Wake County Health and Human Services Board Meeting Minutes
May 21st, 2026

Board Members Present:
Lily Chen
Dr. Ojinga Harrison
Wanda Hunter
Trey McBrayer
Dr. Tonya Minggia
Dr. Jim Peterson
Ann Rollins
Commissioner Cheryl Stallings
Irv Trust
Dr. Kelcy Walker Pope

Guests Present:
None

Staff Members Present:
Akanksha Acharya
Tisha Adams
Jennifer Brown
Ben Canada
Mikayla Crawford
Sheila Donaldson
Barbra Gonzalez
Anika Hamilton
Kevin Harrell
Shamika Howell
Brittany Hunt
Lee Little
Annemarie Maiorano
Jenelle Mayer
Michelle Mulvihill
Ken Murphy
Shanta Nowell
Modupe Omosaiye
Tina Payton
Morgan Poole
Melissa Pullen
Mike Ranck
Catherine Rivera
Lechelle Wardell
Tammy Whitaker
Diamond Wimbish

Call to Order
Chair Ann Rollins called the meeting to order at 7:40 a.m. The meeting began with brief introductions.

Next Board Meeting – June 25th, 2026

Approval of Minutes
Chair Ann Rollins asked for a motion to approve the April 23rd, 2026 Board meeting minutes. There was a motion by Mr. Irv Trust and Dr. Jim Peterson seconded. The minutes were unanimously approved.

Treasurer's Report
In the absence of Treasurer Terry McTernan, Ms. Brittany Hunt (Executive Assistant) provided the Treasurer's Report. In April, the fund was reported as $9,317.95. Since then, there had been $150 donated from Board members' stipends. This brought the new total to $9,467.95.

Legislative Update
(Presented by Mr. Ben Canada)
Mr. Ben Canada (County Manager's Office Chief of Staff) provided an update on federal and state legislation.

The County, admittedly, had been receiving a great deal of pressure over the years to take on costs from the federal government. HR1 was continuing this trend with administrative costs for the Supplemental Nutrition Assistance Program (SNAP) coming in the next fiscal year and, if nothing changes, SNAP benefit cost-share impacting the County further in the next year and a half to two years. With Medicaid administrative costs and other potential reductions, the stress was heavy. Mr. Canada did note that he had not yet seen changes to federal grant amounts as of yet.

State legislation was also pushing costs down to the counties. In a bit of positive news, the General Assembly was starting to consider the "Blue Ridge" loophole decimating property tax base, though these impacts were still being felt. The General Assembly was also considering levy limits on local government property taxes. The State continued to push unfunded mandates and, at the same time, State agencies simply were unable to keep up with community needs and demands.

The impacts of HR1 on Wake County were severe, outlined for SNAP and Medicaid below.

- SNAP
  - Roughly 80,000 enrolled in Wake County
  - $15 million in benefits paid out monthly
  - 4,200 applications and 3,000 recertifications received monthly
  - County administration costs about $11 million for one year
- Medicaid
  - About 220,000 total enrollment – 18% of Wake County population
    - Includes about 50,000 added through Medicaid Expansion
    - When including Medicaid Expansion, those on Medicaid represent about one in five County residents
  - 6,800 applications and 12,000 recertifications monthly
  - County administration costs about $23 million for one year

HR 1 Impacts on Wake County

	October 2026	December 2026	October 2027
What Changes?	Federal share of SNAP administration cost decreases from 50% to 25%	Medicaid Expansion enrollees start having two re-det's per year instead of one; New work requirements	States will be required to pay share of SNAP benefits paid out.
What will this cost Wake County?	$2.5M to $4.0M	$2.3M to $3.3M	Tens of millions $$$$
What decisions remain?	Will the State Legislature continue NC's participation in SNAP?	Will State Legislature continue NC's participation in Medicaid Expansion?	Will the State Legislature cover these SNAP costs? Will NC continue to provide SNAP benefits?

