

Meeting of the
North Carolina Child
Fatality Task Force

December 12, 2022



Child Fatality Task Force



***Our Children, Our Future,
Our RESPONSIBILITY***



Welcome & Approval of Minutes

Minutes from last meeting on 10-31-22 have been posted on the CFTF website, the minutes have been sent out and the link to the minutes is also on your agenda. (Those here in person also have a hard copy.)

Housekeeping

- Take breaks as needed, but please be sure to be present for voting
- Help yourself to **refreshments**
- **Handouts** you have are also posted on CFTF website
- Keep in mind this is the last meeting of the study cycle which means:
 - We have A LOT of committee recommendations to cover today in a short amount of time
 - **Your presence for every vote today is important**
 - We won't have time to address new topics that aren't on the agenda but please let CFTF leadership know of your questions or interest in topics unrelated to today's agenda so that we can address them outside of this meeting.
- THANK YOU to the Department of Insurance for hosting us!

Today's Agenda

(posted on CFTF website
& sent last week)

- Recommendations and updates from each committee (six recommendations from committees are on your agenda)
- Data from the 2021 Youth Risk Behavior Survey

*[Note about 2021 child death data:
anticipated to be finalized soon and will share
data when released]*



Refresher on CFTF process . . .

- CFTF Committees study data and prevention strategies and determine recommendations they want to make to the full CFTF
- **Types of recommendations are:**
 - **Legislative:** new or changed law; state funding
 - **“Support”** recommendations: CFTF fully supports and takes lead in advancing
 - **“Endorse”** recommendations: CFTF endorses another organization’s efforts to advance
 - **Administrative:** further study; progress via non-legislative efforts
- Full CFTF considers committee recommendations and determines whether to approve
- **Recommendations approved by the full CFTF become part of the 2023 CFTF Action Agenda** that is included in the annual report submitted to the governor and General Assembly



Intentional Death Prevention
Committee Recommendation
and Updates

Intentional Death Prevention Committee Recommendation

SUPPORT an appropriation of \$550,000 in nonrecurring funds and \$110,000 in recurring funds to enable the Office of the Chief Medical Examiner to conduct comprehensive toxicology testing in all Medical Examiner jurisdiction child deaths.

Background and highlights of information presented in committee

- This recommendation came from the State Child Fatality Prevention Team
- This was on the 2022 CFTF Agenda but was not taken up in 2022 legislation
- Currently, the NC Office of the Chief Medical Examiner does not have the necessary resources to conduct comprehensive toxicology screening in all child deaths under their jurisdiction.
- Comprehensive toxicology testing can identify information related to a child's death that helps to explain more about the circumstances of the death that may be relevant to inform strategies for the prevention of deaths and injuries.

States that limit postmortem pediatric toxicology testing

- ▶ NC OCME currently performs a volatile only analysis on cases with an **established cause/manner of death**
 - ▶ Example: motor vehicle crash, suicide by hanging or fatal gunshot wound
- ▶ At a minimum, states (other than NC) will expand testing to at least a limited immunoassay panel to test for common illicit drugs and/or popular pharmaceutical agents



Why Expand Testing in North Carolina?



- ▶ ADHD medications and antidepressants are the psychotropic drug classes with the highest prevalence among children and adolescents.
- ▶ North Carolina is lacking contributory drug data for the **entire state** involving substances that could potentially exacerbate a known cause of death, such as the drugs in the bloodstream of a young driver, a drowning victim, a suicidal teen (not drug-related) or an underage active shooter who has been killed by law enforcement.
- ▶ These findings can be used by public health professionals, health care providers, state health officials, policymakers, and educators to understand the prevalence of substances (licit or illicit) when death results in **all case types** in the pediatric population.



Necessary Resources

- Comprehensive drug screening/confirmation increases number of samples processed and analyzed in the laboratory
 - Personnel
 - Sample preparation
 - Instrument operation
 - Data analysis
 - Report certification
 - Standards and Reagents
 - Analysis requires certified reference material and reagents for every additional assay conducted
 - Equipment
 - Laboratory Equipment
 - Laboratory needs additional basic equipment to accommodate additional sample preparation processes (centrifuge, rotators, sample concentrator)
 - Robotic Sample Preparation Equipment
 - Automation of sample preparation process decreases prep time and increases accuracy/precision
 - Instrumental Equipment
 - Instruments have finite capacity and throughput capabilities
 - Advanced instrumentation is necessary for detection and quantitation of potent emerging drug targets
 - A sufficient number of instruments must be available for analyst use after sample preparation is complete (currently limited)



Discussion and
voting on
committee
recommendation

SUPPORT an appropriation of \$550,000 in nonrecurring funds and \$110,000 in recurring funds to enable the OCME to conduct comprehensive toxicology testing in all Medical Examiner jurisdiction child deaths.

Intentional Death Prevention Committee Update

Continued progress on strengthening training of professionals on child abuse and neglect reporting





Perinatal Health Committee
Recommendations and
Updates

Perinatal Health Committee Recommendation

Support (endorse?) funding request that has come from NC Medicaid, DHB, for the maternal morbidity and mortality funding bundle which includes funding for an additional incentive for group (prenatal care) visits, funding for broad doula coverage, and funding to increase the bundled payment rate.

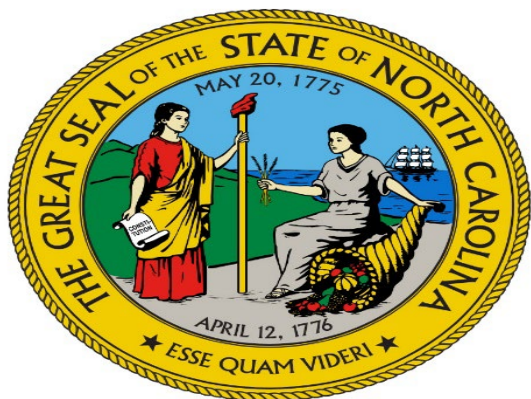
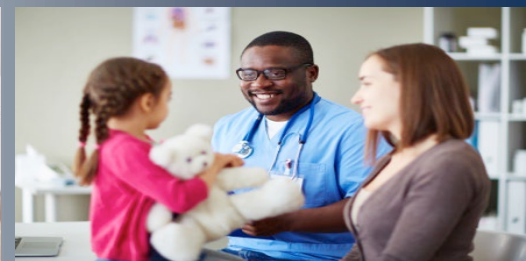
[This is a continued discussion of a recommendation presented at the October 31st meeting]

Background on recommendation

- 2021 Issue application: provider incentives for group prenatal care
- After the committee studied the topic of group prenatal care, there was an administrative recommendation in 2022 whereby the CFTF requested Medicaid to review the current prenatal bundle rate and its impact on group prenatal care.
- NC Medicaid did this review and determined that:
 - NC's bundled payment rate to providers was way below the national standard;
 - increasing the rate to the national standard is needed; funding is needed to add incentives for group prenatal care; and
 - funding is needed for broad doula coverage.

Highlights of information presented at the October 31st meeting of CFTF

- NC Medicaid requested funding for a maternal morbidity and mortality bundle that included **funding for an incentive for group visits, broad doula coverage, and increasing the provider bundled payment rate to 71% of the national standard.**
 - This funding was in the Governor's budget for 2022 but not in the final legislative budget.
 - For 2023, NC Medicaid is making this request again but this time they are seeking to get the bundled payment rate increased to 100% of the national standard.
- Evidence showing **positive health outcomes from doula support.**
- Evidence showing **positive health outcomes from group prenatal care** that include decreasing the rate of preterm and low birthweight births and nearly eliminating racial disparities in preterm birth.
- At its October meeting, the CFTF tabled this topic to take up at the next meeting (today) in order to get more specific information on funding and on doulas.



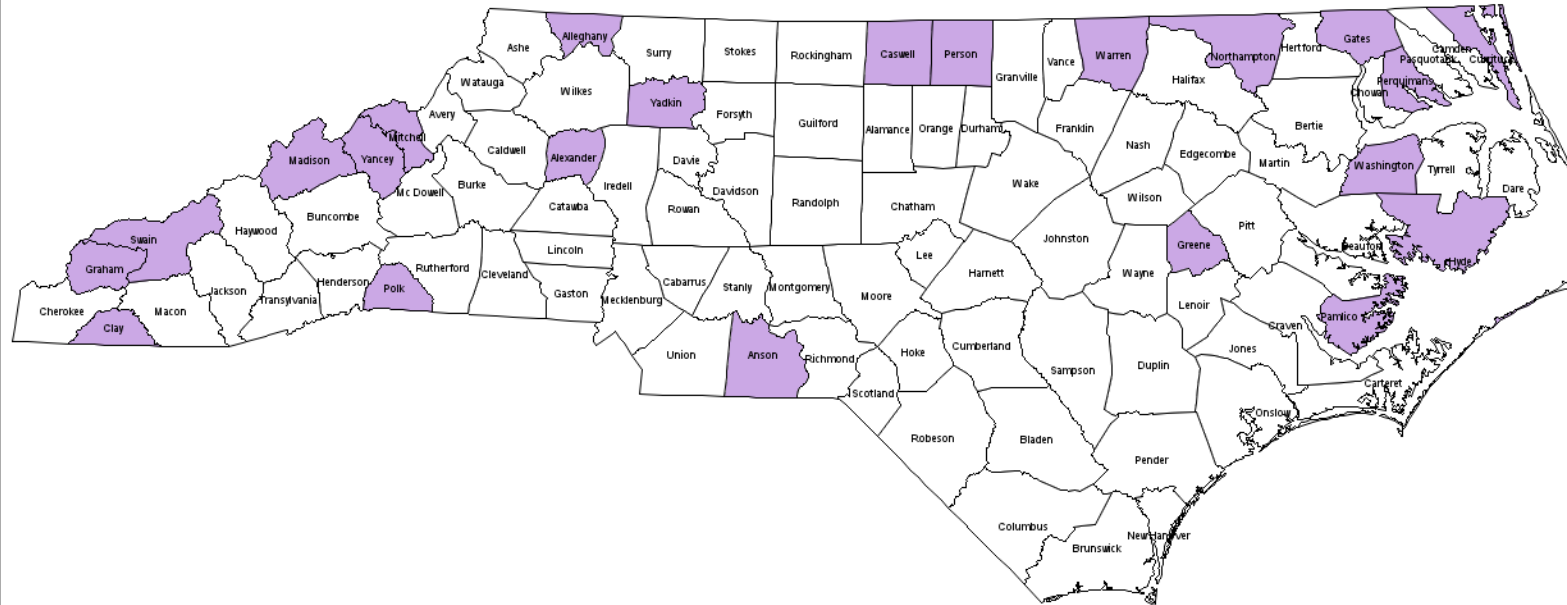
NC Department of Health and Human Services

Maternal Morbidity & Mortality Reduction Bundle

NC DHHS Team

December 12, 2022

North Carolina Counties with No Maternal Health Professionals*, NC 2021



Maternal Health Professionals* ≥ 1 None

*General/Specialty Ob/Gyns, General/Specialty Ob/Gyn Physician Assistants, Certified Nurse Midwives

Data derived from UNC Sheps Health Professionals Data System
 Prepared by NC DHHS/DPH/Title V Office 09DEC2022

Maternal Morbidity & Mortality Reduction Bundle

Increase maternity provider reimbursement

Implement coverage of doula services

Implement coverage of group prenatal care

Doula Services

Evidence for Doula Support during Birth

- 2017 Cochrane Review
- 26 studies across 17 countries, involving > 15,000 women
- Those with support were **more likely** to
 - Have spontaneous vaginal birth
 - Have shorter labors
- Those with support were **less likely** to:
 - Use pain medications
 - Have a cesarean birth
 - Have negative feelings about childbirth experiences.

<https://www.nationalpartnership.org/our-work/resources/health-care/maternity/improving-maternity-doula-support.pdf>

Outcomes of Extended Doula Support

- **Associated with:**
 - **Reduced** likelihood of preterm birth & low birth weight
 - **Improved** breastfeeding outcomes

<https://www.nationalpartnership.org/our-work/resources/health-care/maternity/improving-maternity-doula-support.pdf>

Group Prenatal Care

Findings of Group Prenatal Care

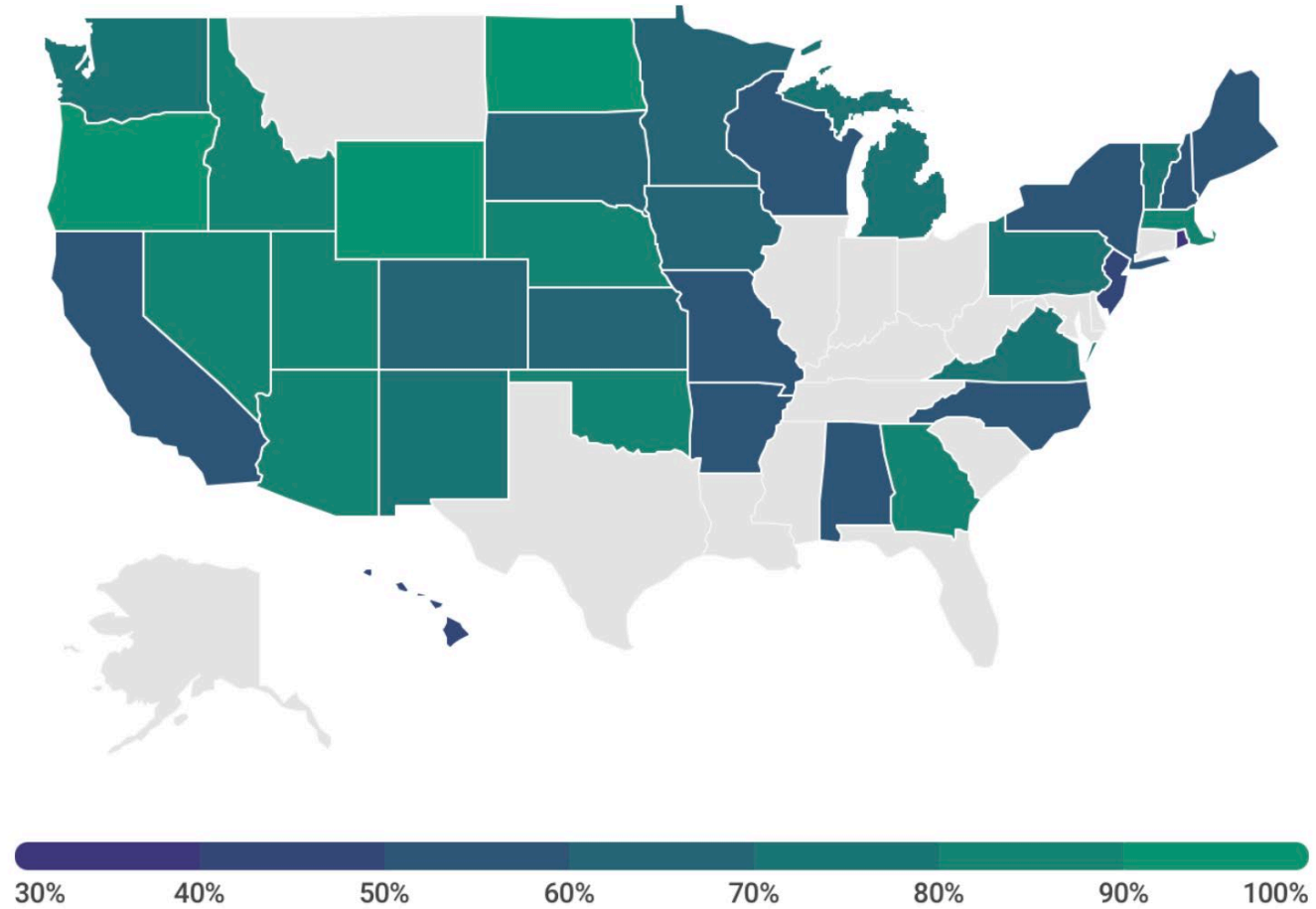
- **Decreases** rate of preterm babies
- **Decreases** rate of low birthweight babies
- **Increases** breastfeeding rates
- Leads to better **pregnancy spacing**
- **Nearly eliminates racial disparity in preterm birth**
- **Cost-saving** by reducing preterm births

Birth Outcomes Findings for Black women

- Reduced **very early preterm delivery** (before 32 weeks).
- **Reduced** preterm delivery.
- **Racial disparity** in preterm birth for Black women relative to White women was eliminated.

