC InCK as Trainer and Capacity Builder

Monthly Integrated Care Rounds create a workforce of specialized pediatric care managers

Behavioral Health and Mental Health resource guide created for Care Managers and Publicly Available
Co-Developed by NC InCK BH workgroup and NC InCK Family Council for Care Managers

THANK YOU

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@DrCharleneWong

Acknowledgements
• Dr. Moira Rynn from Duke University for select data slides
RAPID RESPONSE TEAM

DHHS cross-divisional team meets every weekday to facilitate the resolution of immediate needs for children in DSS custody who are in need of placement at the identified medically necessary level of care by removing barriers created by systemic issues, and by facilitating problem-solving and challenging conversations among county DSS, LME/MCOs, and other stakeholders in the child-serving system.

<table>
<thead>
<tr>
<th>DHHS</th>
<th>Local Partners</th>
<th>Additional Supports</th>
</tr>
</thead>
</table>
| • Division of Child and Family Well-Being  
• Division of Social Services  
• Division of Mental Health  
• Division of Health Benefits  
• Division of State Operated Health Facilities | • LME-MCO  
• County Department of Social Services | • NC Psychiatric Access Line  
• Community Care of North Carolina |
RAPID RESPONSE TEAM: CHILDREN REFERRED

Diagnostic Information

- ADHD, 39%
- PTSD, 27%
- Oppositional Defiant Disorder...
- Disruptive Mood Disorder...
- Conduct Disorder...
- IDD, 11%
- Cannabis Use...
- Autism Spectrum Disorder...
- Major Depression...

80% of children have experienced >10 distinct placements prior to RRT referral.
Average number of placements is 34.
Over 25% of these children have been placed and moved across 50 or more placements.

RRT REFERRAL

Background
- 15-year-old with a history of elopement
- Multiple respite and foster care placement disruptions

Diagnosis and Behaviors
- Co-occurring IDD and Mental Health Diagnosis
- History of aggressive, property destruction, and self harming behaviors

Placement and Level of Care Recommended
- At Time of Referral was staying in the DSS Office
- CCA: Level III or PRTF

Outcome
- Kinship placement with wrap around supports: High Fidelity Wraparound, Intensive In Home, and Day Treatment
- Closed after 48 Days
### RRT Referral

#### Background
- 14-year-old
- 3 IVCs in the month prior to initial RRT meeting.

#### Diagnosis and Behaviors
- Depression, PTSD, TBI
- History of Abuse/Neglect
- History of elopement, property destruction, and self-harming behaviors

#### Placement and Level of Care Recommended
- Emergency Department
- CCA: PRTF
- NCPAL consultation provided to DSS on treatment and placement priorities

#### Outcome
- A new and small Level III identified with wrap around supports arranged by DSS and MCO.
- State hospital prioritized for stabilization prior to group home placement.
- Local and State agencies supporting the completion of the licensure process to ensure smooth step down from state facility.

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North Carolina families are experiencing greater food insecurity than before the pandemic

The number of children experiencing food insecurity in NC rose from nearly

1 in 5 children (before the pandemic)

to as high as 1 in 3 children in rural North Carolina

https://map.feedingamerica.org/county/2018/overall/north-carolina/
https://stodolansky.org/
North Carolina is partnering with Benefits Data Trust on a State Action Plan to increase SNAP and WIC participation

Data Matching & Analysis
- **Match data** across SNAP, WIC, and Medicaid to identify people who may be eligible but unenrolled
- **Analyze** cross-program data to stratify by key equity metrics

Tailored Outreach
- **Use data** to inform outreach strategies
- **Design and implement** tailored outreach strategies

Making it Easier for Families to Enroll
- **Implement** high-value, short-term system changes to help eligible but unenrolled children and families participate and remain in SNAP & WIC (e.g., online recertifications)

Call to action: How you can help individuals and families who may be eligible for nutrition benefits

Share our fact sheet about NC food and nutrition programs:

https://www.ncdhhs.gov/media/10249/download
Call to action: How you can help individuals and families who may be eligible for nutrition benefits

<table>
<thead>
<tr>
<th>Refer families who may be eligible for FNS or WIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General program description</strong></td>
</tr>
<tr>
<td>FNS: Food and Nutrition Services (FNS) is a federal food assistance program that provides low-income families the food they need for a nutritionally adequate diet.</td>
</tr>
<tr>
<td><strong>How to apply</strong></td>
</tr>
<tr>
<td>• Encourage individuals and families who may be eligible to apply in the following ways:</td>
</tr>
<tr>
<td>• Online: epass.nc.gov</td>
</tr>
<tr>
<td>• In person or by telephone to county DSS office</td>
</tr>
<tr>
<td>• By mail or drop off: fill out a paper application and send to county DSS office</td>
</tr>
</tbody>
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