

Trends in Wake County Children's Health

At the request of, and with support from, the John Rex Endowment, the North Carolina Child Advocacy Institute is pleased to provide the following "picture" of the health of children in Wake County.

Thirteen key health indicators are presented for consideration. Any such presentation is constrained by the availability of data. For most indicators, comparative data for Wake and the state are presented for the most recent year available, as well as a comparable base year to indicate progress. For some indicators, comparative data are not available, but the indicators are deemed too important to not include. This also illustrates an overriding theme: better data are needed to enhance decision-making regarding the expenditure of scarce resources.

For each indicator, the rationale for its inclusion is provided, along with an analysis of "how we are doing". Also included are "opportunities to consider". These are meant to be suggestive, not prescriptive. Wake County's political, business, public service, and advocacy communities are in the best position to determine the county's future. Hopefully, the following information will be helpful in formulating the best possible local decisions in the area of children's health.

For almost all the indicators, Wake County is faring better than the state. This is a function not only of the economic health in Wake, but also the commitment of its leaders to invest in children. A major part of this investment is in the form of dedicated public staff, who are joined by a committed private provider community to enhance the health and well-being of Wake County's children.

That said, lots more progress needs to be made. We are pleased that the John Rex Endowment has become part of the process in achieving that progress.

Since 1983, the **North Carolina Child Advocacy Institute** has been a statewide leader in studying issues, making recommendations, and advocating to make North Carolina a better place to be a child and to raise a child.

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Health Insurance for Children

Why does it matter? Access to health insurance greatly reduces financial barriers to care. Studies indicate that children with insurance make better use of preventive care, have fewer and shorter hospital stays, miss fewer days of school due to illness, etc. Access to insurance is a critical component in assuring children's health.

How are we doing? In recent years, North Carolina has made great strides in increasing children's access to health insurance. Happily, Wake's progress in enrolling children in both Medicaid and Health Choice has been even better than the state's, with a resulting uninsured percentage that is substantially below the state average. Outreach efforts in Wake, bolstered by funding from the Rex Endowment, have been the primary reason for this progress. A cautionary note: there continues to be a decline in employer-based health insurance, especially for dependents. In fact, without the availability of public coverage and the extensive outreach efforts, the uninsured rate for children would be climbing in Wake.

Opportunities to consider. Now that overall progress has been achieved, the remaining group of uninsured children is likely to be harder to reach. It may be time to focus on particular target groups, both demographic and geographic, to enhance their access to the public insurance programs. Data should be available from the currently funded Rex Endowment project – Children's Access Program – to provide some direction in this regard. In addition, effective January, 2006, children less than age 6 enrolled in Health Choice are being transferred to Medicaid. It would be prudent to monitor carefully the transfer process in Wake to minimize the "bumps" that might be encountered.

Health Indicator		Current Year	Benchmark Year	% Change
Health Choice Enrollment (December; Ages 0-18)	Wake	7,558	3,435	120.0%
	State	121,836	70,636	72.5%
Medicaid Enrollment (December; Ages 0-18)	Wake	36,907	28,689	28.6%
	State	674,963	559,025	20.7%
Children Without Health Insurance (Percentage; Ages 0-17)	Wake	9.1%	10.1%	-9.9%
	State	11.1%	13.9%	-20.1%

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Preventive Care Under Medicaid

Why does it matter? The benefits of continuous preventive care are indisputable. It is critical that children enrolled on Medicaid participate in such care, both because their health is generally poorer, and because the lack of preventive care leads to more serious episodes of illness. This not only further compromises children’s health, but also increases the costs of care to state and county budgets.

How are we doing? With the implementation of the “Health Check” outreach initiative and the introduction of the Community Care system of creating medical homes for children, both the state and Wake have made remarkable progress in this area. Wake has consistently outperformed the state.

Opportunities to consider. The currently funded Rex Endowment projects – Children’s Access Program and Community Health Center Case Management Program – have contributed to Wake’s progress in this area. As the percentage of those utilizing preventive care increases, it is likely that the remaining children/families will be harder to reach with the message of the benefits of preventive care. It may now be time to focus on particular target groups – demographic, ethnic and geographic – to determine if there are any disparities, and what might be done to enhance participation by these groups. In addition, as children less than age 6 enrolled in Health Choice are transferred to Medicaid (beginning in January, 2006), it is important to assure that these children maintain participation in preventive care.