Maternity Provider Reimbursement Information

Obstetric Code as a Percent of Medicare



Note: states in gray do not bill using the global obstetric code.

Achieving Parity Between Medicare and Medicaid

- Most private payers and Medicaid programs use the RVUs established by Medicare to determine their own payment rates
 - Many states establish their Medicaid payment rates by taking a direct percentage of their local Medicare rate
- Any changes to the obstetric global codes under Medicare could lead to changes by other payers



Example: North Carolina

Pays 59.4% of the local Medicare rate

Medicaid payment for CPT Code 59400 = \$1,393.91

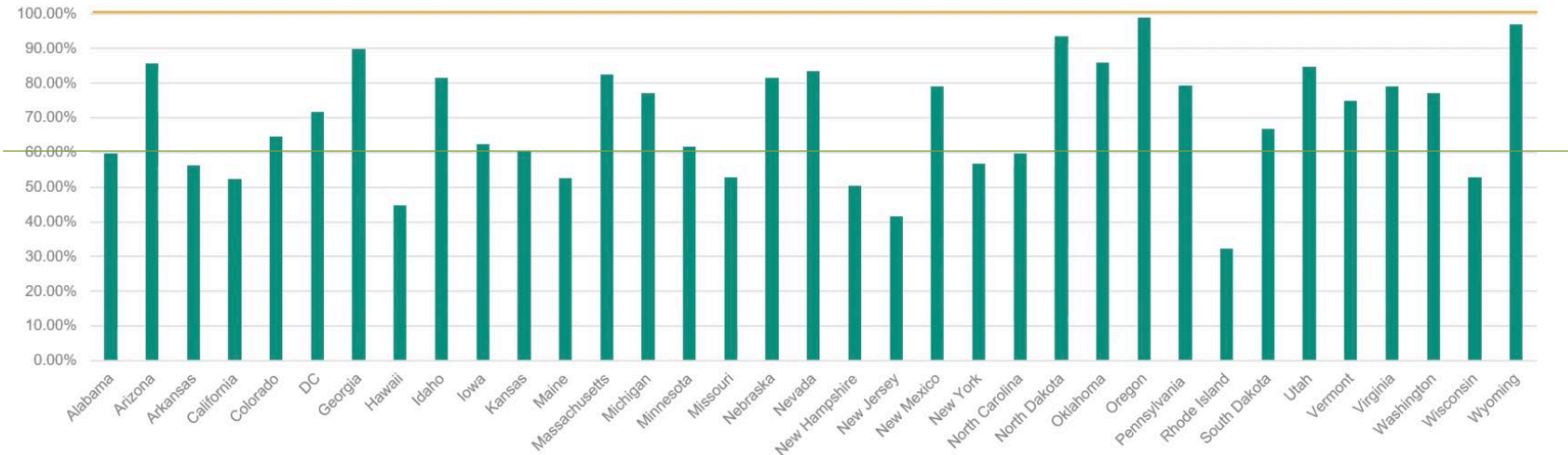


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Current Payment Rates for Obstetric Care

Medicaid Payment Rate for Vaginal Births as a Percentage of the Local Medicare Rate



North Carolina

27



• **SOURCE:**

ACOG Bundled Payment Rates in Surrounding States

State	Pay Parity to Medicare
NC	59.8
Virginia	79.1
South Carolina	N/A
Georgia	89.9
Alabama	59.6
Tennessee	N/A
Kentucky	N/A

Maternal Morbidity & Mortality Reduction Bundle Budget Request

Maternal Morbidity & Mortality Reduction Bundle

- **Total Package: \$27M in recurring costs**

Package Components	Amount
Increase maternity provider reimbursement for bundled payments to be at 100% parity with Medicare rates. We are currently at 59% parity	\$24.5M
Implement coverage of doula services	\$1.5M
Implement coverage of add-on service for group prenatal care	\$1.0M

SOURCE: NC DHHS DHB Financial Planning & Analysis

Maternal Morbidity & Mortality Reduction Bundle

- using blended FMAP from the budget model for each year of the biennium

	SFY 2024	SFY 2025
Total Requirements	\$ 27,000,000	\$ 27,000,000
Federal Share	\$ 18,081,900	\$ 17,960,400
State Share	\$ 8,918,100	\$ 9,039,600

SOURCE: NC DHHS DHB Financial Planning & Analysis

Maternal Morbidity & Mortality Reduction Bundle

- **Total Package: \$800K in non-recurring costs over 2 years**

Package Components	Amount
Doula support funds for training, promotions, and doula engagement	\$550,000
Funds for group prenatal care support for training, promotions, and site set-up	\$250,000
DHHS will continue to engage with our community partners to implement doula services and expand the number of sites providing group prenatal care	Total - \$800,000

Maternal Morbidity & Mortality Reduction Bundle

- **Nonrecurring funds**

- Doula support funds for training, promotions, and doula engagement.
- Funds for group prenatal care support for training, promotions, and site set-up.

	SFY 2024	SFY 2025
Total Requirements	\$ 250,000	\$ 550,000
Doula Services	\$ 200,000	\$ 400,000
Group Prenatal Care	\$ 50,000	\$ 150,000

Questions?

Belinda.Pettiford@dhhs.nc.gov

Velma.taormina@dhhs.nc.gov



Discussion and
voting on Perinatal
Health Committee
recommendation


Support (endorse?) funding request that has come from NC Medicaid, DHB, for the maternal morbidity and mortality funding bundle which includes funding for an additional incentive for group (prenatal care) visits, funding for broad doula coverage, and funding to increase the bundled payment rate.

Perinatal Health Committee Recommendation

Recommendation to SUPPORT legislation, agency action, and policy change to strengthen the statewide Child Fatality Prevention System (set of recommendations)

WHY efforts to strengthen the CFP system have been underway since 2018: the need to ensure . . .

Effective and efficient team reviews of infant and child deaths



Meaningful data capture, analysis, and reporting of information learned from reviews

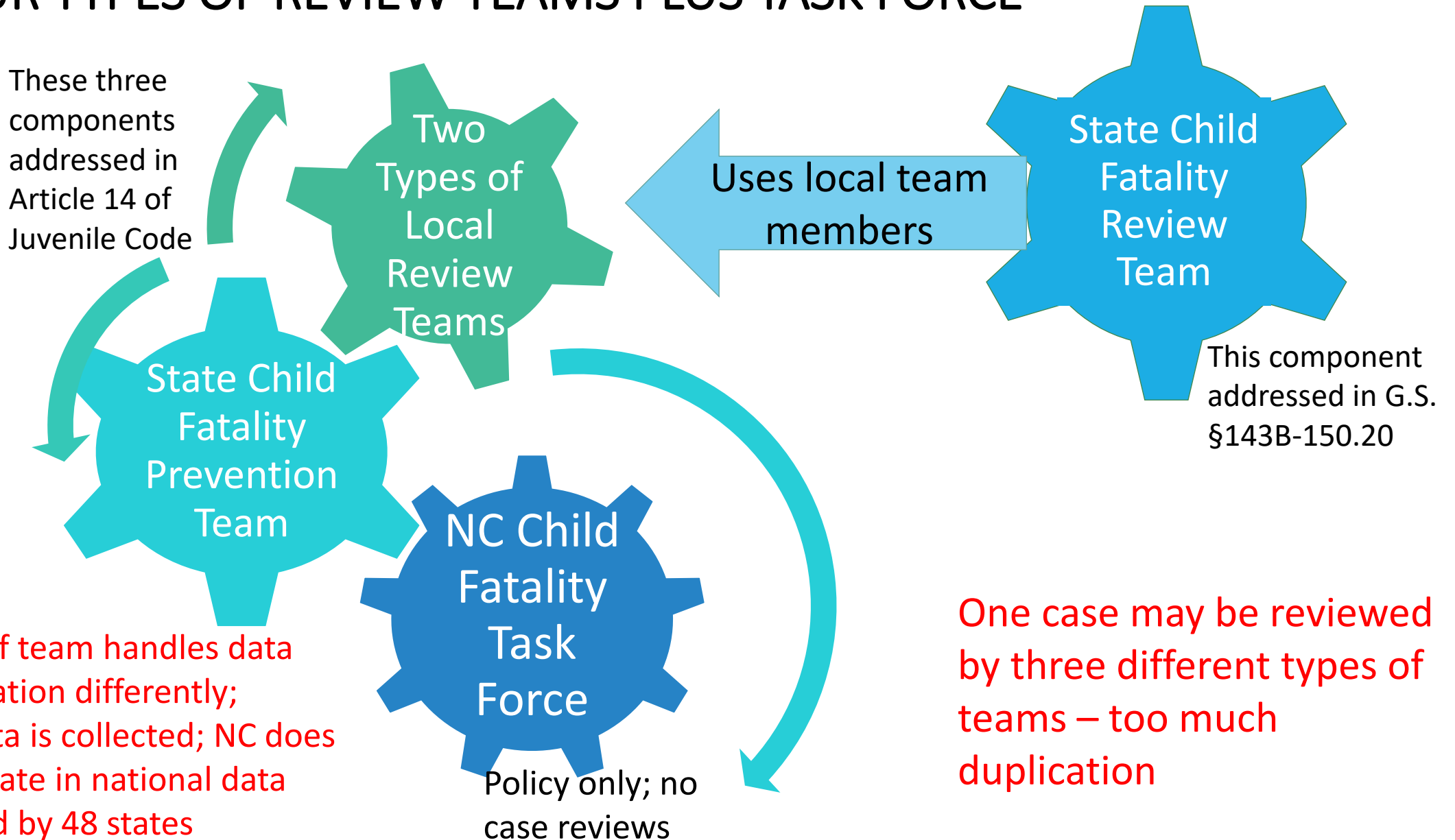


Ability to identify issues and implement prevention opportunities



Saving babies' and children's lives; promoting child wellbeing!

MAIN COMPONENTS OF CURRENT NC CFP SYSTEM: FOUR TYPES OF REVIEW TEAMS PLUS TASK FORCE



HOW Task Force efforts to strengthen the CFP system have progressed and WHO has been involved

HOW

- **Statewide CFP Summit 2018:** 200 people
- **Research on other states' systems & interviews** with leaders from other states
- **Consultation with national experts**
- **Stakeholder discussions** pre- and post-recommendations including Institute of Medicine/DHHS stakeholder group
- **Recommendations adopted in Child Welfare Reform Plan**
- **DHHS study** and implementation planning
- **Legislation** in 2019 (HB 825 included in HB 966) and 2021 (SB 703) that did not become law

WHO

- **CFP professionals from across the state** who came to the summit
- **Child Fatality Task Force**
- **National experts** in child fatality review and prevention
- **Stakeholders** whose work directly involves or relates to child fatality prevention system
- **Center for the Support of Families** (consultants who looked at system & adopted CFTF recs in Child Welfare Reform Plan)
- **NC DHHS leaders**
- **Legislators** who sponsored/supported bills

Common themes repeated from stakeholders made it clear that we need to make changes that will . . .

Capitalize on strengths

Capitalize on current system strengths

Restructure

Restructure the system to address inefficiencies, disconnects, and duplication of efforts

Provide more support

Provide effective training, tools, support, and collaboration opportunities for local review teams

Improve data

Improve data to ensure that information learned from team reviews is appropriately gathered, analyzed, and reported in meaningful ways to inform local and state-level prevention efforts

Create stronger connections & follow-through

Create stronger connections between local and state-level CFP work; ensure accountability and follow-through so that review efforts lead to meaningful change to save lives and promote wellbeing

North Carolina Child Fatality Review System Challenges Compared to Some Other States

NC may have the most complex system in the U.S.

Very large number and types of local and state-level groups (2 local in each county; 3 state-level)

Very large number and types of cases (all) reviewed

Does not use National Fatality Review Case Reporting System as 48 other states do

Weak connection between local teams/data and state-level groups

Does not have centralized, state-level staff to coordinate and support system

Uses 100 CCPTs as Citizen Review Panels

NC's CFP System Strengths

Having multidisciplinary local review teams covering all 100 NC counties

Ability of community leaders on local teams to collaborate and implement prevention initiatives

Having a state medical examiner system with dedicated child fatality staff at OCME

Child Fatality Task Force: experts in child health and safety, state agency leaders, 10 legislators; three committees with additional expertise; history of success in advancing policy

THE PREVENTION

POTENTIAL IS HUGE when these community leaders come together on a local team to understand the circumstances surrounding a death and take steps to prevent it from happening again

AND . . .

local teams need state-level support to optimize their efforts

Local Social Services

Local Health Department

Law Enforcement

District Attorney

Local Community Action Agency

Local School Superintendent

County Board of Social Services

Mental Health

Guardian ad Litem

Health Care Provider

Emergency medical or firefighter

District Court Judge

County Medical Examiner

Local childcare facility or Head Start

Parent of child who died

Recommendation: Support legislation, agency action, and policy change to strengthen the statewide Child Fatality Prevention System through these changes (repeated each year since 2019):

Implement centralized state-level staff with whole system support in one location; OCME child fatality staff remains in OCME; Form new Fatality Review and Data Group to be information liaison.

