Nurture NC

Framework for Action©






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nurture NC

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Executive Summary

From Exploration to Action

Nurture North Carolina emerged when the North Carolina Maternal Health Funders Collaborative confronted an unacceptable reality: maternal and infant health data were moving in the wrong direction, with women and babies dying from preventable deaths. North Carolina received a D+ grade from The March of Dimes 2025 Report Card for preterm birth prevention, ranking 32 out of 52 nationally (all states, Puerto Rico, DC). With 55% of North Carolina births covered by Medicaid and maternal mortality creating significant economic implications for families and communities across the state, coordinated policy action became essential.

Building on the work done by partners across the state and being informed by successful models like Nurture New Jersey, Nurture NC is being created to focus on maternal and infant health policies that can benefit from additional focus and support. Getting to this stage has involved extensive stakeholder engagement and data-driven analysis, in partnership with the Maternal and Child Health Department team at the UNC-CH Gillings School of Global Public Health, to ensure the work remains data-informed.

Strategic Approach: Policy-Driven Change

Nurture NC operates on the principle that sustainable improvements in maternal and infant health require systemic policy change, rather than creating new programs. The initiative focuses on amplifying existing work, removing barriers, and creating enabling environments for community-based solutions. The opportunities described in this framework are intended to reflect activities between 2025 and 2027.

Focus Areas and Strategic Priorities

Through the collaborative prioritization process, the Steering Committee identified three focus areas that represent the highest-impact opportunities for change in North Carolina's maternal and infant health system: maternal workforce, rural access, and public policy. These priorities reflect areas where coordinated action can address systemic barriers while building on existing momentum and stakeholder support.

Focus Area 1: Maternal Health Workforce Opportunities
Address the critical shortage of high-quality providers to improve maternal outcomes in all communities across North Carolina.

- **Priority 1:** Increase the number of midwives across North Carolina
- **Priority 2:** Increase access to doula services in all NC counties

Focus Area 2: Rural Access Opportunities
Reduce geographic disparities in maternal health outcomes by expanding access to high-quality care and support services in rural communities in North Carolina.

- **Priority 1:** Increase access to early and longitudinal routine prenatal care in rural communities across North Carolina
- **Priority 2:** Using available data sources, identify the top 5% of NC counties with cross-sectional indicators that contribute to poor maternal-child outcomes and mobilize philanthropically supported community action coalitions
- **Priority 3:** Seek to understand models for innovative perinatal services to identify opportunities for expansion across NC

Focus Area 3: Public Policy Opportunities
Drive smarter public policy to sustain improvements in maternal and infant health statewide.

- **Priority 1:** In partnership with NC Medicaid managed care plans, increase utilization of Value Added Benefits across all plans and in all Medicaid regions for perinatal and infant-specific benefits
- **Priority 2:** Decrease the incidence of congenital syphilis mortality and morbidity across North Carolina
- **Priority 3:** Endorse and support the deployment of Levels of Maternal Care in North Carolina
- **Priority 4:** Protect existing access to the full array of Medicaid-covered benefits in the pregnancy and postpartum period
- **Priority 5:** Expand access to telehealth behavioral health and substance use services for pregnant women in rural communities by reducing technology barriers
- **Priority 6:** Advance initiatives that promote economic support for mothers and infants

Summary: Moving North Carolina to A+

These priorities represent the foundation for Nurture NC's transition from planning to implementation, advancing maternal health in North Carolina through coordinated policy actions that mitigate the economic and health burdens of maternal and infant mortality on families and communities. While established through data-informed analysis and stakeholder input, these priorities remain responsive to shifts in the political, funding, and healthcare landscapes. Success will be measured not only by policy changes but by improved maternal and infant health outcomes across North Carolina, providing a roadmap for coordinated action while maintaining flexibility to adapt to emerging opportunities and challenges.

Introduction: A Strategic Moment for Support

Improving North Carolina's maternal and child health outcomes demand coordinated, strategic action—and recent shifts in federal funding priorities have created both challenges and opportunities that make state-level innovation more critical than ever. This Framework Document represents the culmination of extensive collaboration, data analysis, and strategic planning by the Nurture North Carolina Steering Committee to address an unacceptable reality: women and babies in our state are experiencing preventable illnesses and deaths.

The Imperative for Action

North Carolina received a D+ grade from The March of Dimes 2025 Report Card for preterm birth prevention, ranking 32 out of 52 nationally (all states, Puerto Rico, DC). With 55% of North Carolina births covered by Medicaid, the economic and human costs of our maternal health crisis ripple through communities across the state. Much work has been done across the state by many partners to address this issue, for example, the work of the Perinatal Health Strategic Plan, the Perinatal Quality Collaborative, and the Child Fatality Task Force. Still, more work is needed to coordinate these efforts and to identify areas that can benefit from additional focus and support.

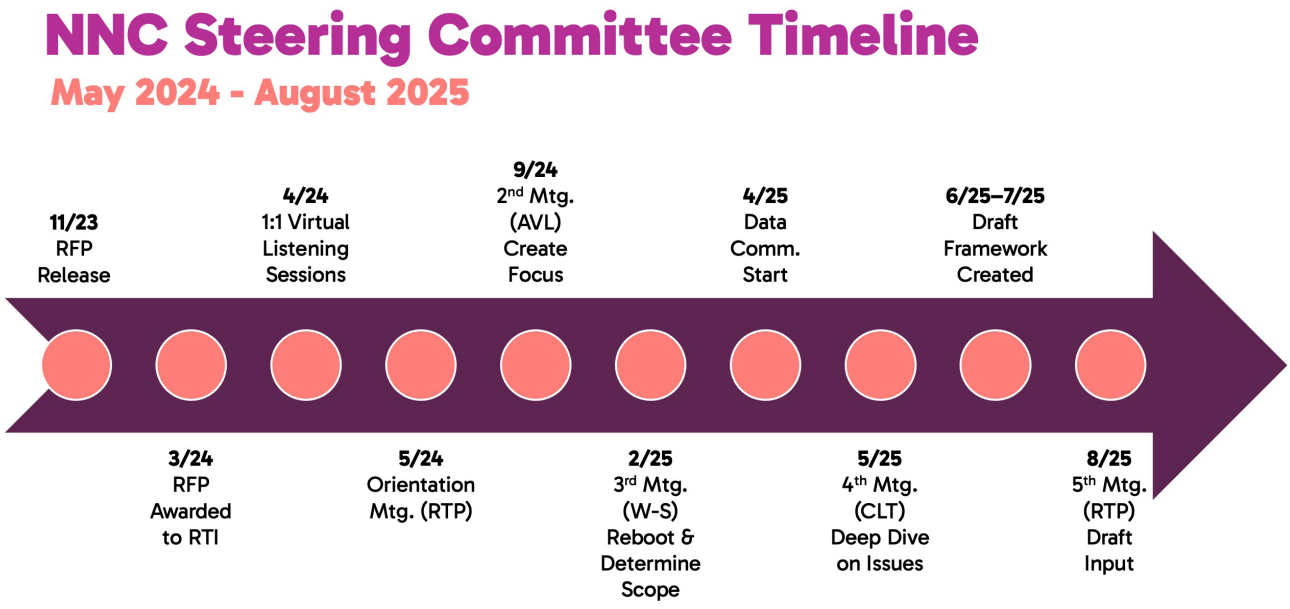
Additionally, the current federal landscape presents both unprecedented uncertainty and strategic opportunities for state leadership and innovative partnerships. Since February 2025, changes in federal budget allocations have increased uncertainty surrounding some maternal health programs while also creating new opportunities for states to take ownership of solutions that work for their unique communities and geographic context. This evolving environment requires North Carolina to lead with creative approaches that address our specific needs rather than waiting for federal direction.

The Steering Committee Process

Since May 2024, a cross-sector Steering Committee of experts and stakeholders has been meeting to determine whether Nurture NC is a viable approach and how it can be structured to address maternal and infant health issues in North Carolina effectively. This collaborative group brings together researchers, funders, business leaders, government representatives, and nonprofits, creating unprecedented cross-sector alignment around maternal health priorities.

The Steering Committee's deliberative process involved extensive analysis of existing initiatives, identification of systemic gaps, and careful evaluation of where coordinated policy action could have the most significant impact. Through quarterly meetings and ongoing engagement, committee members contributed their diverse expertise to shape both the strategic direction and operational framework for Nurture NC. A complete list of Steering Committee members is provided in the appendix.

Over the past two years, Nurture NC conducted a data-informed process to move from exploration to actionable priorities:



Phase 1 (2023-Early 2024)
Landscape analysis and stakeholder mapping

- Completed a comprehensive maternal health landscape report
- Created Maternal & Child Health Equity Action Network (MCHEAN)

Phase 2 (May 2024-August 2025)
Framework development and opportunity identification

- Convened cross-sector Steering Committee with researchers, funders, business leaders, government representatives, and nonprofits
- Reviewed other state maternal and child health initiatives and determined the viability of a Nurture NC initiative
- Developed an initial framework with multiple focus areas and recommendations
- Evaluated and prioritized strategic opportunities

Phase 3 (September 2025-February 2026)
Priority advancement through collaborative prioritization process

- An Advisory Committee will guide organizational structure and specific actions Nurture NC can take to push priorities forward

The Development Process

This Framework Document emerged from a comprehensive, data-informed process that began in spring 2024. The North Carolina Maternal Health Funders Collaborative, confronted with maternal and infant health data moving in the wrong direction, initiated this work through extensive surveys and interviews to gain a deeper understanding of the current maternal health landscape across North Carolina.

Since May 2024, the Nurture NC Steering Committee—a cross-sector group of researchers, funders, business leaders, government representatives, and nonprofits—has engaged in rigorous collaboration through journey mapping exercises, stakeholder engagement, and strategic analysis. Working in partnership with RTI, Faster Glass, and the Maternal and Child Health Department team at the UNC-CH Gillings School of Global Public Health, the Steering Committee developed an understanding of both the strengths and gaps in North Carolina's maternal health ecosystem.