Health Indicator		Current Year	Benchmark Year	% Change
		2003-2004	1999-2000	
Medicaid Enrolled Children Receiving Preventive Care (Percentage; Ages 0-18)	Wake	73.4%	59.6%	23.3%
	State	69.8%	66.8%	4.4%

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Dental Health

Why does it matter? Untreated tooth decay can be painful, and for children it can lead to systemic infections that compromise overall health. Statewide, dental health is perhaps the most compelling unmet need for children.

How are we doing? Access to dental care is a particular problem for indigent children statewide. Even those on Medicaid, for whom financial barriers theoretically are reduced, have poor access to dental care, though the percentage of Medicaid-enrolled children receiving dental services has increased for all age groups in recent years. (The greatest impediment is the lack of dentists willing to accept Medicaid reimbursement rates. In recent years, these rates have been increased dramatically, so more progress should be expected.) Past data for Wake is unavailable, but current data indicate that children in Wake are faring at about the state average.

The lack of access to dental services is reflected in the data indicating the percentage of children entering kindergarten with untreated tooth decay. As expected, though slightly improving, the state is not doing well on this measure. Wake was faring slightly better than the state in 2001, but current comparisons cannot be made, since Wake has declined to participate in the annual survey conducted by the Oral Health Section of the Division of Public Health.

Opportunities to consider. Increasing the number of providers willing to serve indigent children is critical. Wake Health Services' Dental Outreach and Access Program (funded by the Endowment) appears to be a significant step in the right direction. The results of this project should be assessed to determine the level and direction of future investments in this area.

Health Indicator		Current Year	Benchmark Year	% Change
Medicaid Enrolled Children Receiving Dental Services (Percentage; Ages 1-5)	Wake	29.2%	N/A	
	State	28.3%	16.0%	77.2%
Medicaid Enrolled Children Receiving Dental Services (Percentage; Ages 6-14)	Wake	45.2%	N/A	
	State	45.0%	31.0%	45.2%
Medicaid Enrolled Children Receiving Dental Services (Percentage; Ages 15-20)	Wake	31.9%	N/A	
	State	31.9%	18.0%	77.2%
Children with Untreated Tooth Decay (Percentage; Kindergarten)	Wake	N/A	21.0%	
	State	22.0%	24.0%	-8.3%

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Lead Poisoning Prevention

Why does it matter? Elevated blood lead levels (defined as 10 ug/dL or higher) are related to overall compromises in health and specific compromises in learning and development. In NC, it is associated almost exclusively with exposure to lead paint. It is critical to detect lead exposure in the youngest children, who are more dramatically affected by blood lead levels.

How are we doing? Lead paint has been outlawed in residences built after 1977. This important prohibition, plus statewide awareness campaigns, have led to a dramatic statewide drop in the percentage of children (ages 12-36 months) identified with elevated blood lead levels. Wake has enjoyed these reductions as well, and fares better than the state average. It should be noted, however, that 53 infants and toddlers in Wake were identified with elevated levels in 2004.

State protocols recommend that all children should be screened for blood lead at 12 and 24 months (when crawling and hand-to-mouth actions commonly increase the possibility of exposure and ingestion), unless it is clear that they live in residences built after 1977. Though progress has been made in the percentage of children screened, the screening percentages for the state and for Wake remain alarmingly low.

Opportunities to consider. The issue of low screening rates is particularly worrisome. The NC Childhood Lead Poisoning Prevention Program (in the Department of Environment and Natural Resources) has published a plan with an array of recommendations to eliminate childhood lead poisoning in our state. Several recommendations are focused on encouraging primary care providers to screen for blood lead levels in very young children. These recommendations should be given careful consideration by Wake’s public and private providers. In addition, GIS mapping has been completed in Wake, pinpointing where the housing stock is older than 1977. Since this would allow for a more efficient targeting of lead poisoning prevention activities, follow-up of the GIS mapping results should be given serious consideration.

Health Indicator		Current Year	Benchmark Year	% Change
		2004	1999	
Children Screened for Lead (Percentage; Ages 12-36 mos.)	Wake	27.6%	20.1%	37.3%
	State	39.1%	30.4%	28.6%
		2004	1999	
Children with Elevated Blood Lead Levels (Percentage; Ages 12-36 mos.)	Wake	0.9%	2.2%	-59.1%
	State	1.3%	2.3%	-43.5%

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Early Intervention

Why does it matter? The earliest possible diagnosis and intervention services for developmental concerns minimize later developmental delays and disabilities. Thus, children develop and learn more readily, and need to partake of fewer specialized services, which are costly to both the county and the state.