Because this October is when SNAP administrative costs kick in, the current proposed draft of the budget, still yet to be approved as of this meeting, had the cost brought by HR1 reflected to keep up with the loss of reimbursement. In December of 2026, HR1 changes will require additional positions to make up for the workload. The SNAP benefits cost share scheduled for October 2027 brings a great amount of unknowns. Mr. Canada anticipated one of three paths:

- State legislation could find State funds to cover the cost increase and continue the program with State monies or
- State legislation could continue SNAP with local governments paying for it through sales tax money or other funds that the counties could not control or
- State legislation could choose to take North Carolina out of the SNAP program completely. SNAP was not an entitlement and could be removed.

The County was currently receiving roughly $100 million per year in federal funds, largely for public health, housing and homelessness, workforce development, and individual assistance programs. Decreases in formula funding and individual assistance would directly impact residents. Though staff kept an eye on federal appropriations, no significant changes had been made at this time.

Executive orders did continue to impact local policy. The County has made policy changes to comply and will continue to monitor the situation for any future orders and policy changes.

The State General Assembly has a biennium cycle much like congress. Currently, the North Carolina General Assembly was approaching the middle of year two. In theory this was a short session where a few tweaks would be made to the budget, and a few laws would be passed. However, this had not been a traditional short session. Recent General Assembly activity included:

- Medicaid "rebase" appropriations
    - Covers Medicaid costs through June 30th
- Ongoing budget negotiations
- House Committee on Involuntary Commitment and Public Safety (IVC)
- Property taxes

There was a budget update anticipated in the next three to four weeks. Mr. Canada had yet to see specific recommendations out of the IVC and was not as familiar with the Medicaid "rebase" appropriations.

Property taxes, however, were the main revenue source of the County, compromising 75% of annual funding. Typically, the County would expect a growth of $40 to 50 million in new property tax revenue. Because of a couple challenges, it was anticipated that the County would bring in $8 million in FY 2027. This was due to two main drivers – appeals of commercial properties and "Blue Ridge" loophole exemptions.

Owners had the right to appeal the County's appraisal of their property during revaluation. In the 2024 cycle, 2% appealed to the Board of Equalization and Review. Despite this low rate, it still represented 8,900 appeals. It takes a lot of time to process these appeals with a lot of risk without knowing what the property tax will look like in the end. The biggest risk is losing revenue from commercial properties, which have lost value. More appeals to the North Carolina Property Tax Commission require significant time and staff capacity. Wake County's estimated cumulative revenue loss in FY 2027 from appeals was $18 million.

With property tax exemptions, nonprofits are exempt from paying property taxes if they house residents with low or moderate incomes and help connect people in need with housing. State law is vague and can create issues when it's not used as it was likely intended. This stems from a court case (Mitchell County

vs. Blue Ridge Housing) about a decade ago where an apartment complex owner gave a nonprofit organization 0.1% ownership of the complex. Through this court case, it was ruled that, despite the nonprofit only owning 0.1% of the complex, the complex owner could get a 100% property tax exemption and pay $0. It was important to note that, in the court's ruling, the court did not define what the statute means when it says "low" and "moderate income" residents. This, in turn, created a loophole which has since been exploited. While this took a while to catch on, the County has gone from losing hundreds of millions in value to billions in value over the past two or three years.

Tax Year	Properties Qualified	Exempted Value
2020	66	$223,089,037 *
2021	69	$289,993,674
2022	76	$368,306,829
2023	73	$388,014,684
2024	**97**	**$1,428,371,902 ***
2025	**137**	**$2,204,668,044**

* Revaluation

Unfortunately, there are still many complexes that could be eligible through this loophole causing even further loss in property tax revenue. Most are not traditional affordable housing. They are older apartments that have been fully taxable for decades. Rent is already less than 80% of the Area Median Income (AMI) and not decreasing to reflect the property tax exemption. It is estimated that Wake County will incur a $12.3 million loss in revenue in FY 2027 from this loophole.

The County had been doing revaluations of properties every four years. Wake County was transitioning to every two years. This was to keep the property tax fair and to reduce the sticker shock. Mr. Canada acknowledged that from 2020 to 2024, there was an average property tax increase of 50% which, understandably, caused a lot of shock. Revaluations are not about revenue generation but instead are about fairness and accuracy. The Senate had passed a one-year pause on revaluations that take effect in January 2026. Wake County was not affected (as the next County revaluation was scheduled for January 2027). However, it did set a bad precedent and was a concern. Talks, since the passing of the pause, have at least slowed down due to other topics dominating conversation.