As Steering Committee Chair Liz Star noted in her August 2025 remarks: "We started this journey on what felt like a comfortable cruise ship—steady, methodical, with a clear long-term destination. But the seas around us have become stormy. We have made the strategic decision to disembark from the comfortable cruise ship and embark on a faster, more nimble boat."

Purpose and Approach

Nurture NC is fundamentally about coordinating, elevating and advancing the exceptional work already underway across our state. Rather than creating new initiatives, this framework focuses on opportunities to support and coordinate existing efforts, identifying opportunities and partners where gaps exist, and driving advocacy efforts that highlight what is needed to improve the health of North Carolina's moms and babies. While there are myriad ways we might influence these outcomes, the framework identifies those that feel most likely to succeed in the current healthcare landscape.

By working closely with Steering Committee members and other organizations as essential partners, Nurture NC aims to seek opportunities to braid public and private dollars where they can have the most significant impact. The framework establishes pathways for strategic policy support while building the foundation for long-term transformation in how North Carolina supports mothers and babies and the people who care for them.

Framework Organization

This document presents:

- **Seven Core Action Areas** that provide the strategic foundation for all Nurture NC work: Advocate, Engage, Analyze & Prioritize, Educate, Invest, Strategize, and Amplify
- **Three Focus Areas** identified through the collaborative prioritization process: Maternal Health Workforce Opportunities, Rural Access Opportunities, and Public Policy Opportunities
- **Specific Priorities** within each focus area that represent the highest-impact policy opportunities for coordinated action

Intended Audience

This Framework Document serves multiple audiences:

- **Steering Committee members** who contributed to its development and will continue as advisors and champions
- **Policymakers and government leaders** who need a clear understanding of priority areas and opportunities for partnership
- **Healthcare providers and health systems** engaged in maternal and infant health care delivery
- **Funders and investors** seeking strategic opportunities to improve maternal health outcomes
- **Community-based organizations** working directly with mothers, babies, and families
- **Academic and research institutions** contributing data and evidence to support policy change

Strategic Approach: Policy-Driven Change

Nurture NC operates on the principle that sustainable improvements in maternal and infant health require systemic policy change, rather than creating new programs. The initiative focuses on amplifying existing work, removing barriers, and creating enabling environments for community-based solutions.

Seven Core Action Areas

The Steering Committee identified seven strategic action areas by applying the key constraints mentioned above to ensure maximum impact without fragmenting existing efforts. These action areas lift the work already taking place throughout the state and ensure that maternal and infant health is prioritized:

1. **ADVOCATE** - Strategic policy engagement and cross-sector buy-in through data, patient stories, and best practices
2. **ENGAGE** - Cross-sector collaboration and stakeholder convening to foster coordinated action
3. **ANALYZE & PRIORITIZE** - Evidence-based decision making and resource optimization
4. **EDUCATE** - Targeted awareness building with decision-makers and communities
5. **INVEST** - Strategic resource investment and sustainability planning
6. **STRATEGIZE** - Focused priority selection with clear implementation pathways
7. **AMPLIFY** - Elevating existing successful initiatives and increasing visibility

Focus Area 1: Maternal Health Workforce Opportunities

Goal: Address the critical shortage of high-quality providers to improve maternal outcomes in all communities across North Carolina.

Priority 1: Increase the number of midwives across North Carolina

- Develop a deeper understanding of current educational landscape and training programs
- Identify key actions to create opportunities and mitigate barriers
- Address both certified nurse midwives and professional midwives

Priority 2: Increase access to doula services in all NC counties

- Expand the doula workforce through reduced barriers and improved reimbursement
- Focus on Medicaid coverage and expansion of value-added benefits
- Support community-based doula programs

Focus Area 2: Rural Access Opportunities

Goal: Reduce geographic disparities in maternal health outcomes by expanding access to high-quality care and support services in rural communities in North Carolina.

Priority 1: Increase access to early and longitudinal routine prenatal care in rural communities across North Carolina

- Establish shared maternity care models between delivery providers and primary care providers
- Target rural areas with limited specialist access (Maternity Care Deserts)
- Leverage Federally Qualified Health Center (FQHC) partnerships and telemedicine capabilities

Priority 2: Using available data sources, identify the top 5% of NC counties with cross-sectional indicators that contribute to poor maternal-child outcomes and mobilize philanthropically supported community action coalitions

- Develop county-specific improvement plans
- Coordinate resources and technical assistance
- Create replicable models for rural maternal health

Priority 3: Seek to understand models for innovative perinatal services to identify opportunities for expansion across NC

- Address geographic barriers to perinatal care.
- Explore technology solutions and reimbursement models
- Study successful implementations in other states

Focus Area 3: Public Policy Opportunities

Goal: Drive smarter public policy to sustain improvements in maternal and infant health statewide.

Priority 1: In partnership with NC Medicaid managed care plans, increase utilization of Value Added Benefits across all plans and in all Medicaid regions for perinatal and infant-specific benefits

- Maximize existing Medicaid flexibilities and resources
- Coordinate with state agencies on implementation
- Build cross-sector support for education and utilization of these benefits

Priority 2: Decrease the incidence of congenital syphilis mortality and morbidity across North Carolina

- Support public health policy and payer collaboration
- Coordinate prevention and treatment strategies
- Engage healthcare providers and community organizations

Priority 3: Endorse and support the deployment of Levels of Maternal Care in North Carolina

- Work with the cross-sector partners to advance the model
- Study current system gaps and improvement opportunities
- Develop recommendations for policy reform

Priority 4: Protect existing access to the full array of Medicaid-covered benefits in the pregnancy and postpartum period

- Monitor potential policy changes and funding threats
- Advocate for maintained coverage and access
- Build coalitions to defend existing benefits

Priority 5: Expand access to telehealth behavioral health and substance use services for pregnant women in rural communities by reducing technology barriers

- Address rural connectivity, digital literacy, and device access issues
- Support existing state and national initiatives
- Remove existing policy and regulatory obstacles

Priority 6: Advance initiatives that promote economic support for mothers and infants

- Identify evidence based programs ready to be introduced in North Carolina
- Work with partners to create enabling environments in communities
- Advance evidence based on effectiveness and return on investment

Nurture NC Focus Areas

Focus Area 1: Maternal Health Workforce Opportunities

Goal: Address the critical shortage of high-quality providers in all communities across North Carolina with evidence-based data that improves maternal outcomes.

Priority 1: Increase the number of Midwives across North Carolina

Actions

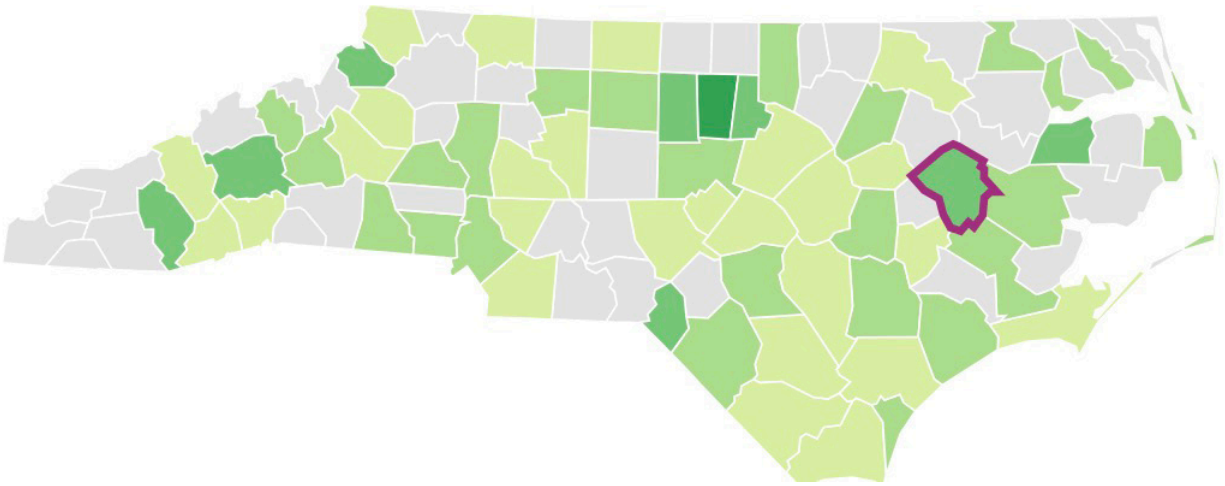
- Develop a deeper understanding of the current educational landscape for the different Midwife training programs across North Carolina.
- Identify key action steps to create opportunities to mitigate current barriers that limit the capacity of this workforce.
- Develop a deeper understanding of the varied types of midwife certifications and how to incorporate these professionals more consistently into the maternal workforce

Supporting Data

- Integrating a midwife workforce into healthcare delivery systems could provide 80% of essential maternal care and potentially avert 41% of maternal deaths (Niles & Zephyrin, 2023).
- Midwives could also help address workforce shortages in the U.S.
    - Nearly half of U.S. counties lack a single obstetrician-gynecologist, and it's estimated that the nation needs 8,000 more to meet demand (Niles & Zephyrin, 2023).
- The American College of Nurse-Midwives reports that CNMs and CMs attended 10.9% of all births in the U.S. in 2022 (American College of Nurse-Midwives, 2023).
- There are three different certification types for midwives – certified nurse-midwives (CNMs), certified midwives (CMs), and certified professional midwives (CPMs) (Graduate Nursing EDU, 2025).
    - CNMs are nurses who have completed a graduate-level nurse-midwife program and passed a certification exam from the American Midwifery Certification Board (Graduate Nursing EDU, 2025). CNMs typically work in clinics and hospitals (Western Governors University, 2025).
    - CMs are non-nurses who complete a graduate-level midwifery degree program and pass a certification exam from the American Midwifery Certification Board (Graduate Nursing EDU, 2025).
    - A CPM has met the certification requirements of the North American Registry of Midwives (NARM) (Graduate Nursing EDU, 2025). Applicants can qualify to take the NARM exam by either apprenticing with a qualified midwife and completing an Entry-Level Portfolio Evaluation Process or graduating from a midwifery program or school accredited by the Midwifery Education Accreditation Council (MEAC) (Graduate Nursing EDU, 2025). A CPM is the only midwifery credential that requires experience and education in home births and birth centers (Western Governors University, 2025). Some CPMs also practice in clinics and doctors' offices (Western Governors University, 2025), but the practice privileges of CPMs vary by state (Graduate Nursing EDU, 2025).

