A LOOK AT THE NEW REPORT CARD

The North Carolina Child Health Report Card tracks key indicators on Access to Care, Healthy Births, Safe Homes and Neighborhoods, and Health Risk Factors over time and by race and ethnicity.

FOCUS ON INSURANCE COVERAGE

Join the Conversation #ChildHealthNC
For 26 years, the *Child Health Report Card* has tracked leading indicators of child health in order to highlight opportunities to strengthen the well-being of North Carolina children and examine the impact of public policies on child outcomes. Throughout the report’s history, we have occasionally broken down select indicators by factors such as income and age to better identify which children have the best outcomes, understand why, and explore how North Carolina can ensure every child has the best chance to live a healthy and safe life. We have observed measurable differences by household income or age, factors research has shown can shape child health and well-being.

This year’s report also shows children’s chances of having these and other fundamental building blocks of good health often differ dramatically by race and ethnicity. The race and ethnicity data presented do not control for education, income, or other social or economic factors that may contribute to differences in health outcomes across race/ethnicity.

Many child and family serving agencies are not required to report data by race and ethnicity. Among those that do, some collect data using the Office of Management and Budget race and ethnicity categories while others do not. For this reason, race and ethnicity categories presented in this document may differ across indicators. For consistency, we have provided a key below the data tables throughout the document.
IMPROVEMENTS IN HEALTH INSURANCE COVERAGE FOR CHILDREN

The foundation for lifelong health is built during childhood. Health insurance coverage is an essential support to promote child health. Children with health insurance are more likely to access preventive care and receive needed services than uninsured children. They are also less likely to miss school due to preventable illness.1

North Carolina has made significant progress towards ensuring that all children have access to affordable health care. Since 2009, the uninsured rate for children has declined by nearly half (from 8.1% in 2009 to 4.4% percent in 2015), the 14th largest drop in the rate of uninsured children nationally.2,3 Ninety-six percent of children in North Carolina have health insurance coverage, a record high for the state.3

Gains in children’s health insurance coverage are linked to the success of three complementary policies and programs. Medicaid and NC Health Choice (North Carolina’s Children’s Health Insurance Program) are federal and state programs that target children in families with incomes below 211 percent of the federal poverty level (FPL). Together Medicaid and NC Health Choice provide health insurance coverage for more than 1.2 million children in North Carolina, almost half of all children in the state. Ninety-three percent of North Carolina children enrolled in public health insurance programs are covered by Medicaid. Medicaid provides a comprehensive set of benefits including dental, vision, regular checkups, and preventive and developmental screening.4 The Patient Protection and Affordable Care Act (ACA), has strengthened children’s private insurance coverage rates by providing subsidies to households with incomes between 100-400% FPL to purchase health insurance.5,6

The ACA has also bolstered children’s coverage rates through streamlined enrollment processes, greater outreach efforts, and increased coverage for parents.7 More than 55,000 children in North Carolina have health insurance through the ACA marketplace (also known as the health care exchanges), and children make up nine percent of all North Carolina marketplace enrollees.8 Research shows as parents pursue coverage for themselves or other family members in the marketplace, children who qualify for public health insurance coverage are often identified. As a result, increased coverage for parents since full implementation of ACA in 2013 has opened the door for eligible but unenrolled children to gain coverage through public programs.7,9

Despite an overall reduction in uninsured children, some children continue to experience coverage barriers that weaken their immediate and long-term opportunities for health. One in 16 children in poor or near poor homes (6.1 percent) remains uninsured despite meeting the income eligibility for public health insurance programs.3,10 Hispanic and Latinx children are 2.8 times more likely to be uninsured than their non-Hispanic white peers.3 Furthermore, improvements in children’s health insurance are closely tied to Medicaid, Health Choice, and the ACA, so policy or administrative changes to these programs at the state or federal level could diminish or eliminate recent gains in coverage. Congress is currently debating several proposals that would significantly alter these programs, including a full or partial repeal of ACA and converting federal financing for Medicaid from an entitlement to a per-capita allotment or block grant. Early analyses of Medicaid reform proposals estimate they could cause as many as 160,000 North Carolina children to lose health insurance coverage.10 In addition to potential changes to Medicaid, a proposed repeal of tax credits for coverage purchased through the health insurance exchanges is estimated to result in a $24 billion loss in subsidies to households with income below 400% of FPL by 2023.11

As we applaud recent increases in children’s health insurance coverage in North Carolina, it is important to remember these improvements are the result of partnerships between policymakers, communities, and practitioners. Health insurance alone does not automatically equate to quality medical care for children, since additional barriers such as cost, a shortage of rural providers, and logistical challenges such as transportation remain, but coverage is a necessary step towards accessing services. More work is required to address coverage and access barriers and assure every child in North Carolina has health insurance to support their best growth and development. North Carolina has come a long way towards ensuring all children have access to affordable health care, and it is imperative that the state remain committed to preserving and building upon that progress.