Implement a centralized data and information system that includes participating in the **National Fatality Review Case Reporting System.**

Reduce the volume of team reviews by changing the types of deaths required to be reviewed to the categories most likely to yield prevention opportunities. [undetermined, unintentional injury, violence, motor vehicle, child abuse or neglect/CPS involvement, SUID, suicide, deaths not expected in next six months, additional infant deaths (review of other categories optional)]

(Recommendations continued)

Reduce the number and types of teams performing fatality reviews by combining the functions of the four current types of teams into one local team with different procedures and required participants for different types of reviews. Teams can choose whether to be single or multi-county.

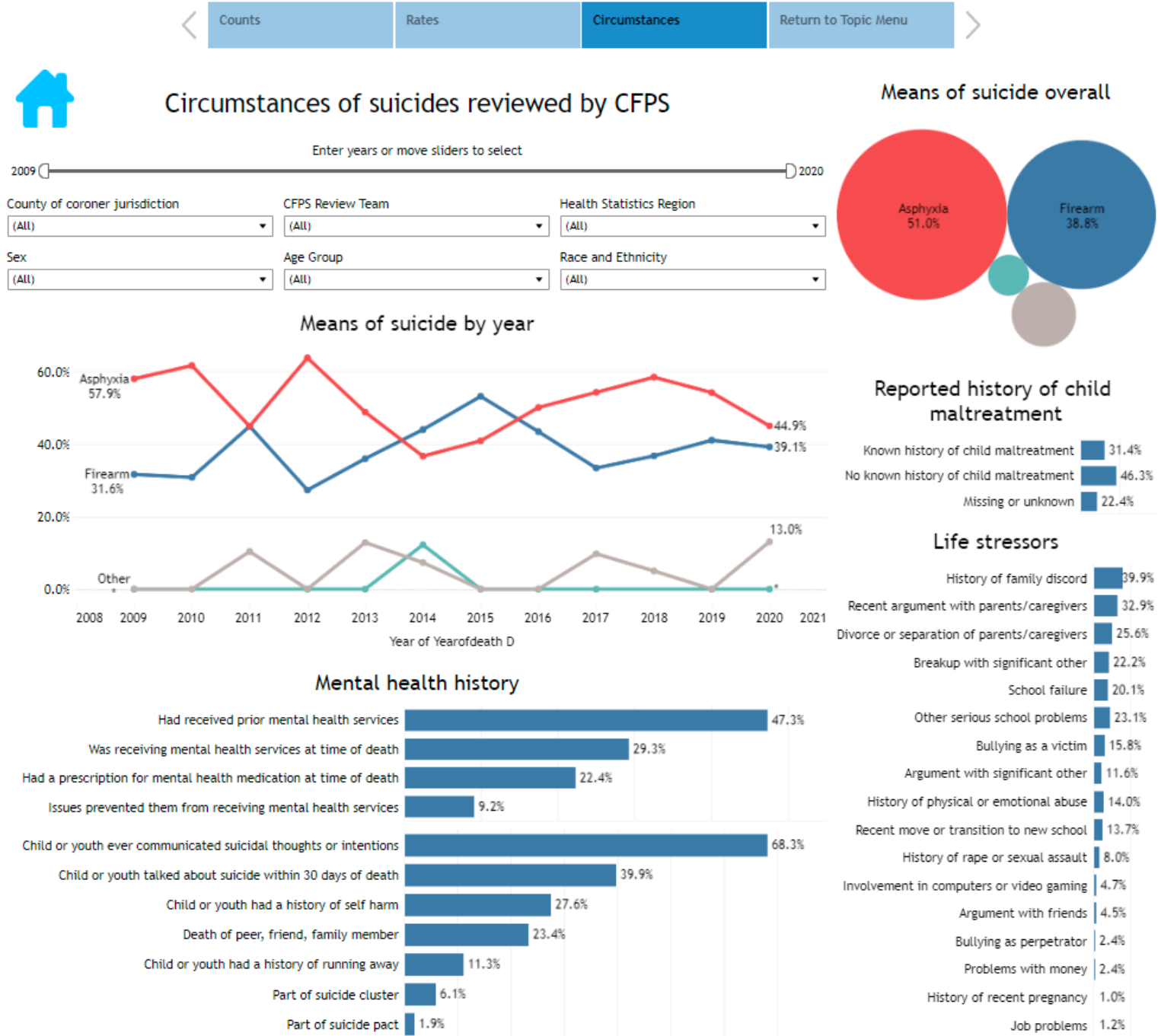
DHHS should study and determine an effective framework for meeting federal requirements for **Citizen Review Panels** and for reviewing active DSS cases on child abuse and neglect.

Formalize the 3 CFTF Committees with required members; **expand CFTF reports** to address whole CFP System and to be distributed to more state leaders.

Funding: Maintain current CFP funding. Appropriate additional funds pursuant to DHHS determinations related to (needs of) state CFP office, local teams, and Fetal and Infant Mortality Review pilot.

Here's what's possible in NC with DATA!

This screenshot of *one tab* of a [suicide dashboard](#) from [Colorado's Child Fatality Prevention System](#) provides an example of the type of data report that could be produced in North Carolina through participation in the [National Fatality Review Case Reporting System](#) used by 48 states but not NC.



Opportunity for those who work in the NC CFP System to gather, learn, and re-energize!

Child Fatality Prevention Summit March 30, 2023!

Sponsored by the Jordan Institute for Families, UNC School of Social Work, in partnership with the NC Department of Health and Human Services

Let us know if you want to join the **Summit Planning Committee!**

Local Team
Perspective
...

Paula Yost, JD, Chair of local
CCPT/CFPT, Cabarrus County

Amanda Treadway, Chair of
local CFPT, Iredell County

Discussion & Voting on CFP Recommendations

SUPPORT legislation, agency action, and policy change to **strengthen the statewide Child Fatality Prevention System** through these changes:

- **Implement centralized state-level staff with whole-system support in one location in DHHS** (however OCME child fatality staff remains in OCME); form new Fatality Review and Data Group to be information liaison.
- Implement a centralized electronic data and information system that includes **North Carolina participating in the National Fatality Review Case Reporting System** used by 48 other states.
- **Reduce the volume of team reviews by changing the types of deaths required to be reviewed by fatality review teams to be according to certain categories most likely to yield prevention opportunities.** [undetermined, unintentional injury, violence, motor vehicle, child abuse or neglect/CPS involvement, SUID, suicide, deaths not expected in next six months, additional infant deaths (review of other categories optional)]
- **Reduce the number and types of teams performing fatality reviews by combining the functions of the four current types of teams into one (local team)** with different procedures and required participants for different types of reviews and giving teams the option to choose whether to be single or multi-county teams. DHHS should study and determine an effective framework for meeting federal requirements for Citizen Review Panels and for reviewing active DSS cases.
- **Formalize (in statute) the 3 CFTF Committees with certain required members and expand CFTF reports to address whole CFP System and to be distributed to additional state leaders.**
- **Funding: maintain current CFP funding and appropriate additional funds** pursuant to DHHS determinations related to (the needs of) state office, local teams, and Fetal and Infant Mortality Review pilot.



2021 Youth Risk Behavior Survey Data

(Selected topics)

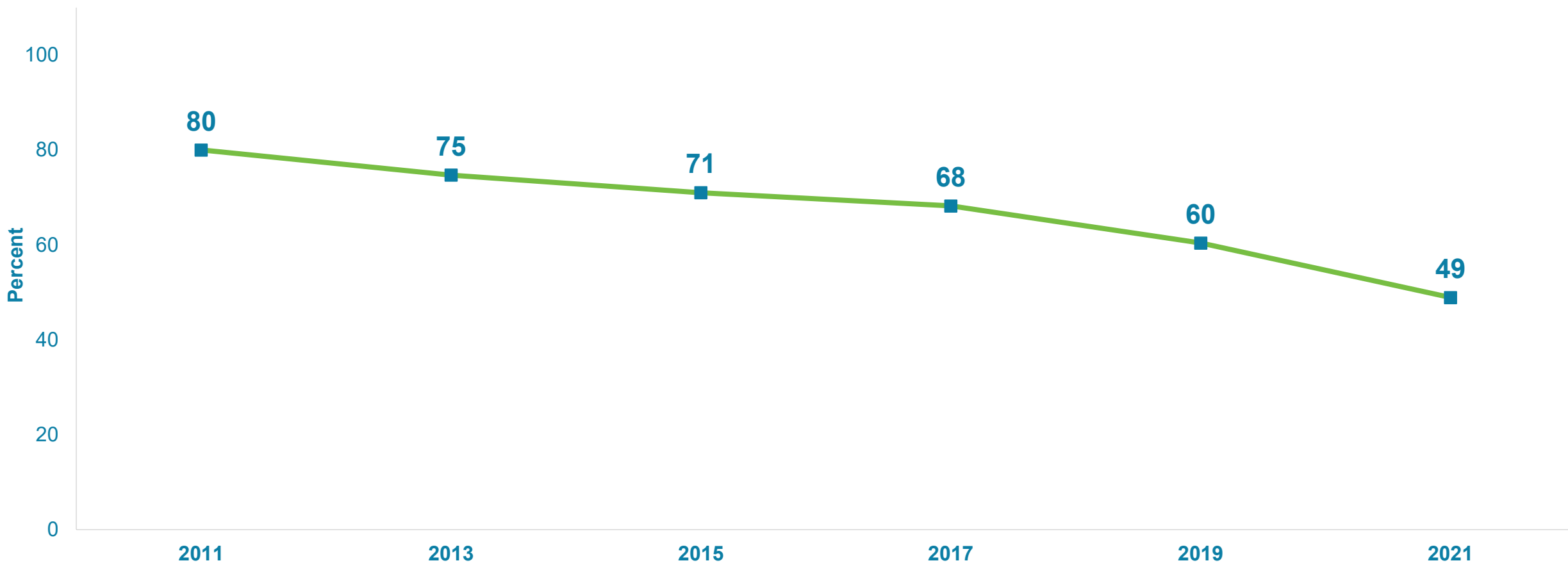
Ellen Essick, Ph.D.

Section Chief, Healthy Schools and
Specialized Instructional Support

Office of Academic Standards

NC Department of Public Instruction

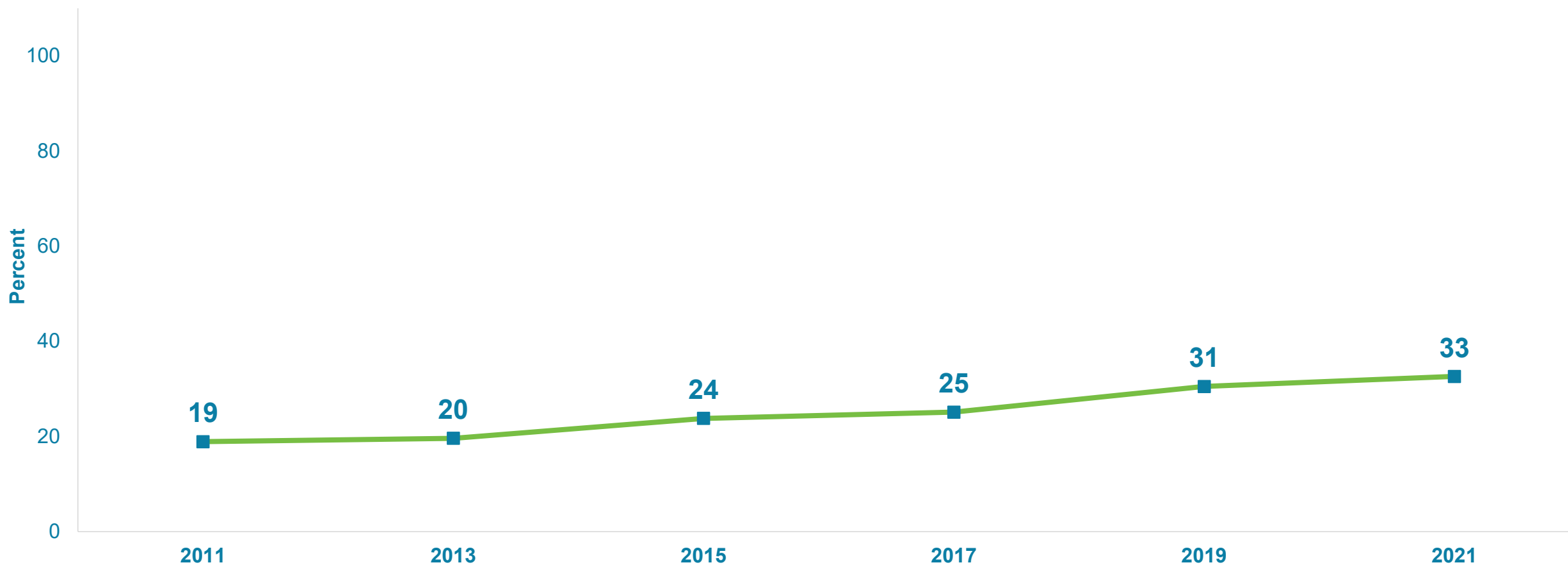
Percentage of High School Students Who Strongly Agree or Agree That They Feel Good About Themselves



*Decreased 2011-2021 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).]