- CNMs and CMs are qualified to provide the same level of care, but not all states license CMs (Graduate Nursing EDU, 2025). CNMs/CMs can provide a full range of primary health care services in all stages of life, from the teenage years through menopause, including general health check-ups, screenings, and vaccinations; pregnancy, birth, postpartum, and newborn care; gynecologic care including miscarriage and abortion treatment; treatment of sexually transmitted infections; and prescribing medications, including all forms of pain control medications and birth control (American College of Nurse-Midwives, 2023).
- NC Senate Bill 20/Session Law 2023-14 removed the physician supervision requirement for CNM practice. CNMs with fewer than 24 months and 4,000 hours of practice are required to have a collaborative provider agreement in place with either a physician or a CNM with a minimum of four years and 8,000 hours or practice.
- While there are no CPM programs located in NC, the National Midwifery Institute offers a MEAC-accredited distance learning program that NC residents are eligible to enroll in (National Midwifery Institute, 2018).
- In 2025, legislation was introduces in both chambers of the North Carolina General Assembly to establish a Certified Professional Midwives Licensing Act - SB 617, HB 495.
- In Pitt County, which houses the only CNM/CM program in NC, the rate of certified nurse midwives is 0.9 per 10,000 population, compared to the overall state rate of 0.43 per 10,000 population (Sheps Health Workforce NC, 2024).

Certified Nurse Midwives per 10,000 Population by County, North Carolina, 2024



Critical Partners

ECU, NC General Assembly, NC Nursing Schools, NC Community Colleges, Child Fatality Task Force – perinatal health committee, NC Certified NM Association, NC Certified Professional Midwives, AHEC, NCMS/ObGyn, NCAFP, NCCHCA, Academic Partners

Priority 2: Increase access to doula services in all NC counties in the near- and long- term.

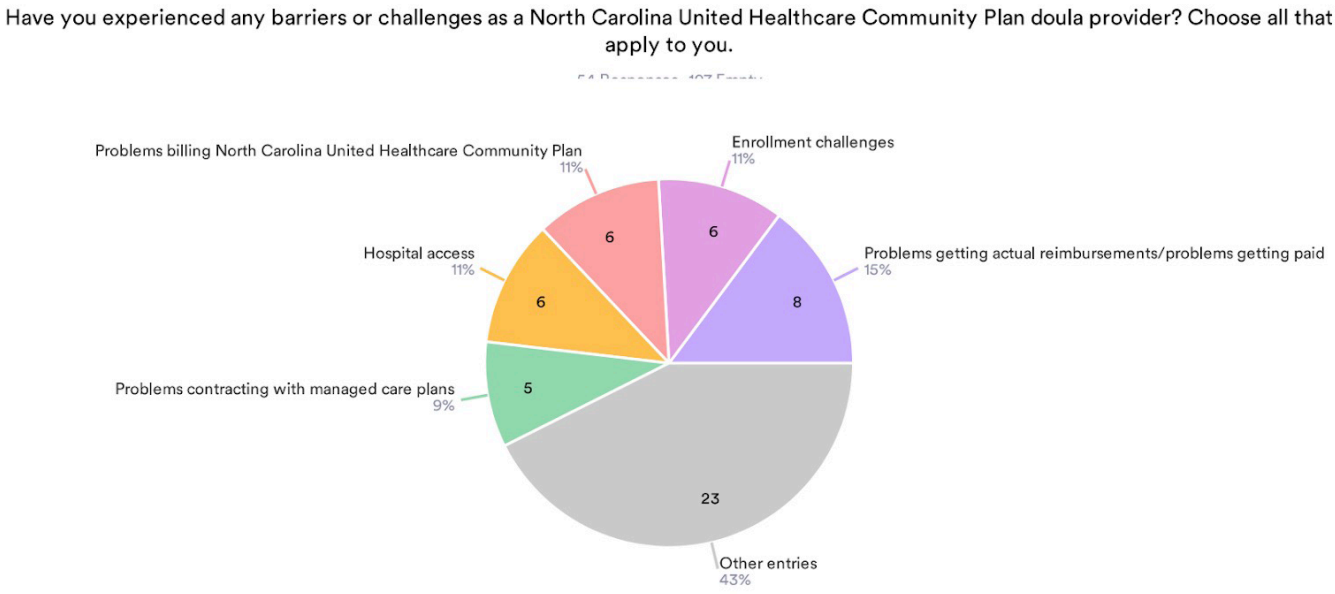
Actions

- Support ongoing advocacy for expanding coverage of doula services as a routine and paid benefit by Medicaid and Commercial payers in NC.
- While awaiting broad coverage and associated challenges, expand the doula value-added benefit consistently across NC Medicaid Managed Care Plans including optimizing the available offerings by all plans in all NC zip codes.
- Request that the Division of Health Benefits (DHB) publicly track regions where doula services are offered by health plans to help members choose health plans that have services that meet their needs.
- Request that the DHB utilize the above web location to trend doula utilization over time by plan and zip code.
- Minimize current barriers for doulas to access hospitals by partnering with the North Carolina Healthcare Association to:
    - Waive fees required for doulas to obtain privileges and/or badge access.
    - Standardize documentation required to gain access to support clients to minimize administrative burden.
- Identify a partner to create a Doula Directory by area of state that is updated in near real-time.

Supporting Data

- Doula care is associated with improved health outcomes among Medicaid enrollees.
    - According to a retrospective, observational cohort study by Falconi et al., females who used doulas had a 47% lower risk of Cesarean delivery, a 29% lower risk of preterm birth, and were 46% more likely to attend a postpartum checkup (Falconi et al., 2024).
- Medicaid programs that routinely cover doula services – including California, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, Oklahoma, Oregon, Rhode Island, Virginia, Washington DC (NASHP, 2024).
- NC Senate Bill 463 (2025-2026 session) proposes Medicaid coverage for doula services; specifies parameters of covered services, updates coverage policies, and determines credentialing requirements (General Assembly of North Carolina, 2025).
- All Standard Plans offer doula services as a value-added benefit, but not consistently across geographies.
    - Value-added benefits for doula services limit the administrative burden of becoming an enrolled Medicaid provider and biller, allowing more doulas to receive payment through Medicaid.
    - Value-added benefits do not increase state budget spend for Medicaid.

- As more doula services are available, an emerging barrier is physical access to hospitals and health systems as well as shared understanding of the doula role in the labor and delivery setting.
    - 11% of NC United Healthcare Community Plan doula providers selected hospital access as a barrier to providing care.



Critical Partners

A Cure 4 Moms, HealthConnect One, NC Preferred Health Plans and Tailored Plans, NC Association of Health Plans, NC Medicaid, NC DHHS, Commercial Payers, NCGA, March of Dimes, NCMS, Forsyth Birth Stories, other doula networks

Focus Area 2: Rural Access Opportunities

Goal: Reduce geographic disparities in maternal health outcomes by expanding access to high-quality care and support services in rural communities across North Carolina.

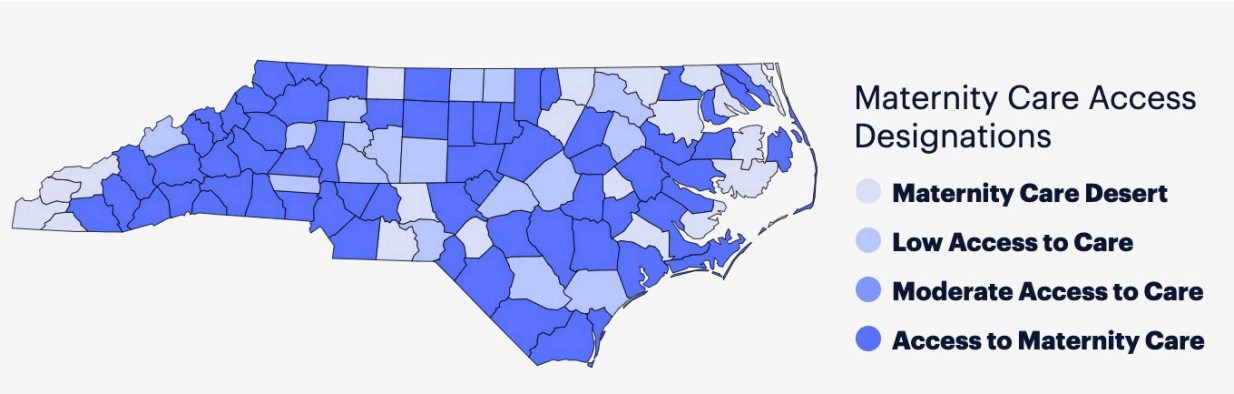
Priority 1: Increase access to early and longitudinal routine prenatal care in rural communities across North Carolina.