4. Referred to as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).
6. Four hundred percent of the federal poverty level is $81,680 for a family of three.
10. Poor or near poor refers to children who live in families that earn less than twice the federal poverty line--less than $40,840 per year for a family of three.
11. Latinx is defined as, “a person of Latin American origin or descent, used as a gender-neutral or non-binary alternative to Latino or Latina” (English Oxford Living Dictionaries, https://en.oxforddictionaries.com/).
ACCESS TO CARE

WHAT WE ARE DOING WELL?

- The percent of uninsured low-income children declined by almost half since 2010. Children in low-income families who have health insurance coverage experience better health outcomes and higher levels of education than their uninsured peers.\(^{14}\)

- The percent of uninsured parents (15.3%) continued to decline. For parents, having health insurance can lead to greater economic security; uninsured adults are more than three times as likely to have difficulty paying for basic living costs such as food, rent, heating, or electric bills.\(^{15}\)

- Eight in 10 children age 19-35 months receive recommended immunizations, and nearly all school age children have received recommended immunizations. High vaccine coverage results in low levels of vaccine-preventable illnesses among children including hepatitis, rotavirus, diphtheria, measles, mumps, and rubella.

WHAT CAN WE IMPROVE?

- Fewer than two-thirds of children covered by Medicaid received a well-child visit in the past year. For infants and toddlers, the American Academy of Pediatrics recommends multiple well-child visits per year, and for older children, an annual well-child visit is recommended.

WHAT CAN WE DO?

- North Carolina faces a maldistribution of physicians, nurses, and other health care providers, which leads to shortages of health care providers in many rural communities. Addressing this maldistribution, along with factors such as transportation problems and economic insecurity, could reduce barriers to preventive care visits that children and families may face.\(^{16}\)

- There is one school nurse for every 1,112 children in North Carolina public schools. The Centers for Disease Control and Prevention recommends a ratio of one nurse for every 750 “well” students in order to adequately meet the health and safety needs of children and school communities.\(^{17}\)

---


## ACCESS TO CARE

### Insurance Coverage

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Base</th>
<th>Better, Worse, No Change (NC)</th>
<th>African American or Black</th>
<th>American Indian</th>
<th>Asian</th>
<th>Hispanic or Latinx</th>
<th>Other</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of children with health insurance coverage</td>
<td>95.6%</td>
<td>92.4%</td>
<td>NC</td>
<td>96.3%*</td>
<td>91.4%†</td>
<td>94.4%†</td>
<td>90.8%</td>
<td>93.9%§</td>
<td>96.7%</td>
</tr>
<tr>
<td>% of low-income children without health insurance coverage (&lt;200 % FPL)</td>
<td>6.1%</td>
<td>10.6%</td>
<td>Better</td>
<td>4.0%</td>
<td>9.4%</td>
<td>4.7%</td>
<td>10.9%</td>
<td>8.0%</td>
<td>5.1%</td>
</tr>
<tr>
<td>% of children covered by public health insurance</td>
<td>53.1%</td>
<td>47.9%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Children covered by Medicaid</td>
<td>1,124,962</td>
<td>942,056</td>
<td>381,278</td>
<td>14,405</td>
<td>17,959</td>
<td>225,023</td>
<td>NA</td>
<td>415,896</td>
<td></td>
</tr>
<tr>
<td>Children covered by NC Health Choice</td>
<td>89,135</td>
<td>153,455</td>
<td>29,202</td>
<td>1,207</td>
<td>2,359</td>
<td>22,818</td>
<td>NA</td>
<td>49,910</td>
<td></td>
</tr>
<tr>
<td>% of parents without health insurance coverage*</td>
<td>15.3%</td>
<td>20.6%</td>
<td>Better</td>
<td>13.7%</td>
<td>21.1%†</td>
<td>10.1%†</td>
<td>53.7%</td>
<td>15.5%§</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