North Carolina - YRBS, 2011-2021 - QN109

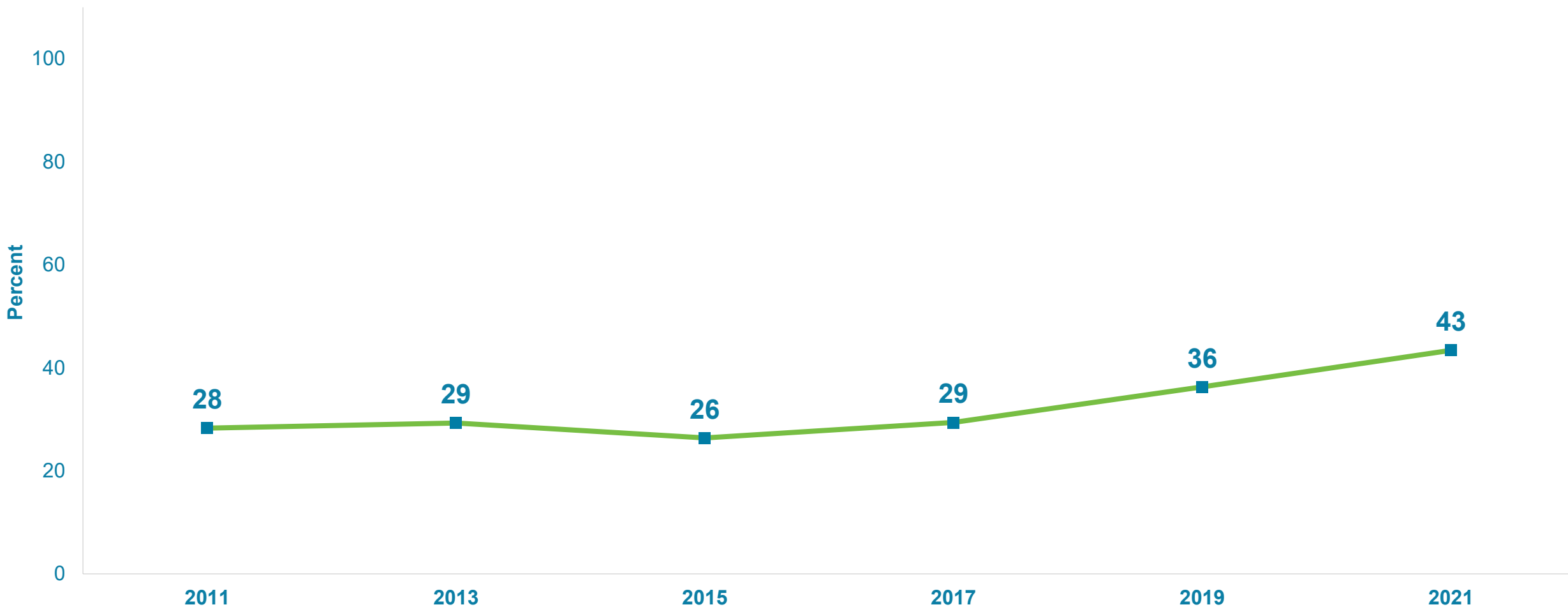
Percentage of High School Students Who Agree or Strongly Agree That They Feel Alone in Their Life



* Increased 2011-2021 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).]

North Carolina - YRBS, 2011-2021 - QN110

Percentage of High School Students Who Felt Sad or Hopeless



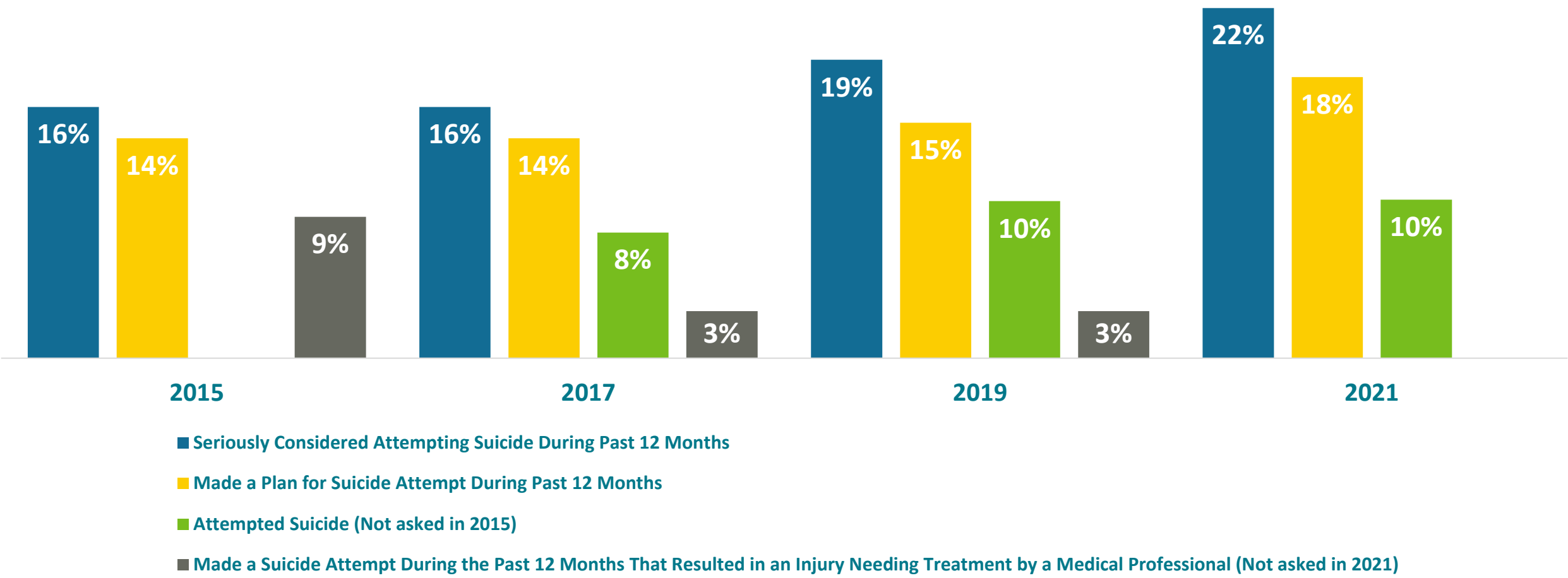
*Almost every day for ≥ 2 weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey

†Increased 2001-2021, no change 2001-2015, increased 2015-2021 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$).

Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).]

North Carolina - YRBS, 2011-2021

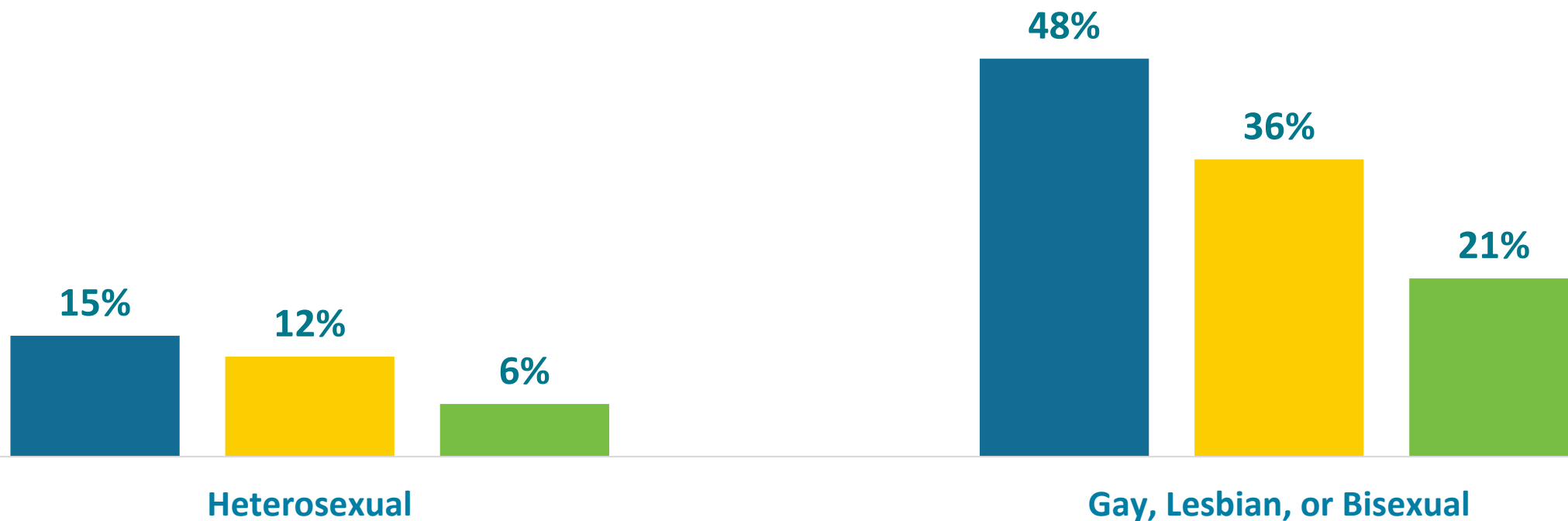
Suicidal Behaviors 2015-2021 NC High School Students



Source: NC High School Youth Risk Behavior Survey

Suicidal Behaviors

2021 NC High School Students



- Seriously Considered Attempting Suicide During Past 12 Months
- Made a Plan for Suicide Attempt During Past 12 Months
- Attempted Suicide During the Past 12 Months

Source: NC High School Youth Risk Behavior Survey

Seriously Considered Suicide

2011-2021 NC High School Students



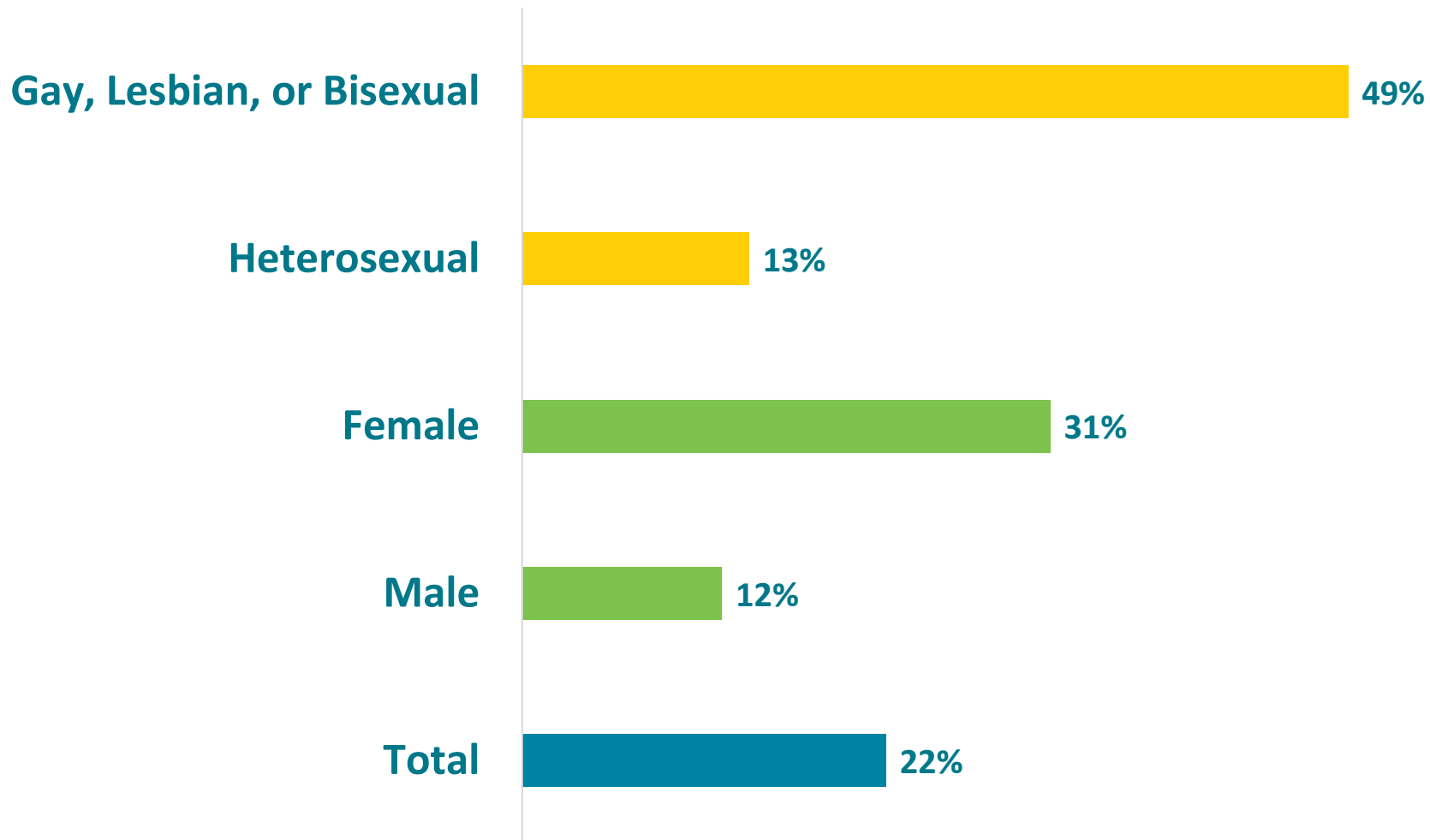
	2011	2013	2015	2017	2019	2021
■ Female	15%	22%	21%	21%	23%	30%
■ Male	14%	12%	11%	11%	15%	14%

■ Female

■ Male

Source: NC High School Youth Risk Behavior Survey

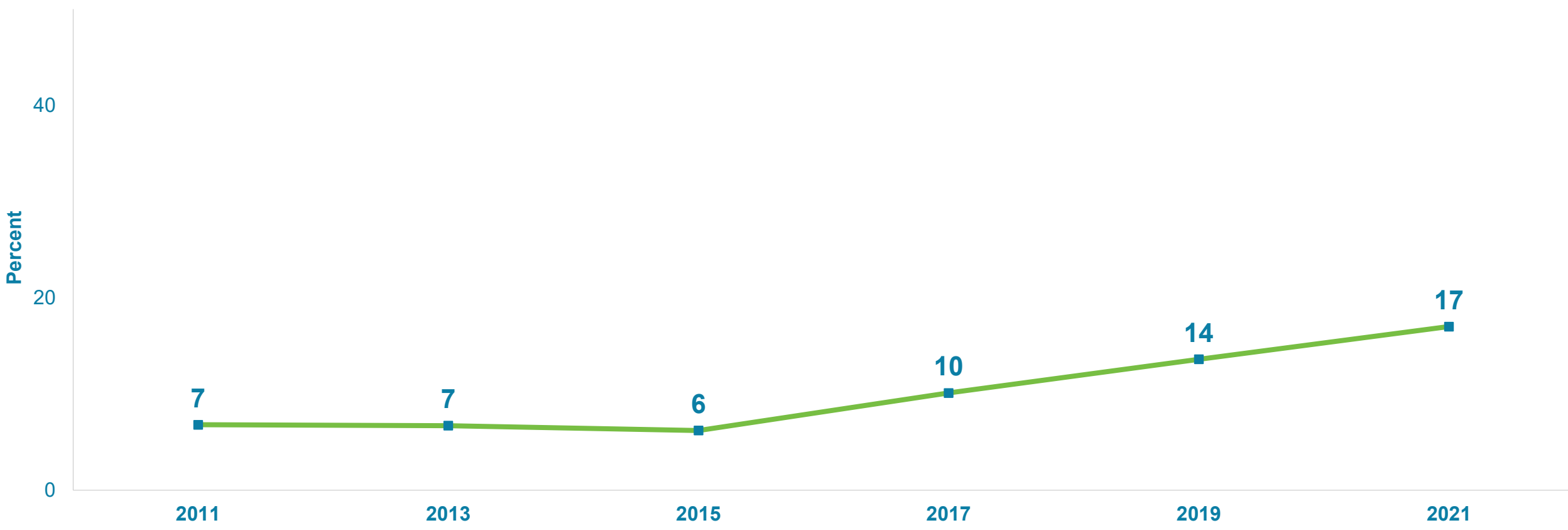
Percentage of High School Students Who Did Something to Purposely Hurt Themselves Without Wanting to Die*