How are we doing? Perhaps the most effective program in this area is the Early Intervention Program, a state-federal partnership offering screening, diagnosis and intervention services for children from birth through age two. NC is noted for having one of the best such service systems nationally, serving more than 12,000 infants-toddlers in 2004-2005. Nevertheless, due largely to funding constraints, this statewide caseload represents only about 60% of the children estimated to be in need of such services. Similarly, while Wake’s caseload has increased exponentially in recent years, estimates indicate that less than half of the potential need is being met.

Opportunities to consider. This service program is currently being re-designed as a result of a growing number of referrals, which are far beyond the program’s capacity to respond. In part the increase is due to a new federal law which requires referrals of all children under age 3 who have been confirmed as abused or neglected, and in larger part due to the increased use of the program by primary care providers. It appears that not only will the Early Intervention Program need to be re-designed, but also the involvement of other providers – medical providers, child care providers, etc – in a systemwide response to the developmental morbidity that is being identified. The Rex Endowment might consider a role in convening and facilitating a Wake response to this burgeoning challenge. Parenthetically, this is related closely to the Rex Endowment’s project – Pediatric Developmental Surveillance Project.

Health Indicator		Current Year 2004-2005	Benchmark Year 1999	% Change
Children (Ages 0-2) Served by Early Intervention	Wake	943	321	193.8%
	State	12,436	6,873	80.9%

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Child Abuse and Neglect

Why does it matter? This is one of the greater tragedies of our culture. Child maltreatment results not only in immediate physical and emotional harm, but also has long-lasting effects on development, overall child and adult health, and even increased contacts with the juvenile and criminal justice systems. All of this is quite costly in both human and fiscal terms.

How are we doing? Based on the best available data, which indicate some improvement, NC is not doing especially well. Over 27,000 children were substantiated as victims of child abuse and neglect in 2003-04. The state substantiation rate per 1,000 children has declined dramatically, but this may be an artifact of the continuing introduction of the state's Multiple Response System, which includes a uniform investigation and substantiation decision-making process. Counties traditionally have had a fair amount of leeway in deciding which reports of maltreatment to investigate. This perhaps explains the fact that the substantiation rate in Wake has traditionally been much lower than the state average. When the Multiple Response System is fully implemented in 2006, wide county-based variances may be minimized.

Opportunities to consider. It would probably be best to simply review the implementation results of the Multiple Response System in Wake County. This may provide guidance for the future involvement of the Rex Endowment in the overall challenge of child maltreatment. Additional guidance may come from a recent report from a Task Force on the Prevention of Child Maltreatment sponsored by the NC Institute of Medicine. This report includes an array of recommendations. After consideration, the Endowment may be of assistance in implementing relevant recommendations within Wake.

Health Indicator		Current Year	Benchmark Year	% Change
		2003-2004	1998-1999	
Cases Investigated for Child Abuse or Neglect	Wake	4,908	3,895	
	State	113,557	104,329	
		2003-2004	1998-1999	
Cases Investigated for Child Abuse or Neglect (Rate/1,000)	Wake	26.5	26.0	2.1%
	State	55.2	54.5	1.2%
		2003-2004	1998-1999	
Children Substantiated as Abused or Neglected (Unduplicated)	Wake	1,163	1,006	
	State	27,310	32,115	
		2003-2004	1998-1999	
Children Substantiated as Abused or Neglected (Rate/1,000)	Wake	6.2	6.7	-7.4%
	State	11.8	16.8	-30.0%

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Alcohol, Tobacco and Substance Abuse

Why does it matter? These risk-taking behaviors in the teen years not only compromise the health of our youth, but also their potential for education. Studies also link poorer adult health and more frequent contacts with the juvenile and criminal justice systems for youth who frequently use these “gateway” substances.

How are we doing? The “Healthful Living” portion of the school curriculum provides information on the dangers of these substances, and encourages abstinence. This is reinforced by public awareness campaigns. A major problem is that we cannot track progress in this area with great accuracy. The best source for statewide estimates is the “Youth Risk Behavior Survey” (of students in grades 9-12) conducted every two years by most school systems in conjunction with the Centers for Disease Control and Prevention. The survey shows improvements in overall statewide estimates, though usage is still alarmingly high (25% for cigarettes; 21% for marijuana; 42% for alcohol/beer). Since the survey relies on self-reporting, there are some questions regarding the validity of the results. However, the survey is the best tool available.

