NORTH CAROLINA CHILD HEALTH Report Card

2017

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

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WHY FOCUS ON RACE AND EQUITY?

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.

DEMOGRAPHICS

THERE WERE **120,826 live births** & **2,228,050 children under age 18** IN 2015

	Current	Base	African American or Black	American Indian	Asian	Hispanic or Latinx[11]	Other	White
Percent of live births by race and ethnicity	2015 100%	100%	23.8%	1.4%	NA	15.0%	4.4%	55.5%
Percent of children under age 18 by race and ethnicity	2015 100%	100%	22.9%	1.1%†	2.8%	15.4%	4.4%§	53.0%
Percent of children under age 5	2015 26.3%	2011 27.4%	25.7%	24.5%†	26.4%	29.3%	31.7%§	25.3%
Percent of children in excellent or good health	2011/12 96.7%	NA	96.4%	NA	NA	93.0%	97.1%	97.9%

NOTE: May not add to 100% due to rounding

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

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[11] 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.[12] 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.[13]

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.

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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.
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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**.**

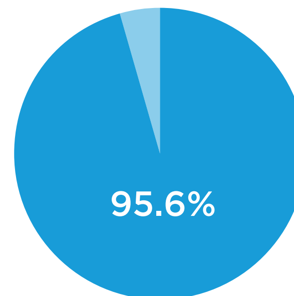
WHAT CAN WE IMPROVE?

- 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.

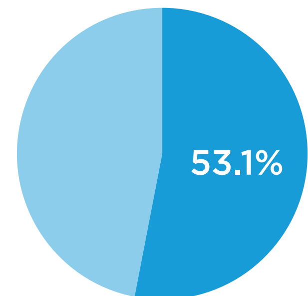
WHAT CAN WE DO?

- 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]

CHILDREN'S HEALTH INSURANCE COVERAGE



95.6% of children in North Carolina had health insurance coverage in 2015.



53.1% of children in North Carolina received health insurance through public programs in 2015.

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16. North Carolina Institute of Medicine. *North Carolina Rural Health Action Plan: A Report of the NCIOM Task Force on Rural Health*. Morrisville, NC (2014).
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ACCESS TO CARE

	Indicator	Current	Base	Better, Worse, No Change (NC)	African American or Black	American Indian	Asian	Hispanic or Latinx[11]	Other	White
A	**Insurance Coverage**	2015	2011							
A	% of children with health insurance coverage	**95.6%**	92.4%	NC	96.3%*	91.4%†*	94.4%‡*	90.8%	93.9%§*	96.7%
A	% of low-income children without health insurance coverage (<200 % FPL)	**6.1%**	10.6%	Better	4.0%	9.4%	4.7%	10.9%	8.0%	5.1%
A	% of children covered by public health insurance	**53.1%**	47.9%		--	--	--	--	--	--
A	Children covered by Medicaid	**1,124,962**	942,056		381,278	14,405	17,959	225,023	NA	415,896
A	Children covered by NC Health Choice	**89,135**	153,455		29,202	1,207	2,359	22,818	NA	49,910
A	% of parents without health insurance coverage*	**15.3%**	20.6%	Better	13.7%	21.1%†	10.1%‡	53.7%	15.5%§	8.7%
C	**Health Services Utilization**									
C	% of children with Medicaid who received a well-child checkup in the past year	**58.7%**	59.7%	NC	NA	NA	NA	NA	NA	NA
C	**Oral Health**	2016	2010							
C	% of kindergarten students with untreated tooth decay	**15.0%**	15.0%	NC	NA	NA	NA	NA	NA	NA
C	% of children with Medicaid who use dental services	2015	2011							
C	Ages 1-5	**58.0%**	56.0%	NC	NA	NA	NA	NA	NA	NA
C	Ages 6-14	**61.0%**	60.0%	NC	NA	NA	NA	NA	NA	NA
C	Ages 15-20	**44.0%**	44.0%	NC	NA	NA	NA	NA	NA	NA
D	**School Health**	SY 2014-15	SY 2010-11							
D	School nurse ratio	**1 : 1,112**	1 : 1,201	Better	NA	NA	NA	NA	NA	NA
D	School counselor ratio	SY 2013-14								
D		**1:379**	NA	NA	NA	NA	NA	NA	NA	NA
B	**Immunization**	2015	2013							
B	% of children ages 19-35 months with appropriate immunizations	**80.0%**	76.6%	NC	69.5%	NA	NA	79.6%	NA	84.6%
B		SY 2015-16	SY 2011-12							
B	% of children with appropriate immunizations at school entry	**96.3%**	96.4%	NC	NA	NA	NA	NA	NA	NA