*Such as cutting or burning themselves on purpose one or more times during the 12 months before the survey

North Carolina - YRBS, 2021

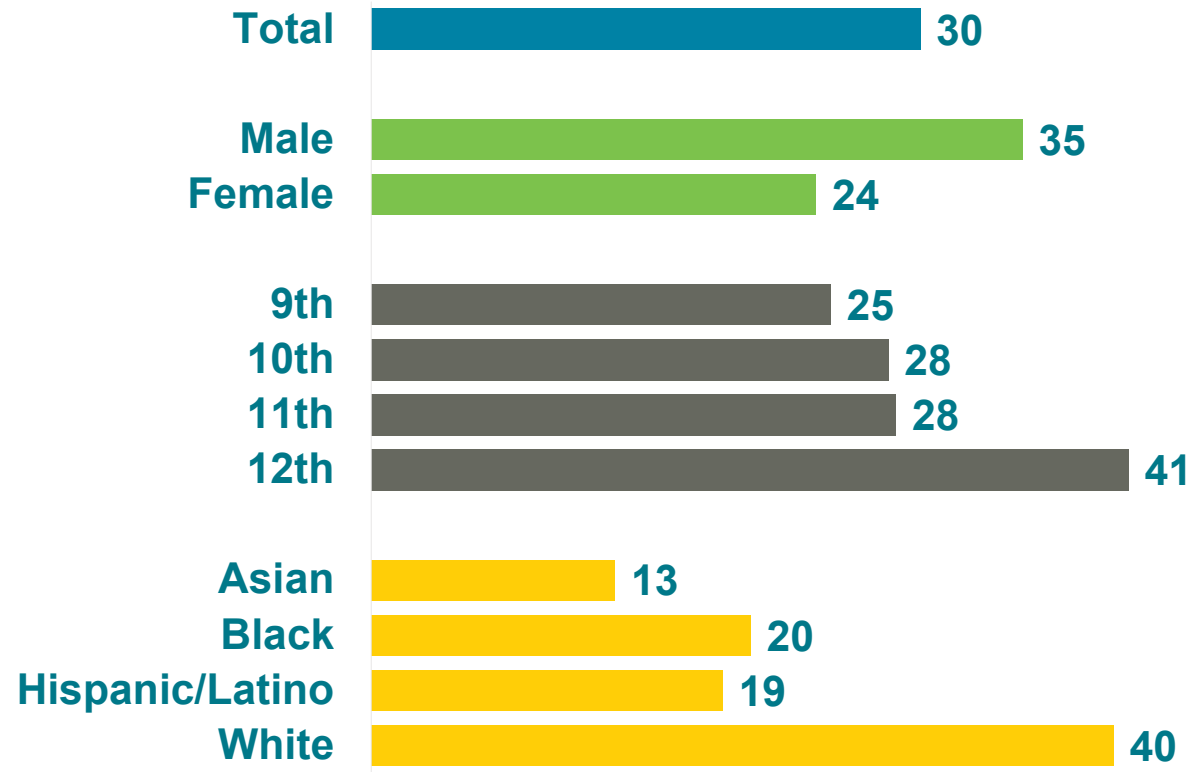
Percentage of High School Students Who Did Not Go to School Because They Felt Unsafe at School or on Their Way to or from School,* 2011-2021**



*On at least 1 day during the 30 days before the survey

**Increased 2015-2021 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).]

Percentage of High School Students Who Reported It Would It Take Them Less Than an Hour to Get and Be Ready to Fire a Loaded Gun Without a Parent or Other Adult's Permission,* by Sex,[†] Grade,[†] and Race/Ethnicity,[†] 2021



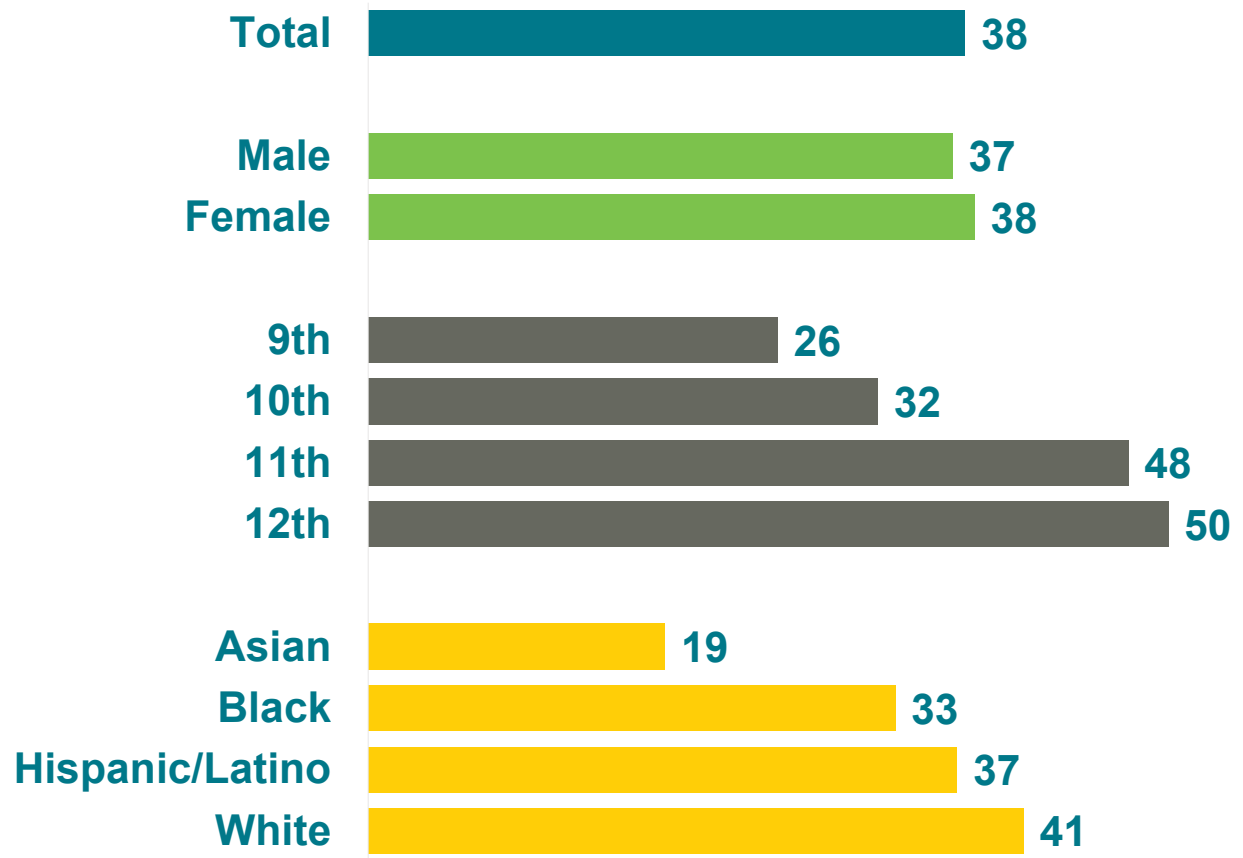
*Gun could be theirs or someone else's and it could be located in their home or car or someone else's home or car

[†]M > F; 12th > 9th, 12th > 10th; W > A, W > B, W > H (Based on t-test analysis, p < 0.05.)

All Hispanic students are included in the Hispanic category. All other races are non-Hispanic.

This graph contains weighted results.

Percentage of High School Students Who Ever Used an Electronic Vapor Product,* by Sex, Grade,[†] and Race/Ethnicity, 2021

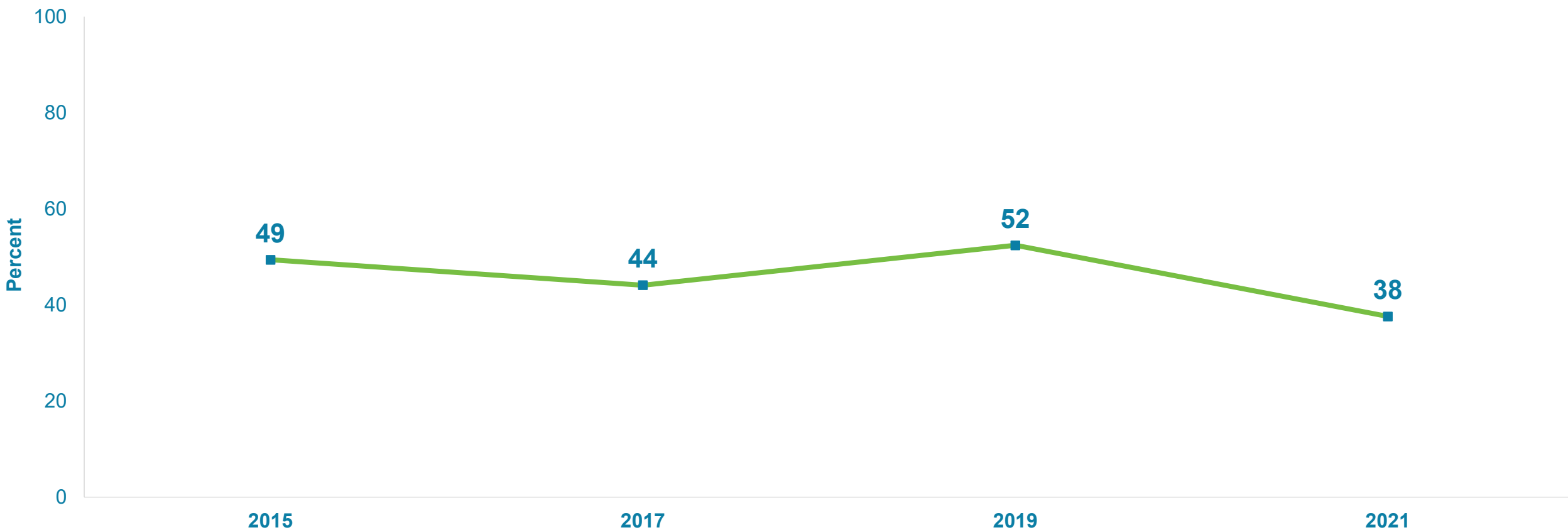


*Including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods [such as JUUL, SMOK, Suorin, Vuse, and blu]

[†]11th > 9th, 11th > 10th, 12th > 9th, 12th > 10th (Based on t-test analysis, p < 0.05.)

All Hispanic students are included in the Hispanic category. All other races are non-Hispanic.

Percentage of High School Students Who Ever Used an Electronic Vapor Product,* 2015-2021**

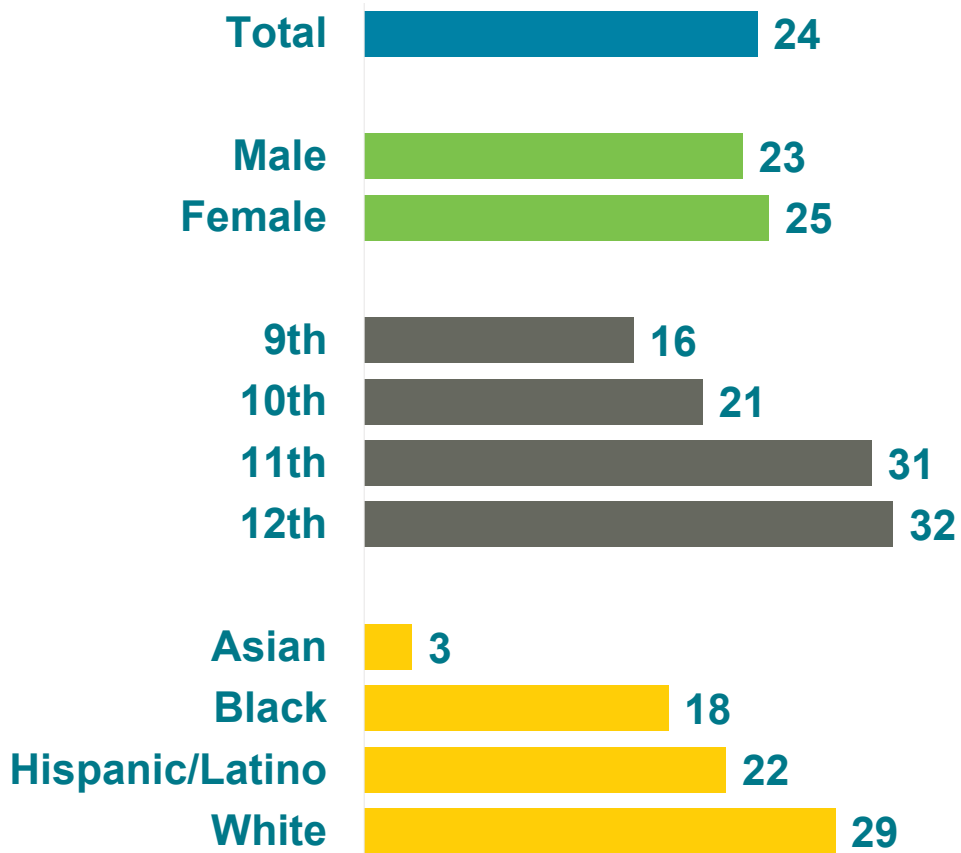


*Including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods [such as JUUL, SMOK, Suorin, Vuse, and blu]

**Decreased 2015-2021 [Based on linear trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$).]

This graph contains weighted results.