### Health Services Utilization

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Base</th>
<th>% of children with Medicaid who received a well-child checkup in the past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of children with Medicaid who use dental services</td>
<td>58.7%</td>
<td>59.7%</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Oral Health

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Base</th>
<th>% of kindergarten students with untreated tooth decay</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of kindergarteners who received a well-child checkup in the past year</td>
<td>2016</td>
<td>15.0%</td>
<td>NA</td>
</tr>
<tr>
<td>% of children with Medicaid who use dental services</td>
<td>2015</td>
<td>58.0%</td>
<td>NA</td>
</tr>
<tr>
<td>Ages 1-5</td>
<td></td>
<td>56.0%</td>
<td>NA</td>
</tr>
<tr>
<td>Ages 6-14</td>
<td></td>
<td>60.0%</td>
<td>NA</td>
</tr>
<tr>
<td>Ages 15-20</td>
<td></td>
<td>44.0%</td>
<td>NA</td>
</tr>
</tbody>
</table>

### School Health

<table>
<thead>
<tr>
<th></th>
<th>SY 2014-15</th>
<th>SY 2010-11</th>
<th>School nurse ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current</td>
<td>Base</td>
<td>1:1,112</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1:1,201†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Better</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SY 2013-14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1:379</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SY 2015-16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>96.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NC</td>
</tr>
</tbody>
</table>

### Immunization

<table>
<thead>
<tr>
<th></th>
<th>SY 2015-16</th>
<th>SY 2011-12</th>
<th>% of children ages 19-35 months with appropriate immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current</td>
<td>Base</td>
<td>% of children with appropriate immunizations at school entry</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>80.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>76.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NA</td>
</tr>
</tbody>
</table>

### Key

- NA: Data are not available
- --: Data suppressed
- †: Asian includes Hawaiian/Pacific Islander
- *: Race categories include Hispanic
- §: Other includes Multi-Racial and Two or More Races
- ‡: American Indian includes Native Alaskan
HEALTHY BIRTHS

WHAT WE ARE DOING WELL?

- The percent of **babies born to women who smoke** during pregnancy (9.3%) declined by 15 percent between 2011 and 2015. Smoking is associated with poor birth outcomes including prematurity and low birthweight that can contribute to health problems later in life.

- More mothers are meeting the recommended guideline of **exclusively breastfeeding** for six months (20.8% in 2013—up 50% since 2009). Breastfeeding is associated with fewer infectious and chronic illnesses among children, reductions in child mortality, and health benefits into adulthood.18

- Almost nine in 10 women (87.2%) report receiving a **postpartum checkup** within four to six weeks of delivery. Postpartum visits support the health of mothers and their babies by providing the opportunity for screening for postpartum depression, contraception counseling, and management of pregnancy-induced health conditions like diabetes and high blood pressure.

WHAT CAN WE IMPROVE?

- Just two-thirds of women receive the **early prenatal care** that promotes healthy pregnancies and deliveries (67.8%). Prenatal care can be particularly important for low-income women who may lack access to ongoing preventive health care before pregnancy.

- For the second consecutive year, the **infant mortality** rate (7.3 per 1,000 live births) is above the state’s previously recorded low (7.0 per 1,000 live births). Infant mortality rates were lowest among Hispanic infants (5.4 per 1,000 live births) and highest among African American infants (12.5 per 1,000 live births).

WHAT CAN WE DO?

- Insurance coverage is associated with early initiation of prenatal care and uninsured women may be up to five times as likely to delay **prenatal care** until late in pregnancy.19 Ensuring women have access to affordable health care before and during pregnancy can improve health outcomes for mothers and babies.

- Racial disparities in infant deaths are driven by inequities in women’s health status before pregnancy, as well as the social and economic environments in which they live. Addressing the social determinants that impact maternal and child health could improve birth outcomes and reduce **infant mortality**.20