Actions

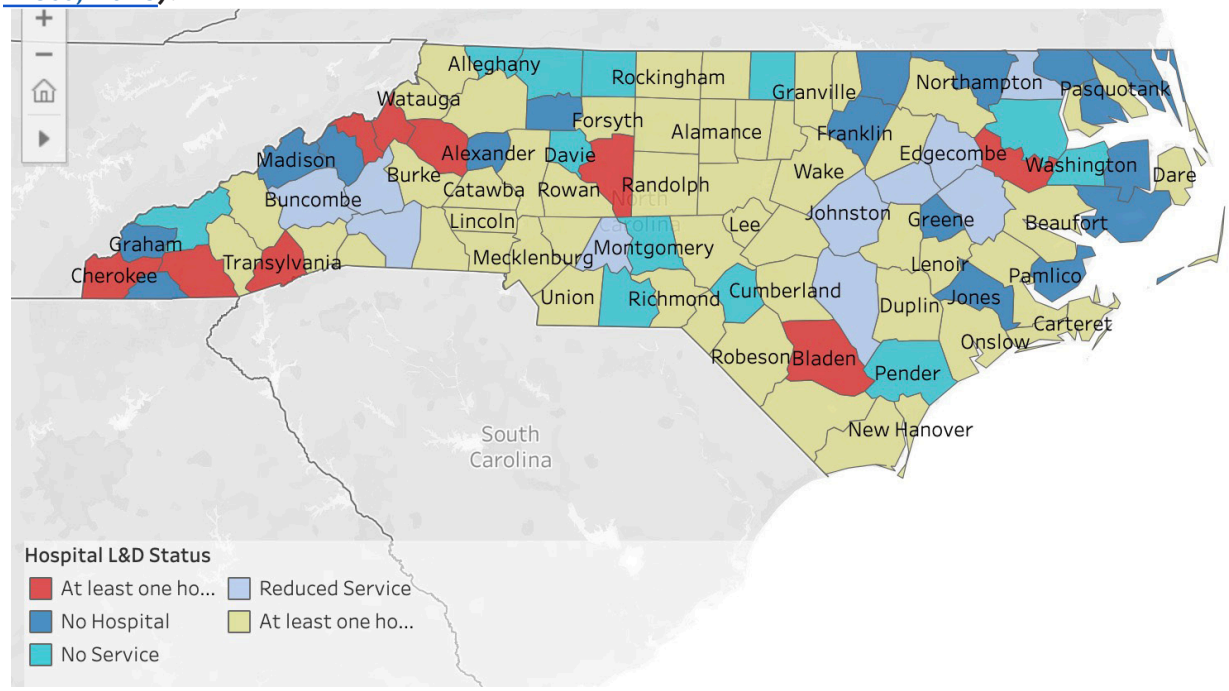
- Highlight opportunities for the "Shared Maternity Care" model of prenatal care in rural health departments and Federally Qualified Health Centers (FQHCs).
- Fund the provision of the comprehensive "Shared Maternity Care" educational resources at no cost to interested practices.
- Fund early capital to incorporate "Shared Maternity Care" into interested practices to overcome opportunity costs.
- Develop and offer a Residency Roadshow, embedding awareness of this model in residency training.
- Support pilots using mobile clinics to provide prenatal services in hard-to-reach rural communities.

Supporting Data

- Maternity care deserts exist in NC and more are focused in rural areas. 20% of counties are maternity care deserts, and 17% of counties have low or moderate access to maternity care (March of Dimes, 2024). 13.4% of women have no birthing hospital within 30 minutes (March of Dimes, 2023).



- The “shared care” maternity care management model improves access to prenatal care and encourages continuity of care for pregnant people in rural areas who otherwise may experience difficulties accessing care (Boyle et al., 2003).
    - “Shared care” divides perinatal and postpartum care among two or more healthcare professionals – usually including a family physician with advanced practice provider support in the local community to provide prenatal care and another healthcare professional (usually an OB/GYN) to see the pregnant person periodically during the pregnancy and deliver the child (Boyle et al., 2003). Therefore, the patient can continue their relationship with their local physician/provider and establish a relationship with an OB/GYN prior to delivery (Boyle et al., 2003).
    - American College of OB-GYN (ACOG) and American Academy of Family Physicians(AAFP) have a joint statement supporting collaborative ambulatory and hospital-based maternity care services (ACOG, 2021).
    - AAFP has existing training modules that can be purchased individually or in bulk to provide the clinical information needed to initiate a shared care maternity management model (AAFP, 2025; AAFP, 2025).
- Rural hospital closures and workforce shortages have led to the centralization of services in urban areas, leaving rural women with longer travel times and poorer outcomes (Carolina Public Press, 2025).



Critical Partners

NCCHCA, NC Association of Local Health Directors, NC Association of Residency Directors, NC Academy of Family Physicians, NC Hospital Foundation, NCGA, NC DHHS DHB, Office of Rural Health

Priority 2: Using available data sources, identify the top 5% of NC counties with cross-sectional indicators that contribute to poor maternal-child outcomes and mobilize philanthropically supported community action coalitions.

Actions

- Encourage and facilitate community and philanthropic partnerships in 5 counties with a combination of highest Maternal Vulnerability Index (MVI) counties with overlapping high maternal and infant mortality, high maternal mental health, high neonatal abstinence to fund a local community action coalition to focus on improving the key indicators (using the established Perinatal Health Equity Colllective (PHEC) measures specifically).
- Preliminary proposed counties: Bladen, Robeson, Swain, Madison, Northampton.

Supporting Data

- The overall MVI score is dependent on reproductive healthcare (access to reproductive care and skilled birth attendants), physical health (prevalence of non-communicable diseases and STIs), mental health and substance abuse (stress, mental illness, and addiction), general healthcare (accessibility, affordability, and utilization of healthcare, including insurance coverage and the state's Medicaid status), socioeconomic determinants (educational attainment, poverty and food insecurity, and social support), physical environment (violent crime rates, housing conditions, pollution, access to transportation).

Highest MVI: Montgomery, **Robeson**, Columbus, Warren, **Northampton**, Anson, **Bladen**, Bertie, Sampson, Greene

Highest SMM (2020-2024): Madison - 163.17, Chatham - 150.33, **Swain - 148.70**, Granville - 147.98, Person - 147.06, Orange - 145.34, **Bladen - 142.94,** Hertford - 141.84, Durham - 138.16, Yadkin - 135.14 (rate per 10,000 delivery discharges) (NCDHHS, 2025)

Highest Infant Mortality (2019-2023): Northampton - 19.7, Washington - 19.2, Edgecombe - 13.8, Martin - 13.7, Bertie - 13.6, Richmond - 13.4, Beaufort - 13.3, Warren - 13.2, **Swain - 12.7**, Hertford - 12.5 (number of deaths to infants less than 1 year per 1,000 live births) (NC-DHSS, 2025)

Highest Maternal Behavioral Health (2020-2024): Madison - 33.4, McDowell - 29.7, Yancey - 29.5, Mitchell - 29.1, Davie - 29.0, Stokes - 28.8, Buncombe - 28.7, Clay - 28.6, Orange - 27.8, **Swain - 27.5** (% of deliveries with perinatal mental health conditions) (NCDHHS, 2025)

Highest Neonatal Abstinence Syndrome (2020-2024): Swain - 49.2, Graham - 43.8, McDowell - 28.7, Jackson - 28.3, Wilkes - 25.6, Caldwell - 24.6, Scotland - 24.4, Richmond - 24.2, Macon - 24.1, Burke - 23.5 (rate per 1,000 newborn discharges) (NCDHHS, 2025)

Critical Partners

PHEC, 5 identified county governments and local health departments, regional and/or statewide funders, SAS, universities and community colleges, NCNG, RTI, MOD, Duke, private foundations

Priority 3: Seek to understand models for innovative perinatal services to identify opportunities for expansion across NC.

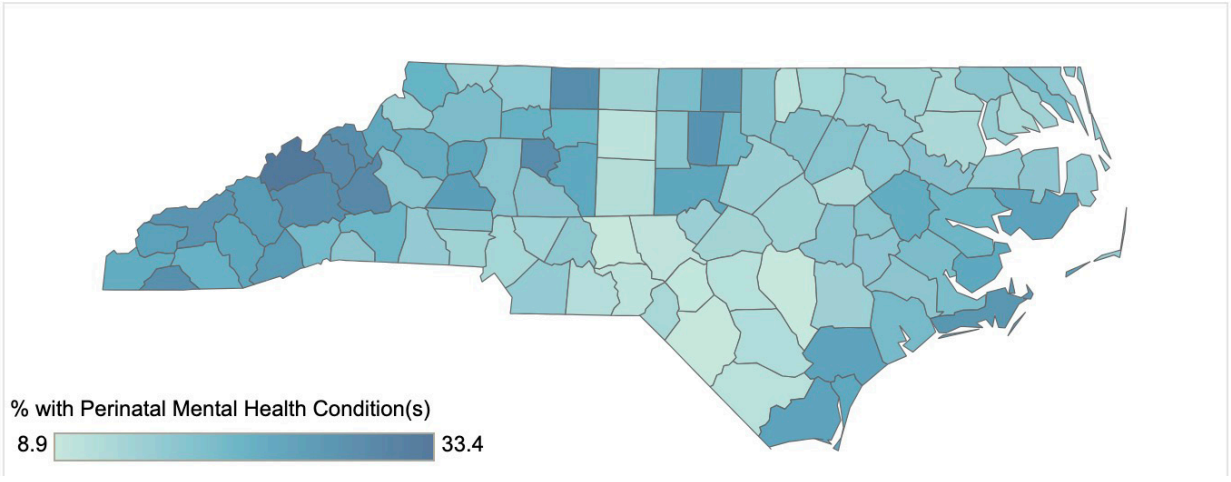
Actions

- Evaluate utilization and outcomes from initiatives delivering innovative perinatal services to new mothers to identify which models should be considered for adoption in NC.
- Identify existing demonstration projects currently deployed in North Carolina.
- Support funding opportunities to pilot programs based on highest quality and strong evidence of effectiveness and feasibility.
- Partner with NC-PAL/NCMATTERS to identify opportunities to increase utilization of available resources by providers in rural counties.