The House had advanced a bill requiring a November ballot question for a constitution amendment which passed on March 20th, 2026. The referendum language is generic. Options include rate caps, levy limits, and valuation limits. Ultimately, the question that will be on the ballot will be along the lines of "Should the legislature limit local property taxes?"

Finally, the House passed a bill to close the "Blue Ridge" loophole. Mr. Canada was unsure if it also passed in the Senate, but it did have strong bipartisan support. There seems to be an understanding that property owners are getting complete exemptions without a public benefit.

It was likely that legislators, after voting the day before, would be focusing on other legislative issues for the time being. Action on the items reviewed was not anticipated until after the election. However, it was

always encouraged to emphasize to legislators the benefits of letting local governments control local priorities.

Vice Chair Wanda Hunter pointed out that North Carolina still did not have a budget. She commented on the many topics being considered by the General Assembly and the push for such unprecedented and detrimental considerations such as the proposed constitutional amendment. Mr. Canada provided the context that some believed having a constitutional amendment on the ballot would encourage voter turnout. The bill itself had been passed to get the question onto the ballot in November.

Ms. Hunter maintained that such an amendment being passed would have deep repercussions not seen on the surface of "lowering property tax." Programs could not be supported at the same level. Messaging was needed to emphasize exactly what this amendment would do. There would no longer be the opportunity to increase the property tax to offset the demands from state and federal governments. The state was still on the same budget from two years before and this would only heighten the lack of urgency around fixing that problem. In her opinion, the gutting of the Voting Rights Act of 1965 was already going to have an impact on voter turnout. These voters needed to be made aware of the actual implications as the working class would not be the ones who would see tax breaks should the amendment pass.

Mr. Canada did affirm that if the legislation constrains the local governments' ability to alter the property tax, counties will not be able to fund education and public health in the way that people want. There had been a consistent and consolidated push from all local governments. However, legislators did not listen. These will be the same state legislators that will need to work on the specifics of the law should it come to pass.

Commissioner Cheryl Stallings agreed that it was about messaging and encouraging voting with the proper understanding of what the question on the ballot really meant. At face value, anyone reading about the prospect of property taxes being lowered would understandably want that. However, it was about informing the public on what taxes pay for and invest in within the community. She reiterated a point made by County Manager David Ellis – the County is standing in a $600 million funding gap created by the state. Most of this - $500 million – is for operating expenses for public education. While County commissioners are responsible for school buildings (building of schools and renovations), the state legislature is responsible for operating expenses (salaries, transportation costs, instruction materials, and routine maintenance). This had, persistently, been underfunded on the state's side. This $600 million – which was itemized by staff – would, if taken back over by the state, equate to reducing the property tax in Wake County by nineteen cents. On average, this would save each taxpayer $900 on their annual tax bill. This would just be the state taking over costs that they had shoved down to the counties without the need of a constitutional amendment at all.

Mr. Irv Trust asked how quickly the General Assembly would be working to address the "Blue Ridge" loophole. Would their efforts assist by the first of 2027? Mr. Canada explained that there seemed to be good momentum to address the loophole. However, the apartment complex owners have retained lawyers who were opposing this. The House has kept the loophole as a standalone bill which passed unanimously. He was unaware if it passed the Senate, though this was entirely possible given the support shown for the bill. He could not give a definitive answer to which fiscal year this might formally address, but he did share that Mr. Marcus Kinrade (Tax Administrator) had read over the highly technical bill. Mr. Kinrade felt confident that it would bring the benefit desperately needed to close the loophole. Commissioner Stallings reassured that the Wake County Board of Commissioners (BOC) were planning for the next budget with the worst scenario in mind so as not to overextend the need on the county.

Ms. Lily Chen asked if there were talking points – specifically towards County budget advocacy – that could be shared as the sheer amount of information and technical aspects could get overwhelming and confusing. However, the County could not make materials to tell citizens how to vote. A one pager on property tax issues was available and could be distributed to be used however the recipient saw fit.