Percentage of High School Students Who Currently Used an Electronic Vapor Product,* by Sex, Grade,[†] and Race/Ethnicity,[†] 2021



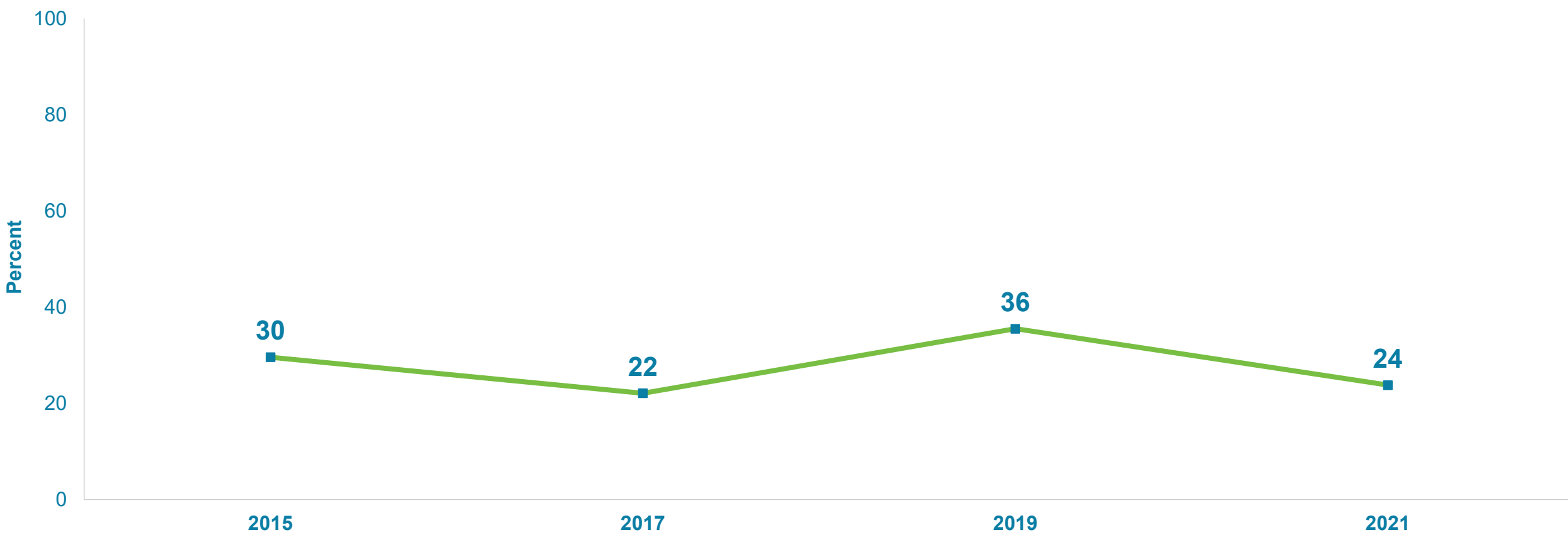
*Including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods [such as JUUL, SMOK, Suorin, Vuse, and blu], on at least 1 day during the 30 days before the survey

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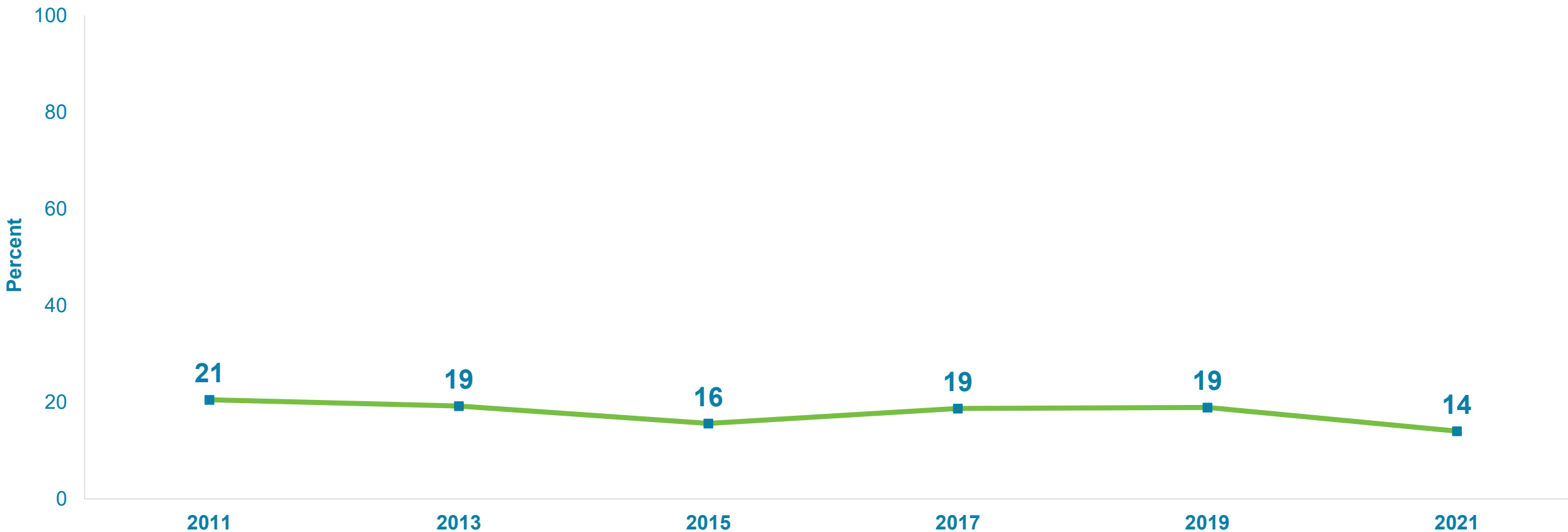
North Carolina - YRBS, 2021 - QN35

Percentage of High School Students Who Currently Used an Electronic Vapor Product,* 2015-2021**



*Including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods [such as JUUL, SMOK, Suorin, Vuse, and blu], on at least 1 day during the 30 days before the survey
 †No change 2015-2021 [Based on linear trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$).]
 This graph contains weighted results.

Percentage of High School Students Who Were Bullied on School Property,* 2011-2021†



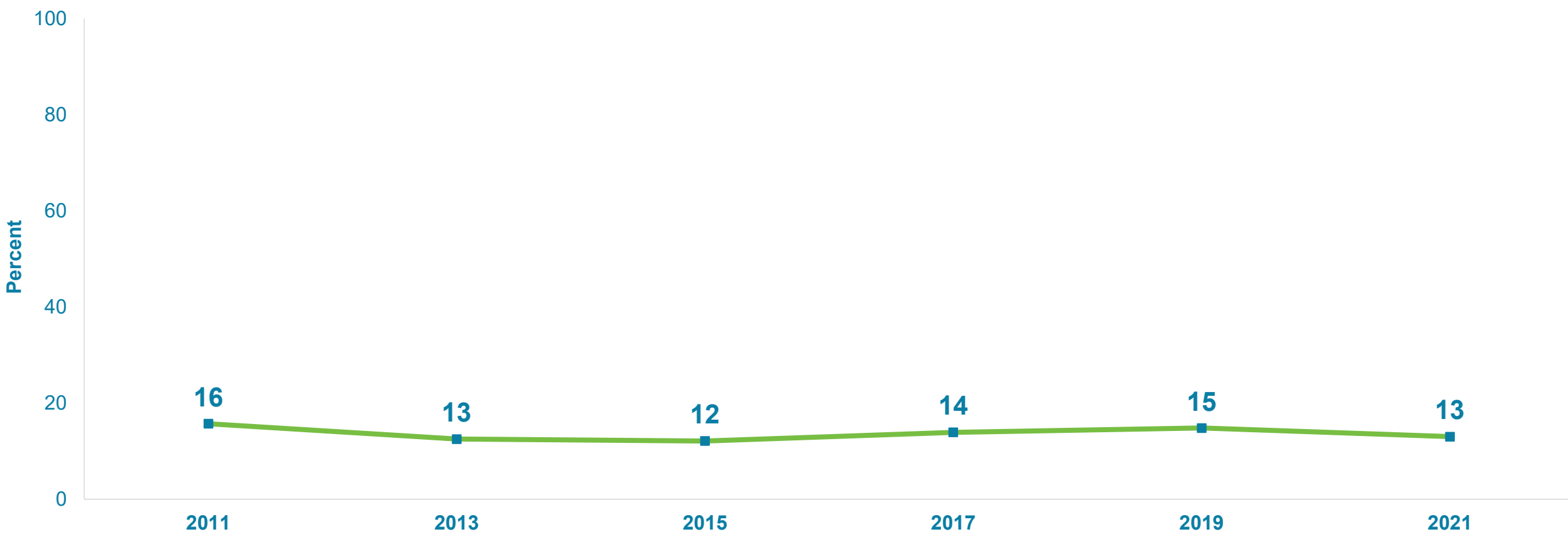
*Ever during the 12 months before the survey

†Increased, 2009-2013, no change, 2013-2021 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).]

This graph contains weighted results.

North Carolina - YRBS, 2011-2021 – QN23

Percentage of High School Students Who Were Electronically Bullied,* 2011-2021†

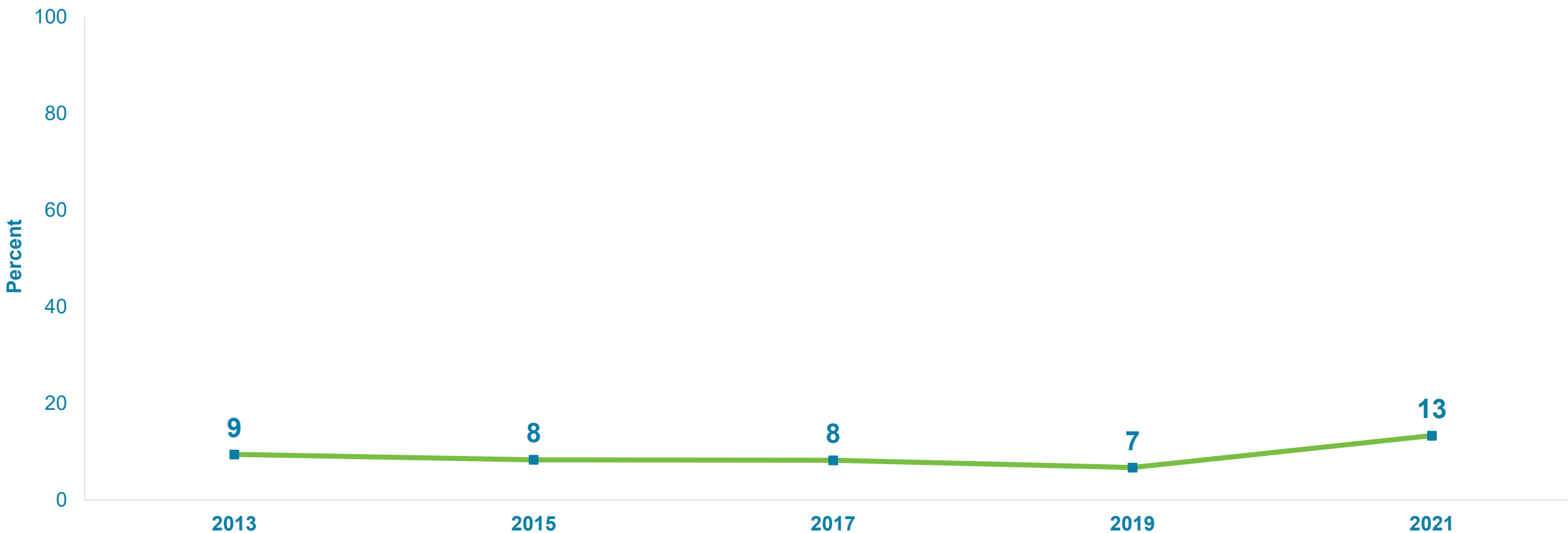


*Counting being bullied through texting, Instagram, Facebook, or other social media, ever during the 12 months before the survey

†No change 2011-2021 [Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$). Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).]

This graph contains weighted results.

Percentage of High School Students Who Experienced Physical Dating Violence,* 2013-2021†

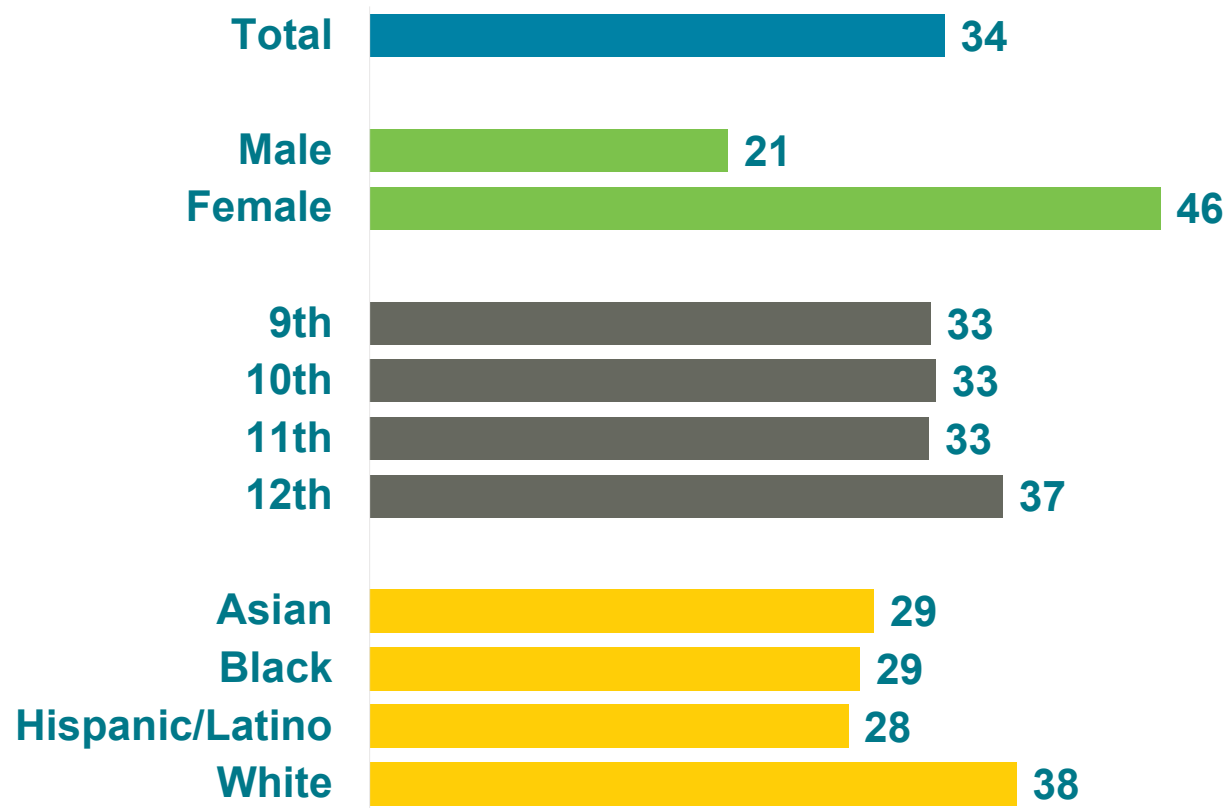


*Being physically hurt on purpose by someone they were dating or going out with [counting such things as being hit, slammed into something, or injured with an object or weapon] one or more times during the 12 months before the survey, among students who dated or went out with someone during the 12 months before the survey

†No change 2013-2021 [Based on linear trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$).]