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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]

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HEALTHY BIRTHS

Grade	Indicator	Current	Base	Better, Worse, No Change (NC)	African American or Black	American Indian	Asian	Hispanic or Latinx[11]	Other	White
C	**Preconception Health**	2015	2011							
	% of women aged 18-44 with health insurance coverage	80.6%	73.6%	Better	88.6%	--	NA	31.4%	90.4%	89.2%
	% of women who describe their overall health as excellent, very good, or good	79.%	79.7%	NC	75.6%	NA	NA	NA	75.7%	80.8%
D	**Birth Outcomes**									
	Infant mortality: infant deaths per 1,000 live births	7.3	7.2	NC	12.5	--	NA	5.4	6.2	5.7
	% of babies who are born before 37 weeks of pregnancy	10.2%	10.2%	NC	14.0%	11.4%	NA	8.7%	8.5%	9.1%
	% of babies who are born at a low birthweight (<2500 g)	9.2%	9.0%	NC	14.5%	11.2%	NA	7.0%	8.6%	7.5%
C	**Maternal Health & Support**	2014								
	% of pregnancies that are intended	55.8%	NA	NA	32.6%	NA	NA	57.2%	58.9%	65.8%
		2015	2011							
	% of babies born to women who smoke	9.3%	10.9%	Better	9.2%	21.8%	NA	1.8%	1.6%	11.8%
	% of women who receive early prenatal care	67.8%	71.2%	NC	59.0%	61.8%	NA	57.4%	66.0%	74.6%
		2014								
	% of women who report adequate or excellent prenatal social support	94.5%	NA	NA	93.0%	NA	NA	92.7%	94.3%	95.7%
		2013	2009							
	Pregnancy-related deaths per 100,000 live births (during pregnancy or shortly after child birth)	21.0	24.5	Better	24.3	--	--	--	NA	24.2
B	**Postpartum Health**	2014								
	% of women who receive a postpartum checkup	87.2%	NA	NA	79.9%	--	--	85.0%	--	92.3%
		2014	2012							
	% of women who experience postpartum depressive symptoms	12.3%	15.6%	Better	19.5%	NA	NA	--	--	11.0%
B	**Breastfeeding**	2013	2009							
	% of babies who were ever breastfed	75.3%	69.1%	Better	62.7%	--	--	80.9%	NA	72.5%
	% of newborns who are breastfed exclusively for at least 6 months	20.8%	13.9%	Better	14.6%	--	--	12.9%	NA	17.6%
	% of babies born at a hospital with Baby Friendly Hospital Designation	28.7%	9.9%	Better	NA	NA	NA	NA	NA	NA

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SAFE HOMES AND NEIGHBORHOODS

WHAT WE ARE DOING WELL?

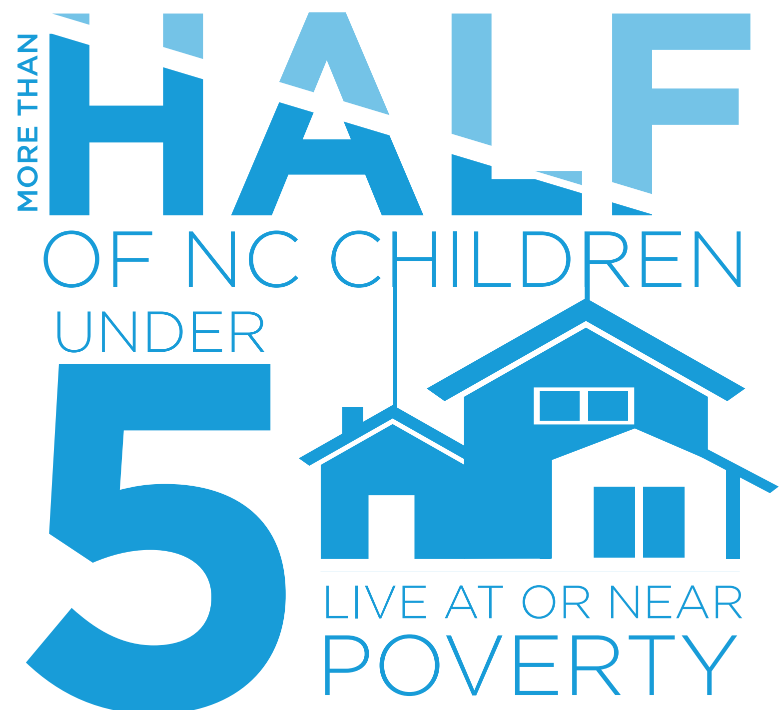
- Nearly four out of five families in North Carolina **eat dinner together** 4 or more days per week. Children who regularly eat dinner with their families are more likely to eat more nutritious foods and are less likely to be overweight or obese.[21]