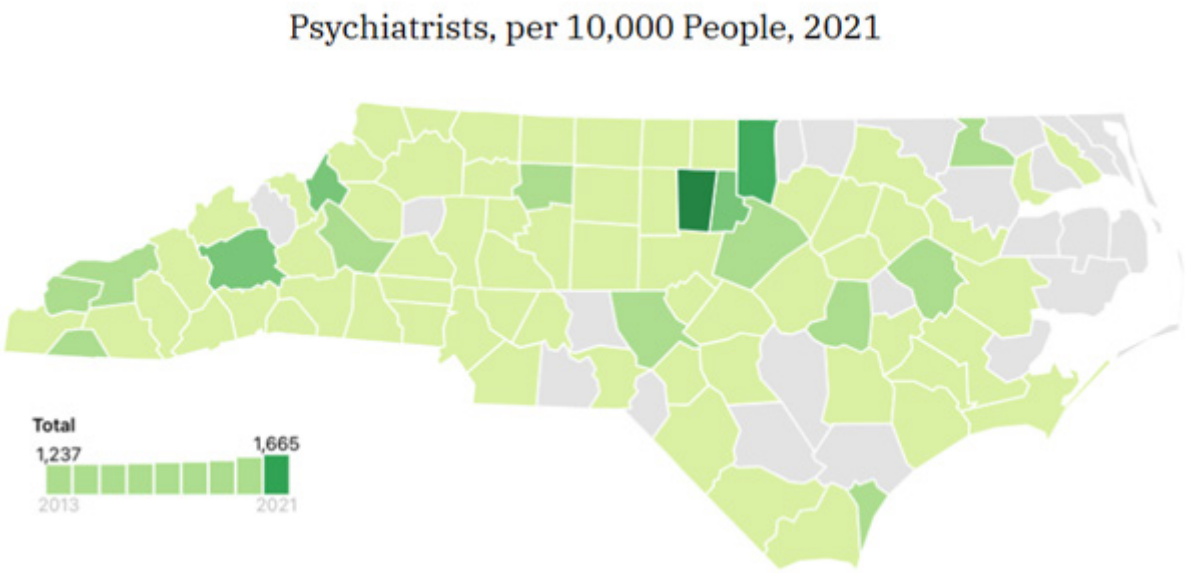
Supporting Data

- The 2018-2020 North Carolina Maternal Mortality Review Report found that mental health conditions were the leading cause of pregnancy-related deaths (32.3%) (NCDHHS, 2025).
- Behavioral health needs of pregnant women are significant in NC. As shown in the graph, co-morbid needs vary across the state. (NCDHHS, 2025)

Percent of Deliveries with Perinatal Mental Health Conditions by County of Residence: 2020-2024

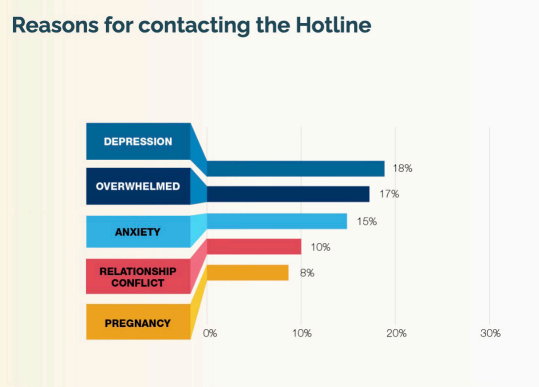


- There are costs associated with leaving behavioral health and other drivers of health untreated. The societal cost of untreated perinatal mood disorders for 2017 pregnancies from conception to five years postpartum was estimated at $14 billion, with the average estimated cost of the mother-baby dyad at $31,800.
- There is a significant lack of perinatal mental health services in NC, with worsening penetration in rural areas.
    - 22 counties in NC have no practicing psychiatrists, with the average number of psychiatrists being worst in rural counties. In metro areas, there are 1.79 psychiatrists per 10,000 people, while in rural counties there are 0.58 per 10,00 people (Lombardi & Lanier, 2023).



- Innovative perinatal care, including virtual care and extended 12 month post-partum care can improve outcomes and decrease costs (Stekelenburg et al., 2025).
- According to a systematic review, telehealth improved maternal depression outcomes in 80% of studies and anxiety in 75% of studies, along with an improvement in depression scores with more telehealth visits (Nair et al., 2018).
- NC-MATTERS (part of NC PAL) provides a free real-time consultation line for providers serving pregnant and postpartum patients to access perinatal mental health specialists, training and technical assistance for providers, and resources for families.
- The Maternal Outreach Through Telehealth for Rural Sites (MOTHeRS) Project through ECU was established to increase access to health care and improve health outcomes for mothers and babies. Telehealth and face-to-face services are rendered to patients at the participating community-based primary care obstetric clinics to address obstetric care for high-risk pregnancies, mental health needs for expectant and new mothers, and food insecurity.
- Neighboring South Carolina has also implemented several programs to increase virtual access to innovative perinatal care:
    - Mom's IMPACTT (IMProving Access to Maternal Mental Health and Substance Use Disorder Care Through Telemedicine and Tele-Mentoring) provides resources and referrals to individuals who are pregnant or within 12 months postpartum who are facing mental health and/or substance abuse challenges; it also offers training and real-time psychiatric consultation for healthcare providers (MUSC Health, n.d.).
    - Listening to Women (LTW): focuses on identifying barriers to postpartum success, infant milestones, and overall family health; uses a text message-based system monitored by MUSC's telehealth team and includes a free virtual visit with a registered nurse 5-7 days after discharge; aims to improve screening and treatment for perinatal mental health and substance use disorders (MUSC Health, n.d.).
    - H.E.A.R. 4 Mamas (Healing, Equity, Advocacy, and Respect 4 Mamas): a text-message program that monitors for signs and symptoms of perinatal complications; if concerns arise, a nurse advocate will follow up by phone to discuss (South Carolina Community Health Worker Association, 2025).

- Nationally, HRSA also has a Maternal Mental Health Hotline that provides free, confidential emotional support and resources for pregnant and postpartum individuals (HRSA, 2025).
    - Since launching on Mother's Day in May of 2022, the hotline has received more than 54,173 calls and texts for various maternal mental health reasons (HRSA, 2025).



- Other innovative perinatal care models are emerging that complement in-person obstetric care, for example
    - Pomelo Care
        - This model provides virtual 24/7 preventive care, behavioral health screening and support, and primary care services through 12 months postpartum.
        - Pomelo Care, 2024 reports that engagement with the program is associated with a 7x increase in mental health screening rates, which can reduce perinatal depression risk by 40%, a 46% reduction in maternal emergency department utilization, a 23% reduction in infant emergency department visits during the first 60 days of life, a 58% reduction in NICU admissions, a 11% reduction in non-birth inpatient stays, and a5% reduction in the cost of care across a Medicaid population.
    - Cabaya Care
        - This model provides comprehensive in-person and virtual wrap-around support throughout pregnancy and postpartum.
        - A multidisciplinary team led by Maternity Navigators (MNs) work closely with members to support their needs including help with physician visits, feeding and nutrition, connection to local resources, birth planning and doula support.
        - Cabaya Care reports engagement with the program is associated with 38% lower preterm birth rate, 25% fewer visits to emergency department, 47% reduction in low birth rates, 11% increase in breastfeeding, 56.5% decrease in post-partum depression rates.
    - Ouma Health
        - This model is a dedicated maternity telehealth platform founded and led by Maternal-Fetal Medicine physicians that provides clinical care nationwide.

Critical Partners

NCPAL/NCMATTERS, Duke Endowment, MUSC, UNC F7, NC DHHS DHB, Commercial Payers, Standard and Tailored Plans, Managed Care Association, UNC CMIH and 4th Trimester Project

Focus Area 3: Public Policy Opportunities

Goal: Drive smarter public policy to sustain improvements in maternal and infant health statewide.

Priority 1: In partnership with NC Medicaid managed care plans, increase utilization of Value Added Benefits(VAB) across all plans and in all Medicaid regions for perinatal and infant-specific benefits.

Actions

- Facilitate the creation of a unified website "landing page" that lists all VAB services available by plan with "easy to navigate" links to access these benefits.
- Engage with health plans to simplify accessing VAB by automatic provision or partnering with maternity providers to deliver the resources.
- Engage with primary care and maternity providers and pregnancy care managers on the availability of VAB services to increase utilization and facilitate access to these benefits by members.

Supporting Data

- Value-added benefits in Medicaid are extra, non-medical services offered by managed care organizations (MCOs) beyond the standard Medicaid benefits. They are designed to improve health outcomes by addressing social determinants of health and reducing costs of more expensive healthcare needs (Hinton & Diana, 2024). These benefits cannot be paid for by Medicaid, so instead, they are funded by the MCO's administrative dollars and are a key benefit in managed care.
- NC MCOs currently identify the following VAB for pregnancy and infant care:

Plan	Member Count (NCDHHS, 2025)	Pregnancy/Infant VAB
Alliance Health (Tailored Plan) (Alliance Health, n.d.)	68,440	No perinatal and infant resources (only asthma management and education and wellness)
AmeriHealth Caritas (Standard Plan) (AmeriHealth Caritas, 2025)	390,527	- community health workers for support and education about prenatal and well-child visits - breast pumps and milk storage bags - infant car seats to members who have completed at least one prenatal visit in the first trimester - a box of diapers and a box of baby wipes to members who complete their postpartum visit within the recommended time frame - pregnancy and postpartum with the Bright Start Program - baby showers at Wellness & Opportunity Centers
Carolina Complete Health (Standard Plan) (Carolina Complete Health, 2025)	278,911	- breast pumps - New Parents' Package supplies, including a choice between a car seat or a pack 'n play, along with diaper - doula education services - community baby showers
Healthy Blue (Standard Plan) (Healthy Blue, 2021)	616,458	- rewards for going to doctor visits (up to $50) -Baby Essentials Catalog (such as stroller, safe sleep kit, breastfeeding support kit, etc.); -community baby shower - doula support (but only in select counties)
Partners (Tailored Plan) (Partners, 2025)	51,454	No perinatal and infant resources (only wellness)