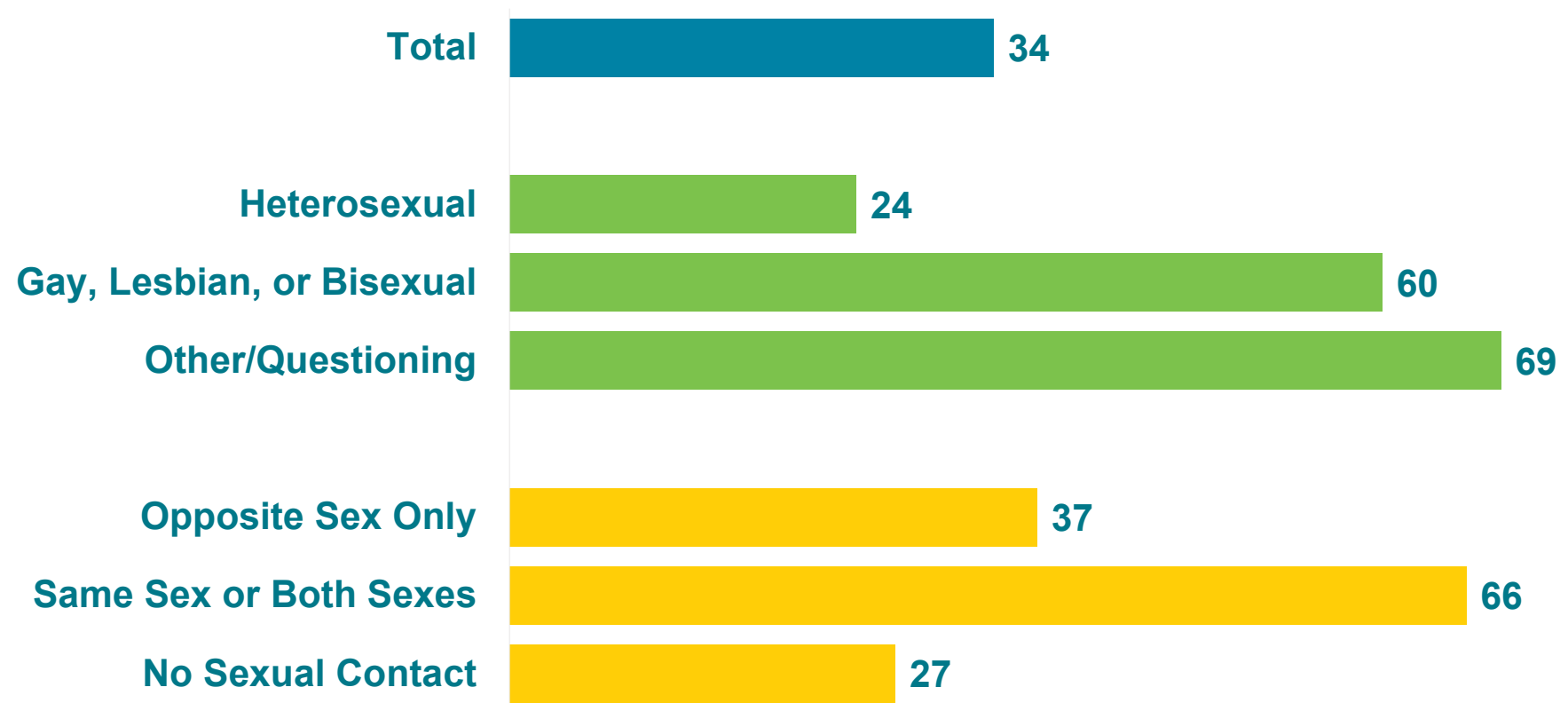
This graph contains weighted results.

Percentage of High School Students Who Reported That Their Mental Health Was Most of the Time or Always Not Good,* by Sex,[†] Grade, and Race/Ethnicity, 2021



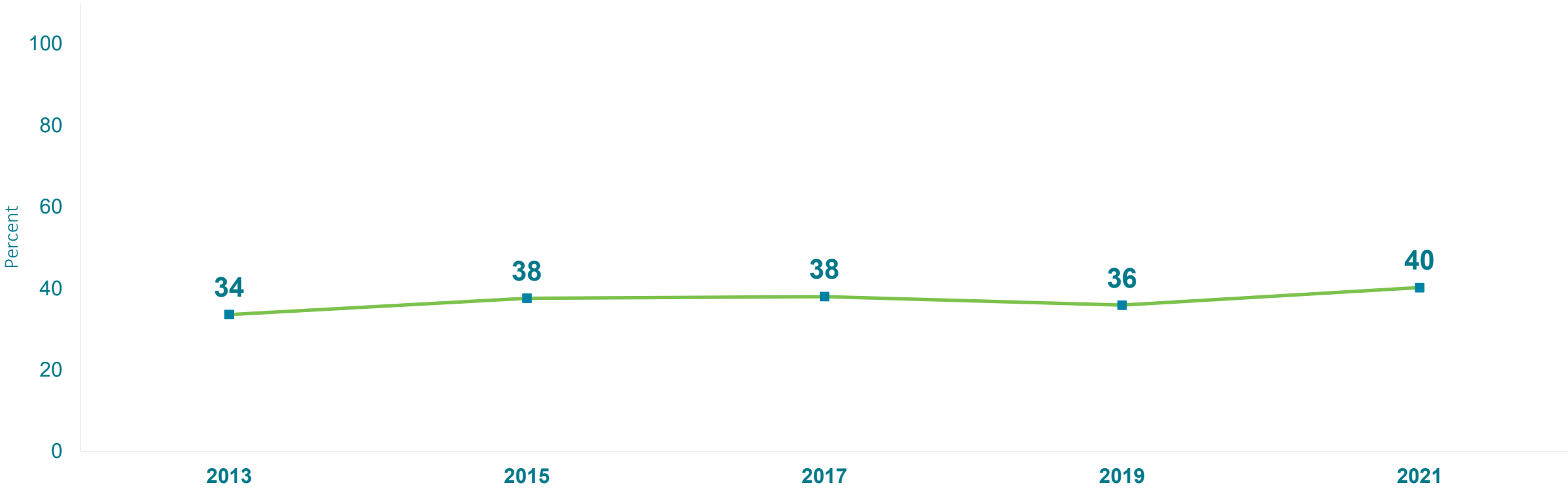
*Including stress, anxiety, and depression, during the 30 days before the survey
[†]F > M (Based on t-test analysis, p < 0.05.)
 All Hispanic students are included in the Hispanic category. All other races are non-Hispanic.
 This graph contains weighted results.

Percentage of High School Students Who Reported That Their Mental Health Was Most of the Time or Always Not Good,* by Sexual Identity and Sex of Sexual Contacts, 2021



*Including stress, anxiety, and depression, during the 30 days before the survey
This graph contains weighted results.


Percentage of High School Students Who Texted or E-Mailed While Driving a Car or Other Vehicle,* 2013-2021[†]



*On at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey

[†]No change 2013-2021 [Based on linear trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade ($p < 0.05$).]

This graph contains weighted results.



Unintentional Death
Prevention Committee
Recommendations and
Updates

Unintentional Death Prevention Committee Recommendation

SUPPORT legislation to strengthen NC's child passenger safety law to address best practices by making the following changes:

- 1. To address importance of younger children riding in rear seat**, require children under age 8 to be properly restrained in the rear seat of a vehicle when the vehicle has a passenger side front air bag and has an available rear seat.
- 2. To clarify the need for infants and toddlers to ride in rear-facing seats**, modify law to say that a child must be properly secured in a weight and height-appropriate child passenger restraint system according to manufacturer instructions, including instructions for the use of rear-facing restraint systems for infants and toddlers.
- 3. To clarify safe transition from booster seat to adult seat belt**, require a child to be properly secured in a weight-appropriate child passenger restraint system until the child is four feet 9 inches tall (57 inches) and the adult seat belt fits properly without a booster seat (law to describe proper fitting of seat belt).

Background

- **NC's child passenger safety statute (N.C.G.S. 20-137.1) differs from the best practice recommendations** of the American Academy of Pediatrics and the National Highway Traffic Safety Administration (NHTSA). (This topic came to CFTF via issue application from NC Child)
- **2020 and 2021:** CFTF had an administrative item on its agenda for **outside highway safety experts to study this issue and come back to it;** the NC Occupant Protection Task Force studied the topic and data was shared with UD Committee.
- AAP new child passenger safety recommendations were expected to be released late 2022 but then were delayed again (major changes not expected).
- NC experts in motor vehicle safety have continued to inform this committee about evidence-driven best practice for child passenger safety.

2017-2021 – NC Youth (0-17 Years Old)

- Assessment of Child Restraint (CR) utilized, other seat belt (SB) utilized (lap belt only, shoulder and lap belt, shoulder belt only), or none by age groupings in fatalities



<u>Front Seat</u>	Fatalities	<u>Age 0-8</u>	<u>Age 9-17</u>
	CR Used (1.3%)	2	0
	SB Used (56.7%)	2	83
	None (42.0%)	5	58
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<u>Back Seat</u>	Fatalities	<u>Age 0-8</u>	<u>Age 9-17</u>
	CR Used (28.9%)	46	0
	SB Used (28.3%)	19	26
	None (42.8%)	24	44
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<u>2nd Back Seat</u>	Fatalities	<u>Age 0-8</u>	<u>Age 9-17</u>
	CR Used (25.0%)	3	0
	SB Used (25.0%)	0	3
	None (50.0%)	2	4

2017-2021 – NC Youth (0-17 Years Old)

- Assessment of Child Restraint (CR) utilized, other seat belt (SB) utilized (lap belt only, shoulder and lap belt, shoulder belt only), or none by age groupings in severe injuries



<u>Front Seat</u>	Severe Injuries	<u>Age 0-8</u>	<u>Age 9-17</u>
	CR Used (1.1%)	10	0
	SB Used (72.5%)	34	610
	None (26.4%)	33	201
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<u>Back Seat</u>	Severe Injuries	<u>Age 0-8</u>	<u>Age 9-17</u>
	CR Used (26.6%)	193	7
	SB Used (39.8%)	83	216
	None (33.6%)	116	137
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<u>2nd Back Seat</u>	Severe Injuries	<u>Age 0-8</u>	<u>Age 9-17</u>
	CR Used (12.7%)	7	1
	SB Used (39.7%)	10	15
	None (47.6%)	12	18

Considerations

- **A 2017 journal article concluded that children are more likely to ride in the recommended type of child restraint when their state's law includes wording that follows best practice recommendations, BUT requirements don't influence when caregivers fail to use a restraint system for children.**
- **NC experts tell us:** best practice evolves and can be impacted by new research or changing car safety technology; best practice can be challenging to effectively convey in the language of a law.
- **THE GOAL: Revise NC's child passenger safety laws to more clearly address best practice recommendations to improve behaviors around child passenger safety AND prevent child injuries and deaths**

Rear Seat Instead of Front Seat

Current NC Law: “In vehicles equipped with an active passenger-side front air bag, if the vehicle has a rear seat, a child less than five years of age and less than 40 pounds in weight shall be properly secured in a rear seat, unless the child restraint system is designed for use with air bags.”

Best Practice: Kids should ride in the back seat until they are 13 years old.

Other states: Varies – some states don’t address; some say must be in rear seat (with some exceptions) if under age 13 (e.g., WA, LA), some say under age 8 (e.g. VA, TN, SC), some younger.

Recommendation to reflect best practice: Strengthen NC’s child passenger safety law to address best practice for children riding in the back seat by requiring children under age 8 to be properly restrained in the rear seat of a vehicle when the vehicle has a passenger side front air bag and has an available rear seat.

Rear facing for infants and toddlers

Current NC Law: None (NC law references being “properly secured in a weight-appropriate child passenger restraint system” & certain systems are designed for rear-facing use with size requirements)

Best Practice: Keep kids rear-facing as long as possible according to height and weight requirements for car seat

Other states: Per the Governor’s Highway Safety Association, **23 states, the District of Columbia and the Virgin Islands require children younger than two (some say under 4) to be in a rear-facing child safety seat** and laws are often written to address height and weight requirements for rear-facing seat and/or seat manufacturer’s height and weight limits. (NC experts have pointed out that if you state a specific age, it could prompt a child to be moved PRIOR to reaching the limits on a particular seat which is not best practice)

Recommendation to reflect best practice: Strengthen NC’s child passenger safety law by more explicitly addressing best practice for infants and toddlers to ride in rear-facing car seats by modifying existing language to say that a child must be properly secured in a weight and height-appropriate child passenger restraint system according to manufacturer instructions, including instructions for the use of rear-facing restraint systems for infants and toddlers.

Booster seats and restraints for older kids

Current NC Law: “A child less than eight years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system.”

Best Practice: Seat belts are designed to fit adults. Booster seats position kids so that the seat belt fits properly – lap belt low on hips and shoulder belt across the collarbone. Kids should be in a booster seat until an adult belt fits properly without the booster.

Other states: Some states have laws that address transitioning from a booster seat to an adult seat belt; such laws may address age or size and may address outgrowing a seat according to the manufacturer’s instructions; such laws may describe proper fitting of an adult seat belt. (NC experts have pointed out that technically, a child may have an adult belt fit them correctly long before they outgrow the maximum size requirements for the booster.)

Recommendation to reflect best practice: Strengthen NC’s child passenger safety law to address best practice for transitioning from booster seat to adult seat belt by requiring a child to be properly secured in a weight-appropriate child passenger restraint system until the child is four feet 9 inches tall (57 inches) and the adult seat belt fits properly without a booster seat. A child is properly secured by an adult safety seat belt if: (a) the lap belt fits across the child's thighs and hips and not across the abdomen; (b) the shoulder belt crosses the center of the child's chest and not the neck; and (c) the child is able to sit with his back straight against the vehicle seat back cushion with his knees bent over the vehicle's seat edge without slouching. (This description of proper fitting is from SC law)



Discussion and voting on UD Committee recommendation

Strengthen NC's child passenger safety law to address best practices by making the following changes:

- 1. To address importance of younger children riding in rear seat**, require children under age 8 to be properly restrained in the rear seat of a vehicle when the vehicle has a passenger side front air bag and has an available rear seat.
- 2. To clarify the need for infants and toddlers to ride in rear-facing seats**, modify law to say that a child must be properly secured in a weight and height-appropriate child passenger restraint system according to manufacturer instructions, including instructions for the use of rear-facing restraint systems for infants and toddlers.
- 3. To clarify safe transition from booster seat to adult seat belt**, require a child to be properly secured in a weight-appropriate child passenger restraint system until the child is four feet 9 inches tall (57 inches) and the adult seat belt fits properly without a booster seat (law to describe proper fitting of seat belt).