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.[22]
- 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.[23]
- 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.[24] 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.[25]



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SAFE HOMES AND NEIGHBORHOODS

Grade	Indicator	Current	Base	Better, Worse, No Change (NC)	African American or Black	American Indian	Asian	Hispanic or Latinx[11]	Other	White
B	**Family Involvement**	2011/12	2007							
	% of families eat meals together four or more times per week	**79.6%**	78.4%	NC	72.7%	NA	NA	77.4%	81.0%	82.3%
	% of families who read to children (ages 0-5) everyday	**44.3%**	54.6%	Worse	30.2%	NA	NA	23.9%	64.0%	53.0%
C	**Housing and Neighborhood Stability**	2015	2010							
	% of children living in households spending over 30% of income on housing costs	**32.0%**	38.0%	Better	47.0%	31.0%	24.0%	44.0%	35.0%	22.0%
		2011-15	2006-10							
	% of children who live in high-poverty neighborhoods	**14.0%**	9.0%	Worse	28.0%	39.0%	9.0%	22.0%	14.0%	5.0%
C	**Environmental Health**	2012	2007							
	% of children who have an asthma diagnosis*	**17.5%**	15.7%		28.1%	NA	NA	NA	11.8%	14.4%
		2014	2010							
	Hospital discharges with primary diagnosis of asthma per 100,000 children, age 0-14	**144.6**	166.0	Better	314.3	245	NA	93.1	297.5	71.8
C	**Child Abuse and Neglect**	2015	2011							
	Children who are investigated for child abuse or neglect	**130,216**	131,658		44,278	2,680	NA	15,256	8,980	59,022
	Children who are substantiated as victims of abuse or neglect	**10,055**	11,333		2,885	227	NA	1,170	784	4,989
	Children who are recommended or received supportive family services	**37,973**	33,673		14,238	400	NA	4,608	2,944	15,783
	Child abuse homicides	**32**	24		NA	NA	NA	NA	NA	NA
D	**Children In Out-of-Home Care**	2015	2011							
	Children in foster care	**15,417**	14,337		4,948	401	NA	1,289	1,273	7,506
	% of children who reenter foster care in 12 months	**4.3%**	3.6%	Worse	4.0%	9.6%	NA	3.0%	4.5%	4.4%
	% of children who exit to permanency within 24 months	**62.6%**	63.7%	NC	57.8%	82.1%	NA	63.0%	59.4%	64.6%
C	**Child Fatality**									
	Child deaths per 100,000 (ages 1-17)	**20.8**	20.6	NC	25.7	--	NA	12.6	--	20.6
	Ages 1 to 4	**31.6**	24.1	Worse	40.5	--	NA	17.6	--	31.2
	Ages 5 to 9	**11.8**	13.2	Better	11.9	--	NA	--	--	13.0
	Ages 10 to 14	**14.4**	14.8	NC	20.2	--	NA	--	--	13.3
	Ages 15 to 17	**32.6**	38.3	Better	39.0	--	NA	--	--	32.1
	Child deaths (ages 0-17) caused by:									
	Motor vehicle injuries	**83**	98		NA	NA	NA	NA	NA	NA
	All other unintentional injuries	**80**	104		NA	NA	NA	NA	NA	NA
	Homicide	**51**	43		NA	NA	NA	NA	NA	NA
	Suicide	**35**	23		NA	NA	NA	NA	NA	NA
	Child deaths involving firearms (homicides and suicides)	**35**	NA		NA	NA	NA	NA	NA	NA

KEY

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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.