Opportunities to consider. Though additional, specific interventions are needed in this area, it is critical that evaluation methodologies be established to measure the effectiveness of those interventions. A major problem with the YRBS survey is that sample sizes are not large enough to provide county-based estimates. The State Center for Health Statistics is now implementing an expanded population-based random sampling survey technique (CHAMPS) that has the potential to provide county-based estimates for large counties such as Wake. Resources may be needed to assure that an over-sampling in Wake will produce reliable estimates for the county. If needed this might be a wise investment for the Rex Endowment to consider.

A more general prevention-based approach might also be explored. For example, the Search Institute of Minneapolis, through its *Healthy Communities – Healthy Youth* initiative, has developed an approach that encourages parents and community organizations to join together “in nurturing competent, caring, and responsible children and adolescents” based upon instilling positive developmental assets. The Endowment might wish to explore the implementation of such an approach in Wake.

Health Indicator		Current Year	Benchmark Year	% Change
Alcohol, Tobacco and Substance Abuse: Percentage of Students (Grades 9-12) Who Reported Using the Following in the Past 30 Days				
		2005	2001	
Cigarettes	Wake	-	-	
	State	24.9%	27.8%	-10.4%
Marijuana	Wake	-	-	
	State	21.4%	20.8%	2.9%
Alcohol (including beer)	Wake	-	-	
	State	42.3%	38.2%	10.7%

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Mental Health

Why does it matter? In its broadest sense, this indicator includes emotional disorders, developmental disabilities, and substance abuse. National research studies indicate that 8%-15% of our children have challenges in the area of mental health, (though there is considerable debate as to the actual percentage). Obviously, left untreated, mental health problems can lead to monumental health and functional problems, both for the individuals affected, and for society as whole.

How are we doing? At this point, there is no clear consensus on outcome measures (i.e., health status measures) for child mental health as a whole. Though some systems are in place for providers to measure individual patients' progress, these do not provide an overall picture of mental health in a community. Since services are typically underfunded and sometimes entirely unavailable, waiting lists often are the measure for "how we are doing".

Opportunities to consider. Because the public and private response to mental health problems has been considered woefully inadequate, a statewide "mental health reform" initiative is underway. At this point, new guidelines for child mental health services are being revised, and there is considerable consternation among providers and the public regarding the efficacy of current proposals. Thus, though this is a critically important area, it is difficult to suggest a specific opportunity beyond a reminder to stay engaged in the statewide process and then in the implementation of the revised guidelines in Wake. Specific opportunities may emerge from that process.

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Overweight/Obesity

Why does it matter? Overweight/obesity is conservatively defined as a body mass index equal to or greater than the 95th percentile using federal guidelines. Childhood obesity compromises health and function in children and youth. Even more important, it is associated with serious adult health problems, such as high blood pressure, heart disease, diabetes, etc. Eating and physical activity behaviors are established in the formative years. Poor behaviors are hard to change in later years.

How are we doing? Public health concern about overweight/obesity prevalence occurs when it exceeds 5% of the population group. The NC data for all child age groups are well above that level of concern, and are getting worse. There may be an artifact in the 2000 data for Wake, which make it seem that the county has experienced large increases in overweight children for two of the three age categories in the last four years- especially in the preschooler years. Even so, the 2004 data for Wake are similar to state levels, which are themselves alarming. While the children represented in these data are those who receive services in local health departments or school health centers and may not be fully representative of the population as a whole, the data are sending an important signal that should be heeded.

Opportunities to consider. Overweight/obesity is a complex behavioral problem that must be addressed on many fronts. Fortunately, this problem is now the focus of considerable attention at the federal, state and community levels. The state Department of Health and Human Services has embarked on a multi-faceted “NC Healthy Weight” initiative. The Health and Wellness Fund has established a study and grant program to ameliorate the overweight/obesity problem. Wake Schools have received a federal grant in this area. Many counties, including Wake, have held summits of important stakeholders to design interventions best suited to their respective circumstances. While activity swirls in this area, it remains a complicated, cultural problem that defies “silver bullet” interventions. Based on its own summit, Wake will need to carefully monitor interventions at all levels to determine how best to address the problem locally.