Unintentional Death Prevention Committee Recommendation

ENDORSE legislation requiring lifeguards at children's day camps that offer time in the water.

Background information

- **2021 issue application** requested the CFTF to ENDORSE legislation that would require lifeguards at children's day camps that offer time in the water.
- **Topic examined by UD committee in 2021-22 study cycle**
- **2022 CFTF Action Agenda administrative item:**
 - ADMINISTRATIVE SUPPORT for **further study** by the UNC Injury Prevention Research Center to quantify the **potential impact of legislation requiring lifeguards at day camps** that offer time in the water (as it relates to impact on preventing child drownings and near-drownings) to bring information back to the Unintentional Death Prevention Committee; **CFTF to acknowledge the public health efficacy of utilizing lifeguards as a strategy to prevent child drownings** in settings where children are in or around water, including day camp settings.

Highlights of data presented on child drownings & near drownings

- NC - 2010 – 2019 (ten years): **277 accidental drownings** to children 17 and younger
- Between 2016 & 2020: average of 25 child drowning deaths per year; 28 hospitalizations; 223 ED visits
- **Pools are the most common location for child drownings** in NC; most pool drownings of children in NC occur in **residential/private (nonpublic) pools (~75%)**
- The **age group of 1 to 4 has the highest** number of drownings in NC compared to other age groups
- CDC: **African American children ages 5 – 19** drown in swimming pools at rates **5.5 times higher than white children**
- CDC: For every **1 fatal** child drowning, another **8 receive medical care** for a non-fatal drowning

Highlights of other information shared in prior meetings

- Issue applicant discussed a **drowning death that occurred at a day camp in NC** at a pool; no data shared related to other drownings or near-drownings in a camp setting
- **Some states have laws or administrative rules** requiring lifeguards in camp settings when around water (e.g., AL, DE, IN, KY, ME, MD, MA, MI, MO)
- **Issue applicant seeks requirements** addressing lifeguard to camper **ratios, chair heights, swim tests** for all campers
- Strong evidence and stakeholder input was shared about **lifeguards providing an important layer of protection** to prevent drowning
- Information was shared about a **shortage of lifeguards in NC**

Relevant laws and regulatory structures

- Most “day camps” in NC are not regulated in the **context of child care laws and rules**
 - The definition of child care excludes many situations that may be considered a “day camp”
 - A summer day camp may voluntarily seek to be licensed to be eligible to receive child care subsidy payments (DCDEE receives very few applications from summer camps seeking to be licensed).
 - *For licensed child care programs in NC, there are lifeguard requirements for aquatic activities that are enforced by DCDEE. (There are also water safety requirements for children’s foster care camps.)*
- “Day camps” in NC are only regulated in the **public health context** related to **sanitation**
 - Summer camps, including day camps, *that provide food or lodging* for groups of children are required to operate with a permit, however per laws and regulations, **requirements for summer camps are focused on sanitation** (food and water, lodging, vermin control, employee health) and **do not address safety for aquatic activities such as lifeguards.**
 - Local health departments carry out enforcement of any requirements for camp permits.

Bottom line with law and regulation: Currently there is no law or rule in NC addressing water safety at *all day camps* and there is no regulatory structure in NC that addresses or has the authority to address water safety requirements at *all day camps*.

Information related to implementation (per DHHS Deputy General Counsel):

- Legislation like this (to require lifeguards at day camps) involves a regulatory function that would typically be delegated to a state agency.
- Administrative rules would need to be promulgated to address details related to implementation of requirements for lifeguards at day camps.
- The Rules Commission's process for promulgating rules includes a public comment period on proposed rules, a fiscal impact statement addressing any kind of economic impact, and a vote by the Commission on proposed rules.

Highlights from
study by UNC
Injury Prevention
Research Center;
considerations &
recommendation
from Dr. Steve
Marshall

- **Scientific literature is highly supportive of lifeguards as a drowning prevention strategy globally.**
- **There is no way of knowing how many child drownings or non-fatal drownings occur at day camps** or how many could be prevented through this proposed legislation – there are no existing data sources to enable this type of study; **regardless of ability to measure, such a law could be important and effective.**
- **Natural bodies of water can present special challenges** for lifeguards who may not be trained for nature bodies of water – a gap in training that may not be clear to all should be considered.
- While there may be challenges with enforcement and implementation of new requirements, **WHY are there no injury prevention requirements for day camps?**
- Some day camps may already meet such requirements; day camps can choose not to offer time in the water.
- **Dr. Marshall conveyed his strong support for a law that requires lifeguards at children’s day camps offering time in the water.**



Discussion and
voting on UD
Committee
recommendation

ENDORSE legislation requiring
lifeguards at children's day camps
that offer time in the water

UD Committee Recommendation

ENDORSE an appropriation of \$17 million in recurring funds for programs to prevent tobacco/nicotine use and cessation by youth and to prevent harms to infants and children caused by tobacco/nicotine use.

Background

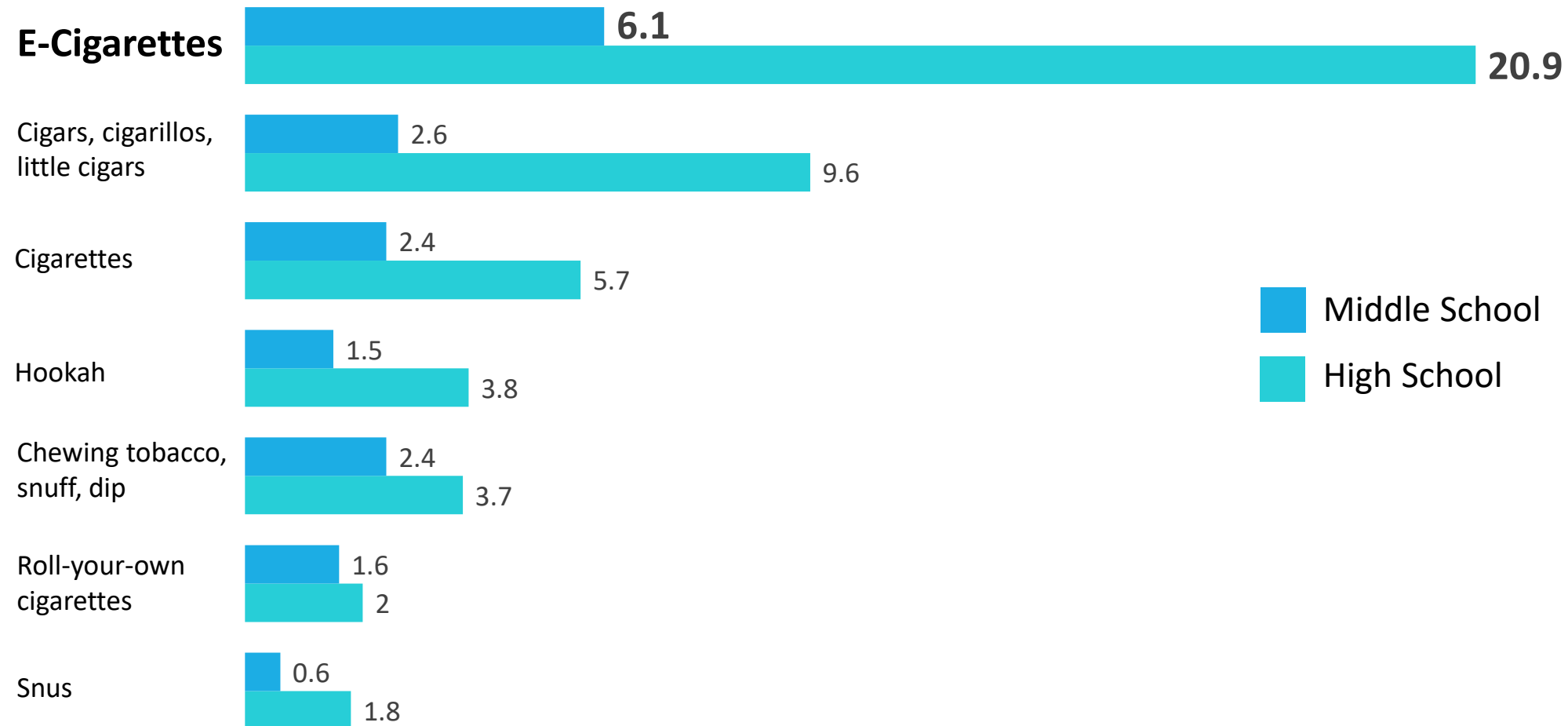
- CFTF Action Agenda has included a **recommendation to endorse efforts for new appropriations for tobacco/nicotine use prevention** each year since **2018**.
- **2021**: issue application requested the CFTF to endorse for 2022 efforts for **recurring funding in the amount of \$17 million for tobacco use prevention programs**, including e-cigarette use prevention programs.
- The **2021/22 state budget** included *nonrecurring* funds totaling \$13 million from the Juul settlement to go to DPH for tobacco and nicotine dependence prevention and cessation activities targeted at youth and young adults

Highlights of information from prior presentations related to tobacco use

- 90% of tobacco users start before the age of 18
- **Nicotine is highly addictive** and **e-cigarettes can contain high doses of nicotine** coming in thousands of flavors attractive to youth.
- Nicotine use while the adolescent brain is developing **can disrupt brain circuit formation.**
- Nicotine is **toxic to developing fetuses** and impairs fetal brain and lung development
- Tobacco use during pregnancy is **associated with leading causes of infant death.**
- Most school staff identify e-cigarette use among students as somewhat or very problematic

2019 Data: E-cigarettes #1 Product Used by Youth

Past 30 Day Tobacco Product Use, NC YTS 2019



2019 estimates may not represent the full population due to low response rate

2021 YRBS
Survey Data
show with
respect to use
of electronic
vapor product
...

38% of all high school kids say they have (ever) used

About 50% of 11th and 12th graders say they have (ever) used

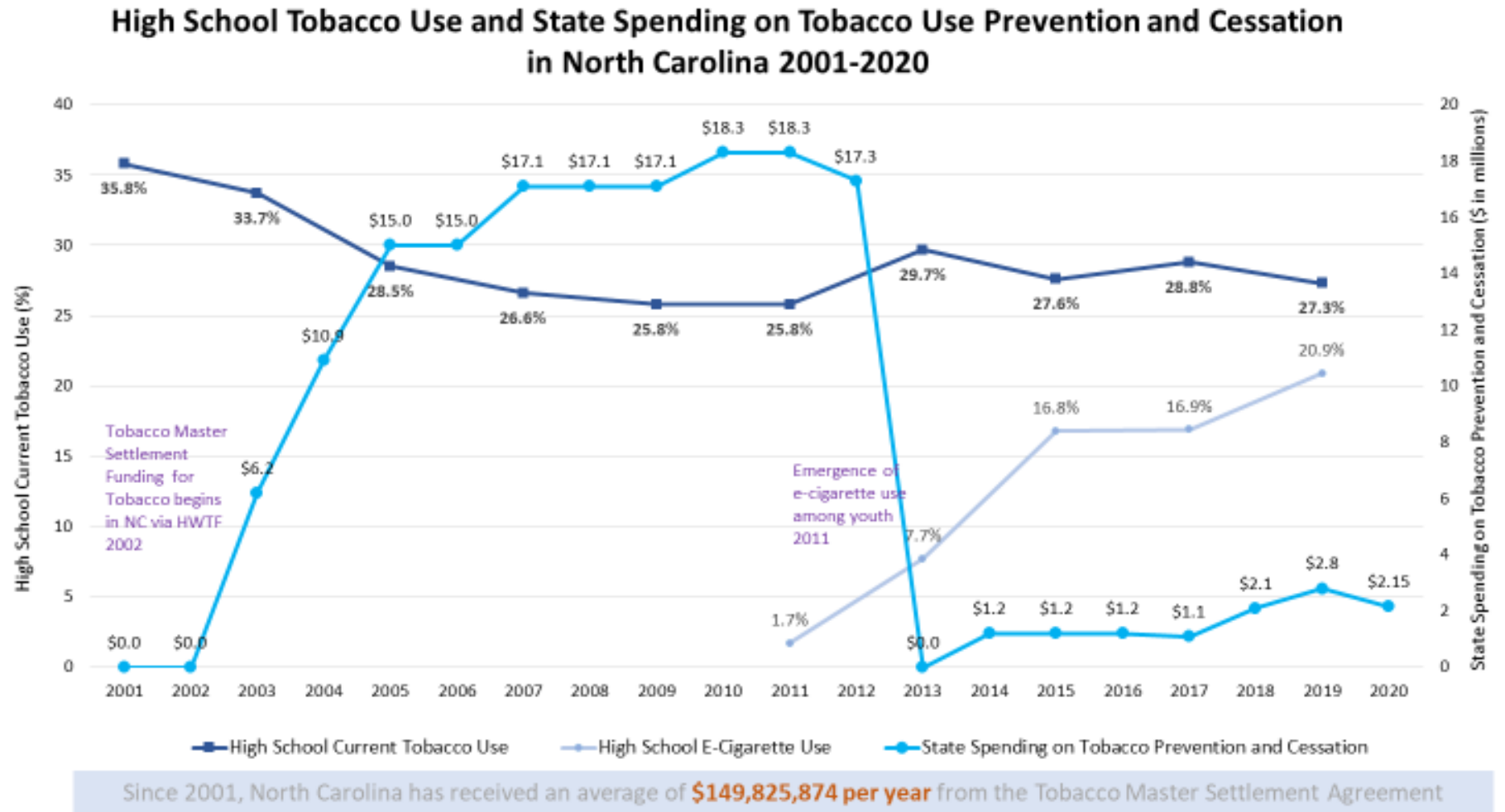
About 24% of high schoolers say they currently use

Over 30% of 11th and 12th graders say they currently use



State spending on tobacco use prevention was cut in 2013 despite the fact that since 2001, NC has received an average of **\$149.8 million per year** from the Tobacco Master Settlement Agreement

Since the 2013 budget cuts, there have been dramatic increases in e-cigarette use among teens



In 2021, North Carolina received \$167 million from the Tobacco Master Settlement Agreement



Discussion and
voting on UD
recommendation

ENDORSE an appropriation of \$17 million in recurring funds for **programs to prevent tobacco/nicotine use and cessation** by youth and to prevent harms to infants and children caused by tobacco/nicotine use.



How CTF work continues . . .



Announcements & Adjourn