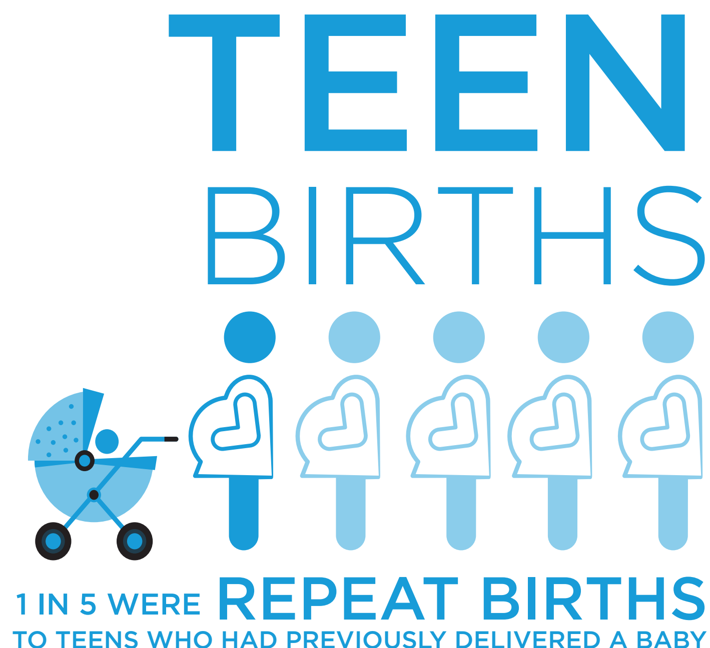
- Just one-third of North Carolina children **meet recommended guidelines for physical activity** (32.5%). Getting enough physical activity is important for kids' physical and mental health, and can improve their performance in school.[28]

- 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]



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HEALTH RISK FACTORS

Grade	Indicator	Current	Base	Better, Worse, No Change (NC)	African American or Black	American Indian	Asian	Hispanic or Latinx[11]	Other	White
F	**Economic Security** % of children who live in poor or low-income homes (<200% FPL)	2015: 48.0%	2011: 50.0%	NC	67.0%	--	34.0%‡	76.0%	52.0%§	33.0%
F	% of children ages 0-5 who live in poor or low-income homes	2015: 52.6%	2012: 55.2%	NC	71.1%	51.0%	30.7%	77.5%	NA	37.1%
C	**Education** % of high school students who graduate on time	SY 2016: 85.9%	2012: 80.4%	Better	82.9%	82.0%	93.4%	80.1%	83.0%§	88.6%
C	% of fourth grade students reading at grade-level	2015: 38.0%	2011: 34.9%	Better	23.0%	19.0%†	59.0%	23.0%	47.0%§	51.0%
B	**Teen Pregnancy** Birth to teen girls ages 15-19 per 1,000	23.5	34.8	Better	29.7	43.4	NA	42.4	12.0	17.0
B	% of births to girls ages 15-19 that are repeat	22.9%	24.6%	Better	23.8%	20.7%	NA	26.1%	20.2%	20.7%
D	**Healthy Eating & Active Living** % of children who live in food insecure households	2014: 22.0%	2010: 25.0%	Better	NA	NA	NA	NA	NA	NA
D	% of children who meet recommended guildelines for physcial activity*	2012: 32.5%	2010: 45.8%	Worse	28.0%	NA	NA	NA	--	32.7%
D	% of children ages 10-17 who are overweight or obese*	2012: 36.4%	2007: 33.7%	Worse	NA	NA	NA	NA	--	32.4%
D	**Tobacco, Alcohol, and Substance Use** % of high school students who currently use:	2015	2011							
	Cigarettes	13.1%	17.7%	Better	10.8%	--	3.8%	14.9%	9.2%§	14.6%
	Smokeless tobacco	8.6%	11.0%	Better	4.9%	--	3.0%	7.4%	5.9%§	10.5%
	Electronic vapor products	29.6%	NA	NA	27.9%	--	7.7%	29.8%	22.9%§	31.3%
	Marijuana	22.3%	24.2%	Better	27.9%	--	4.4%	22.4%	24.7%§	19.9%
	Alcohol (including beer)	29.2%	34.3%	Better	25.2%	--	10.4%	24.2%	25.3%§	32.9%
	% of high school students who have ever used: Cocaine	4.5%	7.1%	Better	5.7%	--	2.5%	7.0%	3.7%§	2.9%
	Prescription drugs without a doctor's prescription	17.9%	20.4%	Better	15.8%	--	8.4%	14.1%	21.9%§	19.5%
D	**Mental Health** % of high school students who attempted suicide in the past year	2015: 9.3%	2011: 5.0%	Worse	13.6%	NA	3.4%	14.0%	21.6%	5.5%
D	% of past-year major depressive episode among adolescents aged 12-17	2013-14: 11.4%	2009-10: 7.4%	Worse	NA	NA	NA	NA	NA	NA
D	% of adolescents (age 12-17) with major depressive episode who received treatment	2010-14: 40.7%	2008-12: 36.0%	Better	NA	NA	NA	NA	NA	NA

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

DATA NOTES AND SOURCES

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Grades and Change Over Time: Grades are assigned by a panel of health 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 agency or 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." Percent change and trends have not been given for population count data 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.

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