Health Indicator		Current Year	Benchmark Year	% Change
		2004	2000	
Overweight (Percentage; Ages 2-18)	Wake	17.40%	9.9%	75.8%
	State	17.00%	14.8%	14.9%
Overweight (Percentage; Ages 2-4)	Wake	16.2%	7.4%	118.9%
	State	14.9%	12.2%	22.1%
Overweight (Percentage; Ages 5-11)	Wake	21.3%	16.7%	27.5%
	State	23.8%	20.6%	15.5%
Overweight (Percentage; Ages 12-18)	Wake	20.8%	24.3%	-14.4%
	State	27.2%	26.0%	4.6%

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Pre-school Vision Screening

Why does it matter? Approximately 5% of pre-schoolers have eye problems, almost all of them correctable if caught early. Amblyopia, reduced vision due to lack of use in early childhood, constitutes about 50% of these problems. If not caught early, amblyopia can compromise vision dramatically and irreversibly. Early, universal vision screening is the most cost-effective tool available to prevent serious eye problems.

How are we doing? While school-based vision screening is a successful statewide service in NC, pre-school screening is not yet available statewide. The state Department of Health and Human Services has a \$300,000 appropriation which it contracts to Prevent Blindness NC. By incorporating some of its own resources, PBNC screens approximately 40,000 pre-schoolers each year in child care settings, or about 40% of that statewide target group. In Wake, about 60% of that target was screened in 2003.

Opportunities Undertaken. Early in 2005, the Rex Endowment initiated a two-pronged, three-year project with PBNC. One focus is on the scientific evaluation of the "Vision Research Photo-Screening Technology" when applied to pre-schoolers. There is state and national interest in evaluating the efficacy of this method. At the same time, by the third year, approximately 10,000 young children in child care settings in Wake will receive screening services. The other focus is a demonstration in Wake that would refine the recommendations of a legislative study committee with regard to vision screening. Components would include referral forms, billing procedures, and the training of primary care providers in vision screening techniques. Lessons learned will have statewide significance, while once again enhancing services for Wake's children.

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Infant Mortality/Low Birthweight

Why does it matter? Infant mortality is one of the worst family tragedies, and is often considered an indicator of a society’s overall health status. Low birthweight (5 lbs. 8oz. or less) is a serious correlate of infant mortality and is also associated with developmental disability. While early and continuous prenatal care can ameliorate the problem, low birthweight is usually a function of preconceptional health behaviors. In addition, low birthweight infants usually require an inordinate amount of intensive care, stressing family and health services budgets.

How are we doing? Over the last 15 years, the state’s infant mortality rate has improved dramatically, though in the last few years progress has slowed, and the rate even got slightly worse in 2004. The disparity between white and minority rates remains wide. In Wake, the infant mortality rate has been consistently lower than the state’s, though Wake’s rate also jumped in 2004. The racial disparity in Wake has decreased significantly (though the minority rate is still twice the white rate). This confirms that access to and quality of prenatal and newborn care have been enhanced.

Opportunities to consider. A significant remaining challenge is low birthweight, which has increased in the state and even more so in Wake (though the increase in Wake is entirely in the white population). This relatively intractable indicator is now receiving considerable attention from many groups, including the NC Child Fatality Task Force and the March of Dimes. These groups have been hosting meetings to develop recommendations for improvement in this area. The Endowment may wish to track these recommendations to determine the role the Endowment might play in implementing those that seem to have the most promise for Wake. In addition, the Wake County Healthy Mothers, Healthy Babies Coalition would be a good source for Wake-specific recommendations.

Health Indicator		Current Year	Benchmark Year	% Change
		2004	1999	
Total Low Birthweight (Percentage)	Wake	7.9%	7.7%	2.6%
	State	9.1%	8.9%	2.2%
White Low Birthweight (Percentage)	Wake	6.7%	6.4%	4.7%
	State	7.4%	7.2%	2.8%
Minority Low Birthweight (Percentage)	Wake	11.3%	11.5%	-1.7%
	State	13.4%	13.1%	2.3%
Total Infant Mortality Rate (Rate/1,000 births)	Wake	7.0	6.5	7.4%
	State	8.8	9.1	-3.3%
White Infant Mortality Rate (Rate/1,000 births)	Wake	5.4	3.9	37.6%
	State	6.2	6.8	-8.8%
Minority Infant Mortality Rate (Rate/1,000 births)	Wake	11.3	13.3	-14.9%
	State	15.6	14.8	5.4%

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Asthma

Why does it matter? Asthma in its mild and serious forms limits the daily activities of children and compromises both health and function. It is the number one health reason for school absences. The prevalence of asthma appears to be growing in NC and nationally, a growth largely attributed to the continued deterioration of air quality.