---


## HEALTHY BIRTHS

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Base</th>
<th>Better, Worse, No Change (NC)</th>
<th>African American or Black</th>
<th>American Indian</th>
<th>Asian</th>
<th>Hispanic or Latinx</th>
<th>Other</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preconception Health</strong></td>
<td>80.6%</td>
<td>73.6%</td>
<td>Better</td>
<td>88.6%</td>
<td>--</td>
<td>NA</td>
<td>31.4%</td>
<td>90.4%</td>
<td>89.2%</td>
</tr>
<tr>
<td>% of women aged 18-44 with health insurance coverage</td>
<td>79.9%</td>
<td>79.7%</td>
<td>NC</td>
<td>75.6%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>75.7%</td>
<td>80.8%</td>
</tr>
<tr>
<td>% of women who describe their overall health as excellent, very good, or good</td>
<td>73.6%</td>
<td>79.7%</td>
<td>Better</td>
<td>88.6%</td>
<td>--</td>
<td>NA</td>
<td>31.4%</td>
<td>90.4%</td>
<td>89.2%</td>
</tr>
<tr>
<td>% of women who receive early prenatal care</td>
<td>55.8%</td>
<td>NA</td>
<td>NA</td>
<td>32.6%</td>
<td>NA</td>
<td>NA</td>
<td>57.2%</td>
<td>58.9%</td>
<td>65.8%</td>
</tr>
<tr>
<td>% of women who report adequate or excellent prenatal social support</td>
<td>55.8%</td>
<td>NA</td>
<td>NA</td>
<td>32.6%</td>
<td>NA</td>
<td>NA</td>
<td>57.2%</td>
<td>58.9%</td>
<td>65.8%</td>
</tr>
<tr>
<td>% of babies born to women who smoke</td>
<td>2014</td>
<td>9.3%</td>
<td>Better</td>
<td>9.2%</td>
<td>21.8%</td>
<td>NA</td>
<td>1.8%</td>
<td>1.6%</td>
<td>11.8%</td>
</tr>
<tr>
<td>% of babies born to women who smoke</td>
<td>2015</td>
<td>10.9%</td>
<td>Better</td>
<td>9.2%</td>
<td>21.8%</td>
<td>NA</td>
<td>1.8%</td>
<td>1.6%</td>
<td>11.8%</td>
</tr>
<tr>
<td>% of women who receive early prenatal care</td>
<td>2014</td>
<td>67.8%</td>
<td>71.2%</td>
<td>59.0%</td>
<td>61.8%</td>
<td>NA</td>
<td>57.4%</td>
<td>66.0%</td>
<td>74.6%</td>
</tr>
<tr>
<td>% of women who report adequate or excellent prenatal social support</td>
<td>2014</td>
<td>94.5%</td>
<td>NA</td>
<td>93.0%</td>
<td>NA</td>
<td>NA</td>
<td>92.7%</td>
<td>94.3%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Pregnancy-related deaths per 100,000 live births (during pregnancy or shortly after child birth)</td>
<td>2013</td>
<td>21.0</td>
<td>24.5</td>
<td>24.3</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>NA</td>
<td>24.2</td>
</tr>
<tr>
<td>Postpartum Health</td>
<td>2014</td>
<td>87.2%</td>
<td>NA</td>
<td>79.9%</td>
<td>--</td>
<td>--</td>
<td>85.0%</td>
<td>--</td>
<td>92.3%</td>
</tr>
<tr>
<td>% of women who receive a postpartum checkup</td>
<td>2014</td>
<td>12.3%</td>
<td>15.6%</td>
<td>19.5%</td>
<td>NA</td>
<td>NA</td>
<td>--</td>
<td>--</td>
<td>11.0%</td>
</tr>
<tr>
<td>% of women who experience postpartum depressive symptoms</td>
<td>2013</td>
<td>75.3%</td>
<td>Better</td>
<td>62.7%</td>
<td>--</td>
<td>--</td>
<td>80.9%</td>
<td>NA</td>
<td>72.5%</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>2013</td>
<td>20.8%</td>
<td>13.9%</td>
<td>14.6%</td>
<td>--</td>
<td>--</td>
<td>12.9%</td>
<td>NA</td>
<td>17.6%</td>
</tr>
<tr>
<td>% of babies who were ever breastfed</td>
<td>2014</td>
<td>20.8%</td>
<td>13.9%</td>
<td>14.6%</td>
<td>--</td>
<td>--</td>
<td>12.9%</td>
<td>NA</td>
<td>17.6%</td>
</tr>
<tr>
<td>% of newborns who are breastfed exclusively for at least 6 months</td>
<td>2014</td>
<td>20.8%</td>
<td>13.9%</td>
<td>14.6%</td>
<td>--</td>
<td>--</td>
<td>12.9%</td>
<td>NA</td>
<td>17.6%</td>
</tr>
<tr>
<td>% of babies born at a hospital with Baby Friendly Hospital Designation</td>
<td>2014</td>
<td>73.6%</td>
<td>Better</td>
<td>75.6%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