Chair Ann Rollins asked about the state budget, and it was rumored that an update would be provided within three to four weeks. Commissioner Stallings added that the County budget was scheduled for a vote by the BOC on June 1st, 2026. The BOC was required to vote by June 30th. This was a longstanding expectation for both county and municipal governments. Commissioner Stallings shared that she was in a meeting with representative from President Donald Trump's administration on Medicaid the day prior. The representative shared that guidelines for implementation for HR1 would be released on June 1st. The many converging items and pressures created a tight timeline but one that was necessary.

Ms. Hunter inquired about the Medicaid rebase, but Mr. Canada was not able to provide additional details about this at that time.

Public Health Report: 2025 Chronic Disease Report
(Presented by Ms. Akanksha Acharya, Ms. Michelle Mulvihill, and Ms. Shamika Howell)
Ms. Akanksha Acharya (Senior Epidemiologist) did brief introductions along with Ms. Shamika Howell (Health Promotion and Disease Prevention Supervisor) and Ms. Michelle Mulvihill (Health Promotion and Disease Prevention Supervisor). Ms. Acharya began the presentation by sharing that Epidemiology and Health Promotion and Chronic Disease recognized these numbers represented real people, families, and communities. This report was not just about data but about understanding where people needed support, resources, and prevention to better the chances at living healthy lives. The presentation would begin with a foundation of data sources and population profiles before delving into the "why" – disparities that lingered among chronic diseases and social determinants such as the Social Determinants of Health (SDoH). Data included leading causes as well as mortality trends. Finally, the report closed on the action from these data points – the programs that supported those dealing with the chronic diseases, the community that came together around the conditions, and even impact stories to highlight the benefits of County programs along with the triumphs of client's persistence and determination.

According to the Centers for Disease Control and Prevention (CDC), chronic diseases are health conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases are the leading causes of death and disability in the United States. Three in four adults (75%) have at least one chronic condition. The burden of chronic disease increases with age. Preventing chronic diseases or managing symptoms when prevention is not possible can reduce costs and improve quality of life. This report highlights chronic disease burden in Wake County with a focus on the following:

- Mortality: Understanding the leading causes of death
- Health Disparities: Identifying differences in health outcomes across populations
- Social Determinants of Health: Exploring the conditions that shape a person's health
- Local Prevention Efforts: Wake County Public Health initiatives that make a difference

The report uses the following data sources:

- United States Census Bureau
    - 2024 American Community Survey (ACS) estimates
    - Wake County and North Carolina
- Wake County Public Health (WCPH) Health Promotion Programs
    - January through December 2025 data
- North Carolina State Center for Health Statistics
    - Leading causes of death data
- Survey Data Sources
    - 2025 National Youth Tobacco Survey (NYTS)
    - Monitoring the Future (2025)

National, state, and local data provide a comprehensive view of chronic disease in Wake County.

Wake County's rapid growth and diversity shape both opportunity and health outcomes. Ms. Acharya provided an overview of the population of Wake County for better understanding of the community.