How are we doing? The NC School Asthma Survey was conducted in 1999-2000 on most seventh and eighth graders and produced for the first time relatively accurate estimates of asthma prevalence. The data confirm that asthma is the leading chronic illness among our school-age children, with few urban-rural and racial differences in prevalence. The prevalence in Wake is substantially the same as the state average.

In recognition of the high rate of pediatric hospitalizations due to asthma, the NC Medical Society Foundation and the Community Care Program initiated a project several years ago to educate primary care providers in the management of asthma. This has led to a substantial decline in the asthma hospitalization rate. Once again, Wake has made more progress and fares much better than the state.

Opportunities to consider. Since asthma is a growing concern, the Endowment might want to consider several options:

- There is still a surprising lack of accurate data regarding asthma. The Endowment might want to support a study to update the prevalence figures for Wake. (There appear to be no state plans to replicate the 1999 survey.) The study should also include hospital discharge rates for Wake children, as well as the effects of asthma on school attendance.
- An adjunct to this study would be a review of the progress of the Community Care initiative in reducing hospitalization rates, and what role the Endowment might play in enhancing these efforts in Wake County.
- Similarly, there may be a role for the Endowment to play in supporting school health services in Wake to ameliorate the effects of asthma on school attendance and performance.
- Based in part on the efforts of the NC Child Advocacy Institute and the League of Women Voters of Wake County, the State Board of Education has required that all local school boards adopt policies to reduce potentially harmful school bus diesel emissions by January 10, 2006. The Endowment might play a role in assisting the Wake Board of Education with implementation of the new policy, particularly in the areas of public awareness, as well as the training of bus drivers.

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Health Indicator		Current Year	Benchmark Year	% Change
Asthma Discharges (Rate/100,000 children; Ages 0-14)	Wake	126.7	206.3	-38.6%
	State	180.1	251.3	-28.3%
Reported Asthma Symptoms (Percentage; Grades 7-8)	Wake	N/A	24.8%	-
	State	N/A	28.0%	-
Diagnosed Asthma (Percentage; Grades 7-8)	Wake	N/A	9.6%	-
	State	N/A	11.0%	-

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Teen Pregnancy (Ages 15-17)

Why does it matter? Teen pregnancy is an indicator of the risk-taking behaviors of our youth. Pregnancy at these ages can compromise young women’s health, and more frequently compromises their potential to further their education. Moreover, higher rates of low birthweight and infant mortality are associated with teen pregnancies.

How are we doing? In the past decade, there has been a remarkable national decline in teen pregnancies, and this has been experienced in NC and Wake as well. Researchers indicate that this is a combination of delayed sexual activity and better access to and use of contraceptive methods. There is still a wide disparity between white and minority rates. Wake’s progress in this area has been consistently better than the state’s, though the racial disparity gap remains wide.

Opportunities to consider. Though progress has been made, teen pregnancy remains an important concern. Teen pregnancy is a complex problem that requires a multi-faceted approach. Wake’s public and private agencies have made heavy investments of time, effort, and resources in wrestling with this problem, and these overall collaborative efforts are an underlying basis for the progress that has been made. Based on past success, additional opportunities for success might best be identified by agencies and coalitions working in this area (Wake Human Services; Teen Health; Healthy Mothers, Health Babies Coalition; Wake Schools; etc.). Perhaps a “summit” of these agencies should be explored.

Health Indicator		Current Year	Benchmark Year	% Change
		2004	1999	
Total Teen Pregnancy (Rate/1,000; Ages 15-17)	Wake	21.6	37.3	-42.1%
	State	35.9	47.6	-24.6%
White Teen Pregnancy (Rate/1,000; Ages 15-17)	Wake	15.0	26.9	-44.2%
	State	28.0	37.7	-25.7%
Minority Teen Pregnancy (Rate/1,000; Ages 15-17)	Wake	35.3	60.9	-42.0%
	State	51.5	67.9	-24.2%