Trillium Health Resources (Tailored Plan) (Trillium Health Resources, 2025)	89,387	- Baby Care Kit after a prenatal visit - up to $25 in rewards after a postpartum visit - up to $25 in rewards after completing a pregnancy intendedness course
UnitedHealthcare Community Plan (Standard Plan) (UnitedHealthcare Community Plan, 2025)	487,403	- choice of baby products (car seat, pack n play, diapers, and wipes) - breastfeeding support - community-Based Doula Programs (up to $1,200 value) - community baby showers with gifts, resources, and education - up to $100 in rewards for baby products -electric breast pump
Vaya Health (Tailored Plan) (Vaya Health, 2025)	45,523	- breast pump -lactation education and support
WellCare (Standard Plan) (WellCare, 2025)	497,145	- breast pump - community baby showers - doula program - support and training to parents with a child or children with serious emotional disturbance (SED) and are at risk of out-of-home placement - prenatal gift after completing first prenatal visit (members can select one of the following: stroller, portable playpen, car seat, diapers) - "Good measures" clinical program for gestational diabetes (includes evaluation of SDOH and 1:1 coaching)

- Despite that value-added benefits are available, they are largely underutilized. This is due to several factors including a lack of information and awareness and challenges accessing these benefits. An example of a managed care plan ~500K members reveals while utilization is increasing over time, they are not meaningfully reaching the potential they could to support beneficiaries. In the last quarter of 2023 only 125 members utilized doula services; this number increased slightly to 144 in the first quarter of 2025.
- There is a shortage of readily available information about the utilization of VABs and their impact on beneficiaries' health, making it difficult to assess their true value. (Center for American Progress, 2024)
- VABs are also not standardized, so it's difficult to compare offerings across plans. (Neuman, Biniek & Freed, 2025)
- Communications about health coverage and services can create barriers to beneficiaries who struggle with health literacy. (Center for Health Care Strategies, 2024)
- Obtaining specialist consultations or approvals for VABs can also create administrative barriers. (Wikle et al., 2022)

Critical Partners

NC Peds, NCAFP, NC OBGYN, NC Association of Health Plans, NC Child, NC DHB, NC Association of Local Health Directors, NC Medicaid Member Ombudsman, NCCHCA

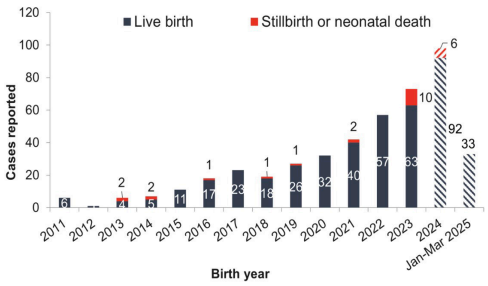
Priority 2: Decrease the incidence of congenital syphilis mortality and morbidity across North Carolina.

Actions

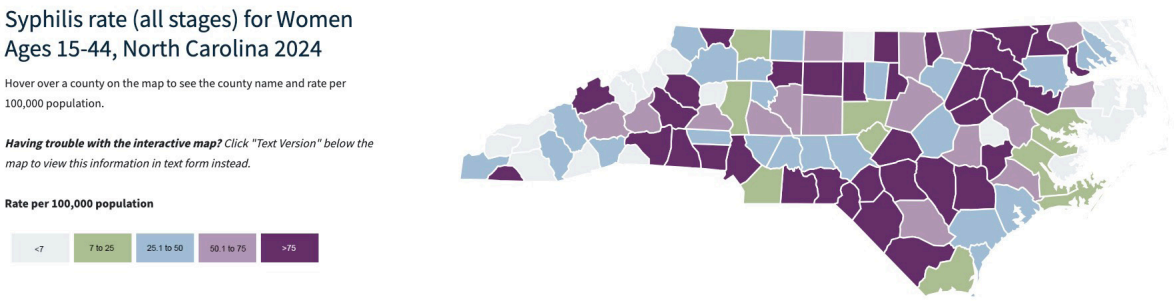
- Support the deployment of claim based triggers by payers when a pregnant person has a syphilis diagnosis to result in an immediate referral to high risk pregnancy care management to facilitate timely treatment and follow up testing.
- Utilizing the claims-based pregnancy trigger, health plans can actively monitor for timely testing for syphilis and flag members who appear to have missed a testing opportunity.
- Fund a dedicated nurse through state public health to track all pregnant women with a syphilis diagnosis to ensure appropriate and timely treatment and follow up testing in collaboration with local health departments, care management and disease intervention specialists.
- Support community based pilots for home or field based Point of Care(POC) testing with maternity providers.
- Support community based pilots home or field based syphilis treatment for hard-to-reach pregnant women.

Supporting Data

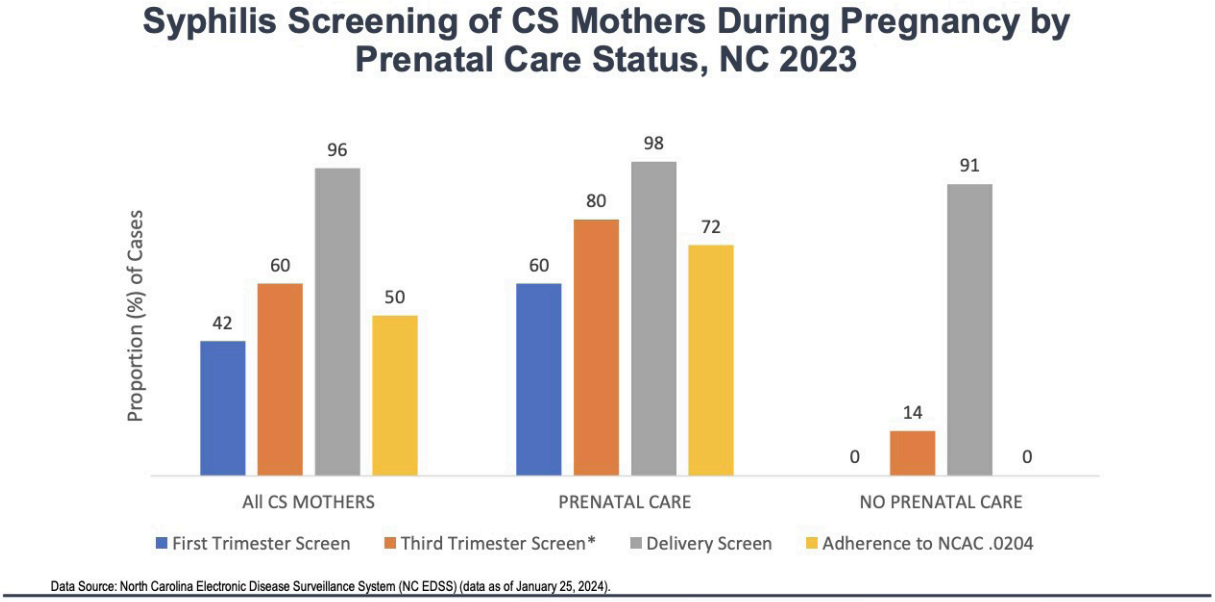
- We have seen a 7,200% increase in cases from 2012 to 2023, and a 28.1% increase in cases from 2022 to 2023 (NCDHHS, 2025).
- Cases of congenital syphilis are rising in NC despite ongoing efforts by public health to reverse the trend through formal media campaigns, public health alerts, and other efforts.
- Recent funding cuts at the federal level have eliminated key positions for disease intervention, tracking, and surveillance.



- Congenital syphilis can result in adverse pregnancy outcomes such as miscarriage, stillbirth, preterm delivery, and perinatal death, but it is preventable through early detection and appropriate treatment of maternal infection during pregnancy (NCDHHS, 2022).
    - North Carolina public health law requires healthcare providers screen all pregnant people for syphilis during the first prenatal visit, between 28-30 weeks gestation, and at delivery to identify and treat congenital syphilis early (NCDHHS, 2022).



- According to NCDHHS data from 2023, 30% of women with babies with congenital syphilis had no prenatal care. Of women who accessed prenatal care, 55% started prenatal care late (in the second or third trimester) (NCDHHS, 2024). Starting prenatal care late indicates they were not tested at the three intervals required by NC public health law.



- 14% of pregnant people receiving prenatal care were not tested for syphilis at the first prenatal visit. Of people whose first prenatal visit was not until the third trimester, 50% were not tested (NCDHHS, 2024).
- These data indicate not only the need to increase access to prenatal care, but to ensure healthcare providers initiate testing for syphilis when pregnant individuals are engaged in prenatal care.

Critical Partners

NC DHB, NC Association of Local Health Directors, NC Association of Health Plans, NC DPH, NC OBGYN, NC Association County Commissioners, NCAFP, NCMS, AHEC, Pharmacy Associations, Planned Parenthood

Priority 3: Endorse and support the advancement of Levels of Maternal Care (LoMC) in North Carolina.

Actions

- Identify the key barriers that have resulted in the failure to advance this widely accepted model that improves maternal health outcomes.
- Partner with lead agencies and programs already endorsing the advancement of LoMC by creating funding opportunities to overcome remaining barriers to the deployment of this model.
- Support legislation that would allow for the required departmental oversight of launching this initiative.
- Support updating the Neonatal Levels of Care.

Supporting Data

- Levels of Maternal Care (LoMC) is a national initiative to improve outcomes but has not been successfully deployed in NC despite years of effort.
    - The goal of LoMCis to provide risk-appropriate care specific to maternal health needs. The classification system establishes four levels of care: basic care (level I), specialty care (level II), subspecialty care (level III), and regional perinatal health care centers (level IV) (ACOG, 2019).
    - These relationships ensure people can give birth safely in their communities while providing support for circumstances when higher level resources are needed (ACOG, 2019).
    - ACOG and the Society for Maternal-Fetal Medicine support LoMC as a best practice (ACOG, 2019; ACOG, 2019).
- The Association of State and Territorial Health Officials (ASTHO) is leading an initiative to update the information available about which states have adopted LoMC guidelines and how they are implementing them, similar to what ACOG did about 4 years ago (Giragosian, 2024).
- CDC is updating the Levels of Care Assessment ToolSM (CDC LOCATeSM) and continues to support that activity (CDC, 2024).
- The Joint Commission has a robust verification program in place and it remains active. They are planning a webinar for the national convening of rural health hospital administrators about LoMC (The Joint Commission, 2020).