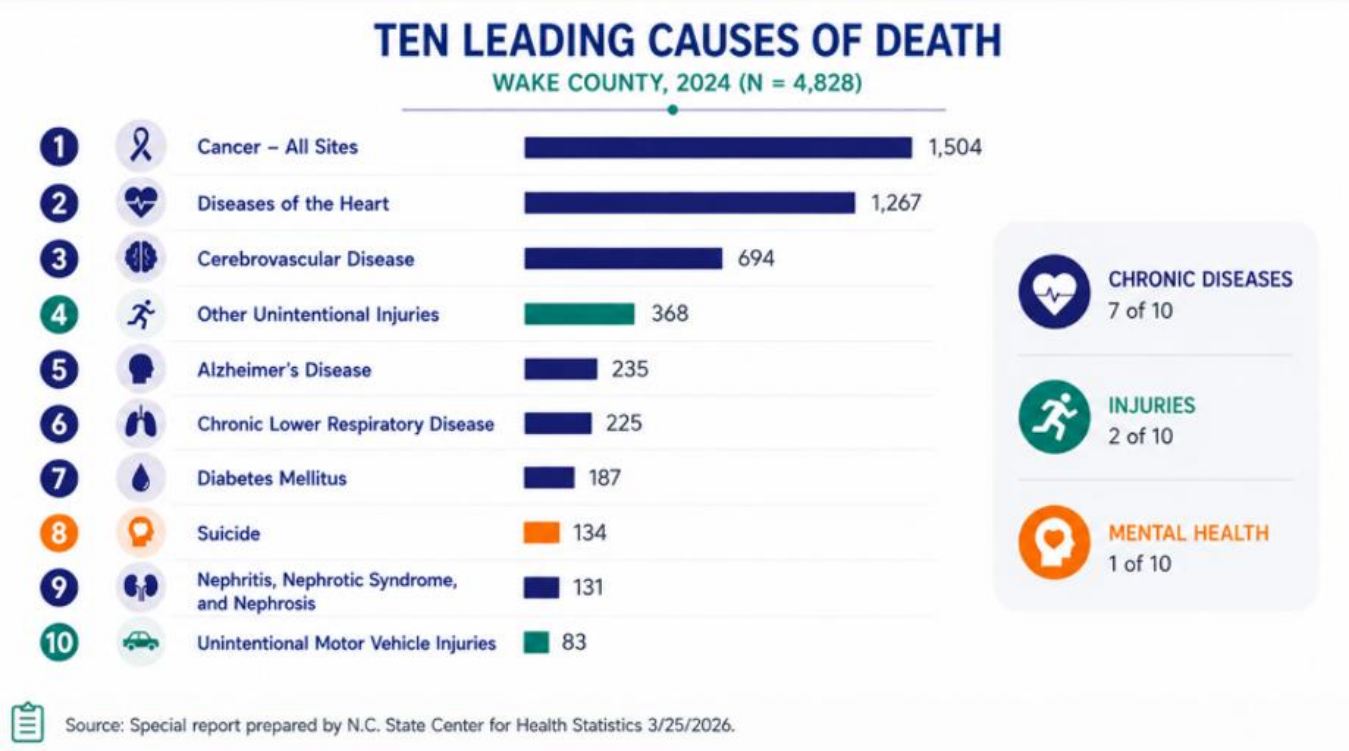
- There were now over one million residents in Wake County with over 103,000 joining since 2020. In a different perspective, this was over 66 people a day – twice the growth as North Carolina as a state.
- The median age for Wake County is 37.7. The population is 55% White, 18% Black, 12% Hispanic, and 10% Asian.
- The median income is $107,000 as compared to the state median income of $74,000.
- While there is a 3.7% unemployment rate in Wake County, 67.8% have employer-based insurance.
- There is a higher disability prevalence among American Indian/Alaska Native populations.

Figure 3: The Five Key Domains of Social Determinants of Health (SDOH)

Social Determinants of Health (SDoH) were conditions where people are born, live, work, and age. Barriers like poverty, food insecurity, and unsafe housing as well as others increased chronic disease risks. This was especially true in the most impacted communities. It was important to note that disparities did not always impact everyone the same, but they could very much influence a person's health. In Wake County, there was a higher burden among those impacted by poverty – 8.6% of the whole population but even higher rates among Hispanic (17.5%) and African American (13.3%) communities. The 3.7% unemployed and 6.0% uninsured also had a higher burden. An imbalance with these barriers led to a higher chronic disease risk. Factors influencing health outcomes (also known as protective factors) included healthcare access, support systems, and opportunities for prevention and treatment. When burdens were greater than access to these protective factors, issues arose.

The solutions? Supporting healthy living conditions and opportunities, using local data to inform community action, and establishing policies that support community health.

However, these solutions were far easier said than done. Despite ongoing efforts, chronic diseases drive most deaths occurring in Wake County as outlined in the data below.



Cancer remains the number one cause of death in Wake County, but, thankfully, rates are declining as shown in the following two figures (#5 and 6).

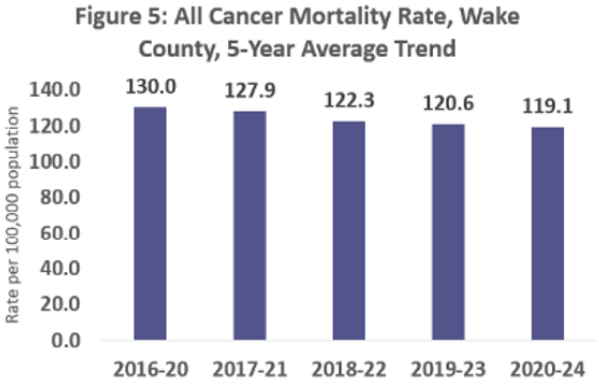
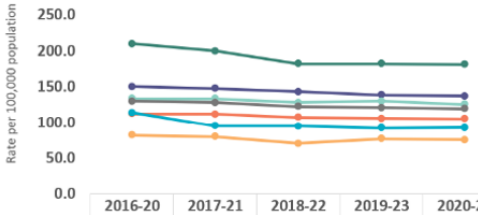