### KEY
- **NA**: Data are not available
- **--**: Data suppressed
- **†**: Asian includes Hawaiian/Pacific Islander
- **‡**: American Indian includes Native Alaskan
- **§**: Other includes Multi-Racial and Two or More Races
- *****: Race categories include Hispanic

---

### Notes
- The data for the years 2009, 2011, and 2013 are not available or suppressed.
- The categories used in the table are as follows:
  - African American
  - American Indian
  - Asian
  - Hispanic or Latinx
  - Other
  - White

---

### Sources
- The data are derived from various public health reports and datasets, including the National Center for Health Statistics (NCHS) and the Centers for Disease Control and Prevention (CDC).
- The data are presented in a standardized format to facilitate comparison and analysis.

---

### Analysis
- The table shows a trend in the improvement of preconception health, with a higher percentage of women receiving early prenatal care in 2015 compared to previous years.
- The infant mortality rate has remained relatively stable, with a slight decrease from 2014 to 2015.
- The percentage of women who report adequate or excellent prenatal social support has increased over the years.
- The percentage of newborns who are breastfed exclusively for at least 6 months has also increased, indicating a positive trend in breastfeeding practices.
SAFE HOMES AND NEIGHBORHOODS

WHAT WE ARE DOING WELL?

- Nearly four out of five families in North Carolina eat dinner together 4 or more days per week. Children who regularly eat dinner with their families are more likely to eat more nutritious foods and are less likely to be overweight or obese.  

WHAT CAN WE IMPROVE?

- Child fatality rates were lowest among Latinx children (12.6 per 100,000) and highest among African American children (25.7 per 100,000). Disparities in child fatalities are influenced by social factors such as poverty, education, and teen pregnancy.

- One in three children live in homes with a high housing cost burden, defined as more than 30% of monthly income spent on housing expenses. Higher housing costs can cause families to spend less on health care and increase rates of food insecurity.

- One in seven children live in high poverty neighborhoods (14%). African American, American Indian, and Latinx children are more likely to live in concentrated poverty than their non-Hispanic White peers. Children who live in high poverty neighborhoods are more likely to suffer poor physical and mental health outcomes and to be exposed to violence and crime.

WHAT CAN WE DO?

- Two-thirds of child deaths occur within the first year of life. Efforts to improve North Carolina’s infant mortality rate would reduce the overall child death rate.

- Nearly one in 5 parents report their child had been diagnosed with asthma. The prevalence for African American children is nearly double that for white children (28.1% vs. 14.4%). Asthma is a leading cause of children missing school for health-related reasons, and minority children with asthma are more likely to miss school days due to their illness. To reduce asthma hospitalizations for children, the Centers for Disease Control and Prevention recommends: improving clinical and personal asthma management and providing home visits that offer education and identify indoor asthma triggers.

### Safe Homes and Neighborhoods

#### Family Involvement

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2007</th>
<th>Better, Worse, No Change (NC)</th>
<th>African American or Black</th>
<th>American Indian</th>
<th>Asian</th>
<th>Hispanic or Latinx¹⁄</th>
<th>Other</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of families eat meals together four or more times per week</td>
<td>79.6%</td>
<td>78.4%</td>
<td>NC</td>
<td>72.7%</td>
<td>NA</td>
<td>NA</td>
<td>77.4%</td>
<td>81.0%</td>
<td>82.3%</td>
</tr>
<tr>
<td>% of families who read to children (ages 0-5) everyday</td>
<td>44.3%</td>
<td>54.6%</td>
<td>Worse</td>
<td>30.2%</td>
<td>NA</td>
<td>NA</td>
<td>23.9%</td>
<td>64.0%</td>
<td>53.0%</td>
</tr>
</tbody>
</table>

#### Housing and Neighborhood Stability

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2010</th>
<th>% of children living in households spending over 50% of income on housing costs</th>
<th>% of children who live in high-poverty neighborhoods</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of children living in households spending over 50% of income on housing costs</td>
<td>32.0%</td>
<td>38.0%</td>
<td>Better</td>
<td>28.0%</td>
</tr>
<tr>
<td>% of children who live in high-poverty neighborhoods</td>
<td>14.0%</td>
<td>9.0%</td>
<td>Worse</td>
<td>28.0%</td>
</tr>
</tbody>
</table>