Critical Partners

DPH, DHSR, DHB, PHEC, NC OB Society, NC Healthcare Association, NC Association of Health Plans, NC Office of Rural Health, ACOG, NC Peds Society

Priority 4: Protect existing access to the full array of Medicaid-covered benefits in the pregnancy and postpartum period.

Actions

- Advocate for the maintenance of all pregnancy and postpartum service coverage to continue in the setting of ongoing impending cuts to services from NC Legislature budget shortfalls, including "optional benefits" such as dental care.

Supporting Data

- 55% of NC births are covered by Medicaid (Kurzydlowski, 2019).
- Because of the One Big Beautiful Bill Act (OBBA), NC state officials estimate that more than 255,000 North Carolinians will lose Medicaid coverage due to the work requirement – not because they're unemployed, but because of the administrative complexity of documenting the work. (Baxley & Blythe, 2025)
    - Implementing the work requirement will force NC to develop a new system of checking employment status, increasing strain on local Department of Social Services offices. (Baxley & Blythe, 2025)
    - Currently, NC collects a 6% tax on providers' net revenue from patients. The OBBA lowers this rate to 3.5%, which will result in billions of dollars in lost funding. (Baxley & Blythe, 2025)
- NC will likely be forced to pick up additional costs due to OBBA, enacting the financial "trigger" law tied to Medicaid expansion and discontinuing expansion (Baxley & Blythe, 2025), resulting in 669,527 people losing coverage (this number changes monthly). (NCDHHS, 2025)
- NC Medicaid budget challenges in the current legislative session which may force NC DHHS to limit services or cut payments to providers and managed care companies.

Critical Partners

NC DHHS, NC DHB, NC General Assembly, DPH, March of Dimes, NC Medical Society, NCHA, NC Dental Society, NC OHC, NC Child

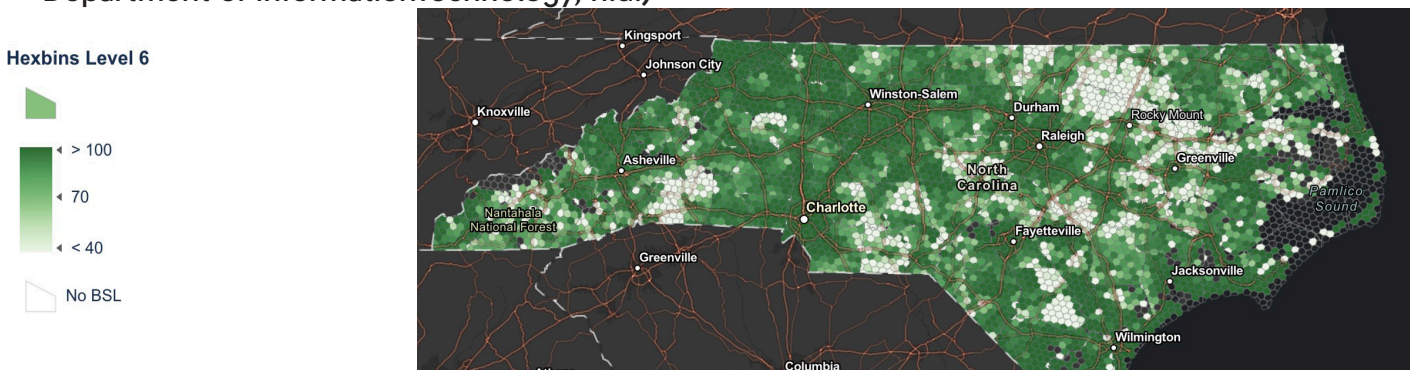
Priority 5: Expand access to telehealth behavioral health and substance use services for pregnant women into rural communities by reducing technology barriers.

Actions

- Increase access to telehealth services in pregnancy by increasing digital literacy in the rural population.
- Increase access to telehealth services by supporting enhanced broadband reach to rural communities across NC.
- Partner with managed medicaid to expand their digital VAB offerings to increase access to devices and broadband costs for pregnant women.
- Encourage creative models of virtual and hybrid virtual care and remote patient monitoring to persist in the Post COVID telehealth contraction for remote services.

Supporting Data

- Telehealth can increase utilization of mental health services.
    - According to a study of Medicare beneficiaries with severe mental illness, patients receiving mental health care at practices that almost exclusively switched to telemental health services had 13% more mental health visits than those receiving care at practices that largely used in-person visits (Wilcock et al., 2023).
- At least 1.1 million North Carolina households lack access to high-speed internet, cannot afford it, or do not have the skills needed to take advantage of the digital economy (NC Project Portal, 2023).
- Rural communities in North Carolina disproportionately lack access to high-speed internet (O'Donnell, 2020).
    - 39% of North Carolinians have access to 25 megabytes per second (Mbps) download speed and 3 Mbps upload speed at $60 or less per month. The inability to afford internet service is one of the most common and pervasive barriers to broadband adoption (Tanberk, 2019).
    - Only 73% of North Carolina households have high-speed internet subscriptions (NC Department of Information Technology, n.d.).
    - Many North Carolinians also lack access to a meaningful device that meets their needs. A smartphone is the only "computer" they own, which remains less efficient and capable than a computer or tablet with a keyboard. Some households don't have a device at all. (NC Department of InformationTechnology, n.d.)



NC Broadband Status Map (NC Department of Information Technology, 2025)

Critical Partners: The Mothers Project, NC Step, NC Office of Rural Health, NC Health Plan

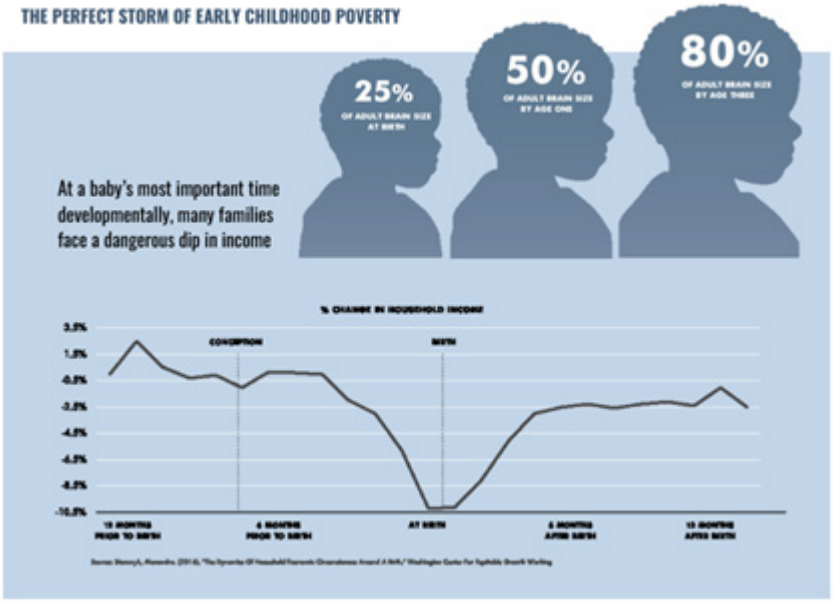
Priority 6: Advance initiatives that promote economic support for mothers and infants

Actions

- Identify evidence based programs designed to promote economic support for pregnant women and infants ready to be introduced in North Carolina.
- Identify what is needed for effective deployment in North Carolina and work with partners to create enabling environments in communities.
- Support funding opportunities to pilot programs and advance the evidence base for feasibility, effectiveness and return on investment.

Supporting Data

- Infancy and early childhood are critical periods of brain development. Center on the Developing Child
- Growing evidence shows the negative consequences of economic instability on early brain development. Blair 2016
- Income plunges, resource demands increase, and poverty spikes right before a child is born and remains high throughout the first year. Stanczyk 2016, 2020



- With some heterogeneity in findings based on program and evaluation design and timing (e.g., during the COVID pandemic), numerous studies show positive effects of economic support of mothers and infants including reduced low birth weight, preterm births, hospital readmissions, increased infant brain activity, breastfeeding, food security, parental participation in the workforce, educational attainment. (Bridge Project, Rx Kids, Baby's First Years)

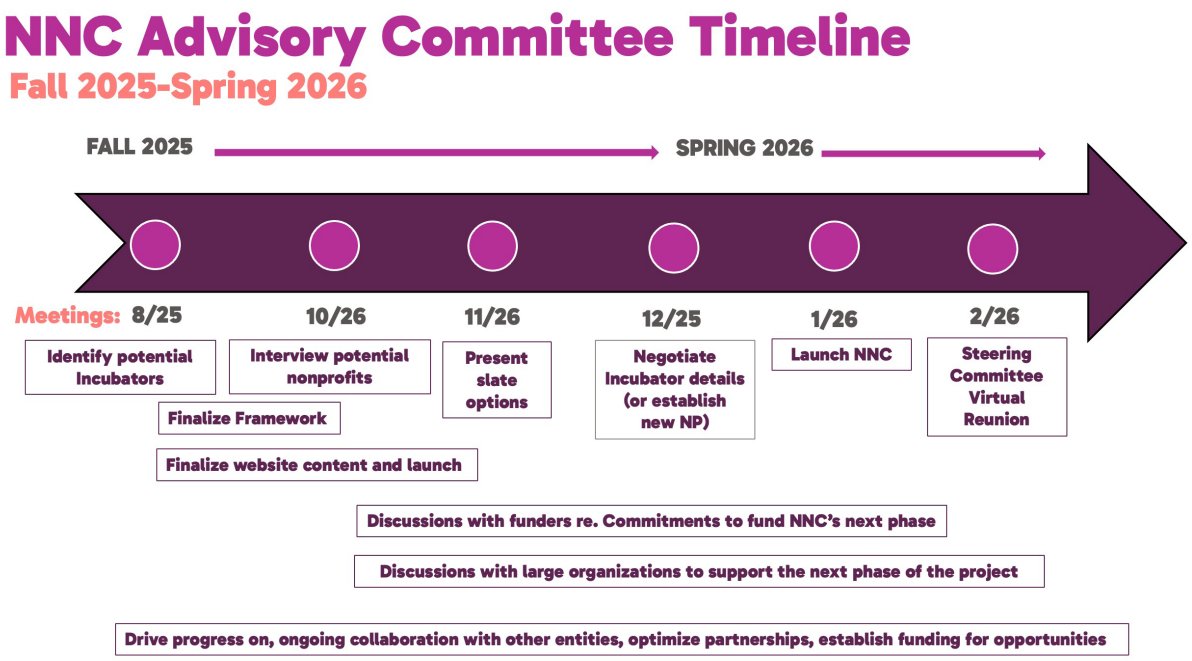
- The Federal Act – H.R.1 allows for a "Baby Bonus" and permits accounts to be established for infants with an initial $1,000 deposit from the government and potential for parental and employer contribution.
- A refundable state Earned Income Tax Credit (EITC) of at least 10% of the federal EITC improves birth outcomes and reduces low birth weight, increases parents' workforce participation, improves household economic security with the greatest effects for single mothers and their children. Thirty-two states (including DC) have adopted a state EITC. Prenatal-to-3 Policy Impact Center 2025
- Rx Kids is an income support initiative for mothers and infants recently expanded in Michigan. Evaluation of the program found:
    - Earlier and increased use of adequate prenatal care.
    - Positive impacts on birthweight, reduction in preterm births, prevention of NICU admissions. Estimated of healthcare savings from statewide replication is $220 million/year in the prevention of premature babies and $268 million/year in the prevention of low birthweight babies.
    - Reduced maternal postpartum depression and anxiety. Studies show reductions in postpartum depression may significantly lower health care expenditures by more than $5,000 per affected mother.
    - More stable housing and 91% reduction in evictions. Stable housing reduces hospitalizations and boosts earnings.
    - Investment in local economy by families' use of funds. $1 invested generated about $1.60 in local activity.
    - An added $1,000 in Rx Kids-like benefits was linked to a 30% decline in CPS referrals. For every $1 spent on cash transfers early in life, the estimated ROI in child welfare costs was $4.20.
- The Bridge Project – is an income support initiative for mothers and young children recently expanded to 8 states and planning for expansion in North Carolina. Findings from the program include
    - 242% increase in economic savings for the parent after 6 months.
    - 63% of mothers in transition housing moved to permanent housing within 9 months.
    - 90% of mothers reported improvement in mental health and stress.
    - 80% of mothers working full or part-time after 18 months.
    - 17% of mothers pursuing post-secondary education.

Critical Partners

NCDHHS/DPH, Local Health Departments, Local Departments of Social Services, Managed Care Organizations/Care Management for High Risk Pregnancies, The Bridge Project, OBGYN Society

Next Steps: Moving from Planning to Action

Implementation Timeline



In August 2025, the Steering Committee affirmed that Nurture NC represents a viable approach to addressing North Carolina's maternal health crisis and is pivoting to immediate implementation to provide the leadership and coordination that the state's maternal health ecosystem desperately needs.

Fall 2025: Framework finalization and Advisory Committee formation

- Identify potential organizational incubators (September)
- Interview potential nonprofit partners (October)
- Present organizational options to Advisory Committee (November)

Winter 2025-2026: Organizational structure and priority activation

- Negotiate incubator details or establish a a new nonprofit (December)
- Launch Nurture NC operations (January 2026)
- Begin priority implementation and partnership development

Spring 2026: Progress evaluation and stakeholder reunion

- Steering Committee virtual reunion for Advisory Committee update (February)
- Strategy refinement based on early implementation learnings

Advisory Committee Formation: A smaller, action-oriented Advisory Committee will be established to identify specific priority actions and inform decisions regarding organizational structure.

> **Track 1: Priority Activation** - Implementing immediate advocacy on identified priorities where "the moment is now", coordinating resources across existing initiatives, maintaining stakeholder engagement, and creating evaluation frameworks to track progress. This involves securing enduring funding to support success in these partnerships.
>
> **Track 2: Organizational Structure Development** - Determining whether Nurture NC should be incubated within an existing organization through a hosted/fiscal sponsorship model or pursue independent 501(c)(3) nonprofit status. The Advisory Committee will conduct discussions with funders regarding commitments to fund Nurture NC's next phase and engage large organizations to support the project.

The Advisory Committee will work with urgency, recognizing that federal funding faces unprecedented uncertainty and that organizations need concrete support and coordination now, rather than in 18 months.

Ongoing Strategic Focus: Throughout this transition, the initiative will drive progress through ongoing collaboration with other entities, optimize partnerships, and establish funding for priority opportunities.

Steering Committee Engagement: The full Steering Committee will reconvene in February 2026 to receive updates from the Advisory Committee on implementation progress and organizational structure decisions, maintaining the cross-sector engagement that has been fundamental to Nurture NC's development.

Conclusion: Moving North Carolina to A+

These priorities represent the foundation for Nurture NC's transition from planning to implementation. The initiative's goal is clear: to move North Carolina from its current D+ grade to an A+ rating through coordinated policy action that addresses the economic and health burdens of maternal and infant mortality on families and communities.

While established through data analysis and stakeholder input, these priorities remain responsive to shifts in the political, funding, and healthcare landscapes. Success will be measured not only by policy changes but by improved maternal and infant health outcomes across North Carolina.

The framework provides a roadmap for coordinated action while maintaining flexibility to adapt to emerging opportunities and challenges. By focusing on policy-level change, Nurture NC aims to support sustainable improvements in North Carolina's maternal and infant health system.

Acknowledgements

Framework Document reflects the extraordinary depth of knowledge, passion, and commitment brought by the 34-member Nurture NC Steering Committee since May 2024. Every idea, strategic priority, and insight in this document emerged from the inspiration and dedication of committee members who attended meetings, engaged in thoughtful discussions, responded to surveys, participated in interviews, and brought their expertise to every interaction.

Bringing the Steering Committee's ideas and data together to develop the framework was a team effort. Contributions were provided by Dr. Shannon Dowler, former NC Medicaid Chief Medical Officer; Dr. Iheoma Iruka and Lucy Burwell from the UNC-CH School of Global Public Health's Maternal and Child Health Department; Gibbie Harris, former Mecklenburg County Public Health Director; and Dr. Kristy Teskey and David Phillips at Faster Glass.

This initiative was made possible through the generous support of founding partners: Kate B. Reynolds Charitable Trust, Dogwood Health Trust, RTI, and the HopeStar Foundation.

As we transition from comprehensive planning to focused implementation, we carry forward not just strategic documents and policy frameworks, but a shared commitment to the mothers, babies, and families across North Carolina who deserve nothing less than the best care and support we can provide. We are fighting for the mother in rural North Carolina who has to drive two hours for prenatal care, advocating for the woman whose voice isn't heard in the delivery room, and creating systems that will embrace and support families at one of the most vulnerable and precious times in their lives.

The work we do—the work outlined in this framework—saves lives. Every priority identified, every partnership forged, and every action taken ripples out to touch mothers, babies, and families across our state. This is the legacy we are building together as we work to move North Carolina from a D+ state to an A+ leader in maternal and infant health.

Support for Nurture NC provided by:

Appendix: Steering Committee Members

Name	Organization	Role
Liz Star	HopeStar Foundation	NNC Steering Committee Chair
Pat Campbell	March of Dimes	Director, Maternal and Infant Health Initiative
Kathy Dail	North Carolina Division of Public Health	Dir. of Community Health Assessment & Improvement
Twylla Dillion	HealthConnect One	Executive Director
Kristen Dorsey	Rural Health Group	Chief Medical Officer
Shannon Dowler	HopeStar Foundation Advisor	Former CMO for Medicaid, Health Policy Consultant
LaPonda Edmondson	NC Healthcare Association	Vice President, Foundation
Jekisha Elliott	NC Medicaid	Associate Director, Program Evaluation
Tim Gabel	RTI International	CEO
Barrett Gunter	United Women's Health	Medical Director
Rachel Hardin	SAS	Head of Life Sciences Business Development
Gibbie Harris	HopeStar Foundation Advisor	Retired Public Health Director
Mark Holmes	UNC Sheps Center	Director
John Hood	John William Pope Foundation	President
Carmen Hooker-Odom	HopeStar Foundation Advisor	Retired NC Dept. of Health & Human Services
Daniella Jaimes-Colina	Piedmont Health Services	CEO
Jay Kennedy	The Duke Endowment	Program Officer for Health Care
Amy Marietta	Mountain Area Health Education Center	Medical Director
Easter Maynard	Investors Management Corporation	Board Chair & Dir. of Community Investment
Martin McCaffrey	Perinatal Quality Collaborative	Director
Shonvá Millien	HealthConnect One	Program Director
Susan Mims	Dogwood Health Trust	CEO

Steering Committee Members (Continued)

Name	Organization	Role
Belinda Pettiford	NC Division of Public Health	Section Chief of Women, Infant, and Community Health
Meg Powell	501 Ventures	Founder and CEO
Michelle Ries	NC Institute of Medicine	Interim President & CEO
Hugh Tilson	NC AHEC	Executive Director
Rebecca Whitaker	Duke Margolis Institute for Health Policy	Research Associate
Sarah Verbiest	UNC Gillings School of Global Public Health	Professor
Marcus Wallace	Blue Cross Blue Shield of North Carolina	Chief Medical Officer
Janelle White	NC Division of Health Benefits	Chief Medical Officer
James Whiteside	ECU Dept. of Obstetrics & Gynecology	Professor and Department Chair
Charlene Wong	Duke University School of Medicine	Associate Professor of Pediatrics