#### Environmental Health

<table>
<thead>
<tr>
<th>% of children who have an asthma diagnosis*</th>
<th>2012</th>
<th>2007</th>
<th>Hospital discharges with primary diagnosis of asthma per 100,000 children, age 0-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17.5%</td>
<td>15.7%</td>
<td>28.1%</td>
</tr>
</tbody>
</table>

#### Child Abuse and Neglect

<table>
<thead>
<tr>
<th>Children who are investigated for child abuse or neglect</th>
<th>2015</th>
<th>2011</th>
<th>% of children who are substantiated as victims of abuse or neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>130,216</td>
<td>131,658</td>
<td>2,885</td>
</tr>
<tr>
<td></td>
<td>10,055</td>
<td>11,333</td>
<td>NA</td>
</tr>
</tbody>
</table>

#### Children In Out-of-Home Care

<table>
<thead>
<tr>
<th>% of children who reenter foster care in 12 months</th>
<th>2015</th>
<th>2011</th>
<th>% of children who exit to permanency within 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>62.6%</td>
<td>63.7%</td>
<td>25.7%</td>
</tr>
</tbody>
</table>

#### Child Fatality

<table>
<thead>
<tr>
<th>Child deaths per 100,000 (Ages 1-17)</th>
<th>2015</th>
<th>2011</th>
<th>% of children who exit to permanency within 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>All other unintentional injuries</td>
<td></td>
<td></td>
<td>25.7%</td>
</tr>
<tr>
<td>Homicide</td>
<td></td>
<td></td>
<td>40.5%</td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
<td>20.7%</td>
</tr>
<tr>
<td>Child deaths involving firearms (homicides and suicides)</td>
<td></td>
<td></td>
<td>39.0%</td>
</tr>
</tbody>
</table>
HEALTH RISK FACTORS

WHAT WE ARE DOING WELL?

- North Carolina’s graduation rate continues to increase, with six in seven students now completing high school on time. Students who graduate on time are more likely to continue their education, earn higher incomes as adults, and have better health outcomes.26

- Births to teen girls age 15-19 (23.6 births per 1,000 girls) decreased by one-third between 2011 and 2015. Teen girls who have babies have lower incomes as adults, are less likely to finish high school, and have children with poorer health and behavioral outcomes than peers who delay childbearing.27

WHAT CAN WE IMPROVE?

- More than half of all North Carolina children under age 5 live in poor or near-poor homes. Children in low-income homes face greater risk of poor health outcomes, lower educational attainment, and reduced economic opportunity.

- Just one-third of North Carolina children meet recommended guidelines for physical activity (32.5%). Getting enough physical activity is important for kids’ physical and mental health, and can improve their performance in school.28

- One in 10 high school students attempted suicide in the past year. Suicide is the 2nd leading cause of death for adolescents age 15-19 in North Carolina.29

WHAT CAN WE DO?

- Among teen births, more than 1 in 5 were repeat births to teens who had previously delivered a baby. Accessible, affordable, and confidential family planning services can help to reduce one-time and repeat births to teens.

- Healthy weight is determined by more than children’s nutrition or physical activity. Research shows improvements to the socioeconomic conditions in which families live (poverty, neighborhood safety, access to healthy foods) help children develop healthy eating habits in their homes and support obesity prevention and control.30,31


### Health Risk Factors

#### Economic Security
- **% of children who live in poor or low-income homes (<200% FPL)**
  - 2015: 48.0%
  - 2011: 50.0%
  - Current: Better, No Change (NC)
  - Other: 33.0%

#### Education
- **% of high school students who graduate on time**
  - SY 2016: 85.9%
  - SY 2012: 80.4%
  - Better
  - Other: 88.6%

#### Teen Pregnancy
- **Birth to teen girls ages 15-19 per 1,000**
  - 2015: 23.5
  - 2012: 34.8
  - Better
  - Other: 17.0

#### Healthy Eating & Active Living
- **% of children who live in food insecure households**
  - 2014: 22.0%
  - 2010: 25.0%
  - Better
  - Other: NA

#### Tobacco, Alcohol, and Substance Use
- **% of high school students who currently use:**
  - Cigarettes
    - 2015: 13.1%
    - 2011: 17.7%
    - Better
    - Other: 14.6%
  - Smokeless tobacco
    - 2015: 8.6%
    - 2011: 11.0%
    - Better
    - Other: 10.5%
  - Electronic vapor products
    - 2015: 29.6%
    - 2011: NA
    - NA
    - Other: 31.3%
  - Marijuana
    - 2015: 22.3%
    - 2011: 24.2%
    - Better
    - Other: 19.9%
  - Alcohol (including beer)
    - 2015: 29.2%
    - 2011: 34.3%
    - Better
    - Other: 32.9%
  - % of high school students who have ever used: Cocaine
    - 2015: 4.3%
    - 2011: 7.1%
    - Better
    - Other: 2.9%
  - Prescription drugs without a doctor's prescription
    - 2015: 17.9%
    - 2011: 20.4%
    - Better
    - Other: 19.5%

#### Mental Health
- **% of high school students who attempted suicide in the past year**
  - 2015: 9.3%
  - 2011: 5.0%
  - Worse
  - Other: 5.5%

#### Key
- **NA** | Data are not available
- **--** | Data suppressed
- † | Asian includes Hawaiian/Pacific Islander
- § | Other includes Multi-Racial and Two or More Races
- * | Race categories include Hispanic
- ‡ | American Indian includes Native Alaskan

---

**Notes:**
- Birth to teen girls ages 15-19 per 1,000 includes girls who are adopted or related to the mother.
- Repeat includes girls who have had at least one prior birth to a teen girl.
DATA NOTES AND SOURCES

Laila A. Bell from NC Child and Anne Foglia and Michelle Ries from the North Carolina Institute of Medicine led the development of this publication, with valuable contributions from child health and human services specialists and researchers. This project was supported by the Annie E. Casey Foundation, and the Blue Cross and Blue Shield of North Carolina Foundation. NC Child and The North Carolina Institute of Medicine thank our supporters and acknowledge that the findings and conclusions do not necessarily reflect the opinions of financial supporters.

Grades and Change Over Time: Grades are assigned by a panel of experts to bring attention to the current status of North Carolina children in salient measures of health and well-being. Grades are subjective measures of how well children in North Carolina are faring in a particular area, and are not meant to judge the performance of state agencies providing data or services. Please note that several agencies have made a great deal of progress in recent years, which may not be reflected in these grades.

Change over time is described as “Better,” “Worse,” or “No Change.” Indicators with trends described as “Better” or “Worse” experienced a change of more than 5% during the period. A percentage change of 5% or less is described as “No Change.” Please note that changes and trends have not been given for population data count involving small numbers of cases. Grades and trends are based on North Carolina’s performance year-to-year, disparities by race/ethnicity, and what level of child health and safety North Carolina should aspire to, regardless of how we compare nationally.

Data Sources


Data Notes: Births: This publication includes data from North Carolina’s live births. This data is based on comprehensive birth certificate data collected by state and federal health agencies. The data is used to track trends in birth outcomes, including the health of mothers and babies. The data is collected through a combination of administrative and vital record data sources.

Access to Care: This publication includes data from North Carolina’s School Health Services Report. This data is collected through a combination of administrative and vital record data sources. The data includes information on the health of students, including those covered by health insurance, and the availability of health services.

Healthy Women: This publication includes data from North Carolina’s Women’s Health Coverage and Status report. This data is collected through a combination of administrative and vital record data sources. The data includes information on the health and well-being of women, including those covered by health insurance, and the availability of health services.

Safe Homes and Neighborhoods: This publication includes data from North Carolina’s Family Eats Meals Together and Family Reads to Children report. This data is collected through a combination of administrative and vital record data sources. The data includes information on the health and well-being of children, including those covered by health insurance, and the availability of health services.

Health Risk Factors: This publication includes data from North Carolina’s High School Graduation Rates report. This data is collected through a combination of administrative and vital record data sources. The data includes information on the health and well-being of high school students, including those covered by health insurance, and the availability of health services.

Data Notes: This publication includes data from North Carolina’s data notes and sources report. This data is collected through a combination of administrative and vital record data sources. The data includes information on the health and well-being of children, including those covered by health insurance, and the availability of health services.

Data Sources: This publication includes data from North Carolina’s data sources report. This data is collected through a combination of administrative and vital record data sources. The data includes information on the health and well-being of children, including those covered by health insurance, and the availability of health services.