Figure 6: All Cancer Mortality Rates by Race, Ethnicity and Sex, Wake County, 5-Year Average Trend

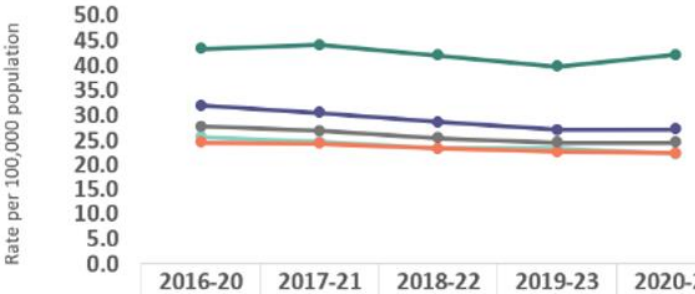


	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	209.9	199.6	182.0	182.1	181.1
White Men	150.1	147.6	142.9	138.5	137.0
African American Women	133.5	133.7	128.0	129.8	125.2
White Women	112.0	111.7	107.4	105.7	105.3
Hispanic Men	113.9	95.0	94.4	91.8	92.6
Hispanic Women	82.1	79.7	70.4	76.7	75.2
All	130.0	127.9	122.3	120.6	119.1

The top drivers of cancer mortality were lung cancer, prostate cancer, breast cancer, and colon cancer.

Lung cancer declines overall, but some groups see increases. Lunch cancer was the leading cause of cancer death in wake County from 2020 to 2024. While the overall mortality decreased by 12% from 2016 to 2020 and 2020 to 2024, there were higher rates among men (African American and White) compared to women. The most recent concern was a 6% increase in African American men after prior declines.

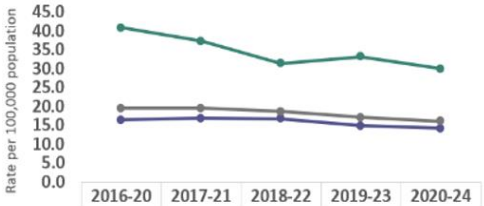
Figure 7: Trachea, Bronchus and Lung Cancer Mortality Rates by Race and Sex, Wake County, 5-Year Average Trend



	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	43.3	44.1	42.0	39.8	42.1
White Men	32.0	30.5	28.6	27.1	27.2
African American Women	25.6	24.7	23.3	23.3	22.2
White Women	24.5	24.3	23.3	22.7	22.4
All	27.8	26.9	25.4	24.6	24.5

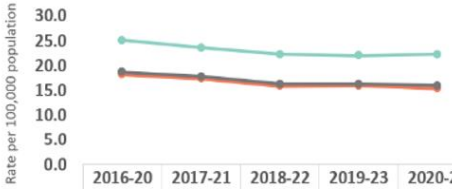
Rates for both prostate and breast cancer had declined over time, but disparities still very much existed. The rate for both cancers was much higher for African Americans as compared to White men and women.

Figure 10: Prostate Cancer Mortality Rates by Race, Wake County, 5-Year Average Trend



	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	40.9	37.3	31.4	33.2	30.0
White Men	16.4	16.9	16.7	14.9	14.2
All	19.5	19.5	18.6	17.1	16.1

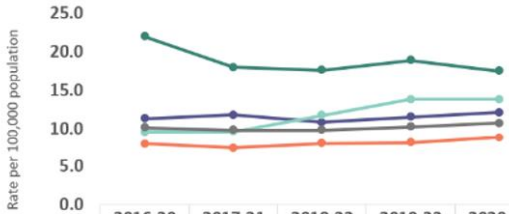
Figure 11: Breast Cancer Mortality Rates by Race, Wake County, 5-Year Average Trend



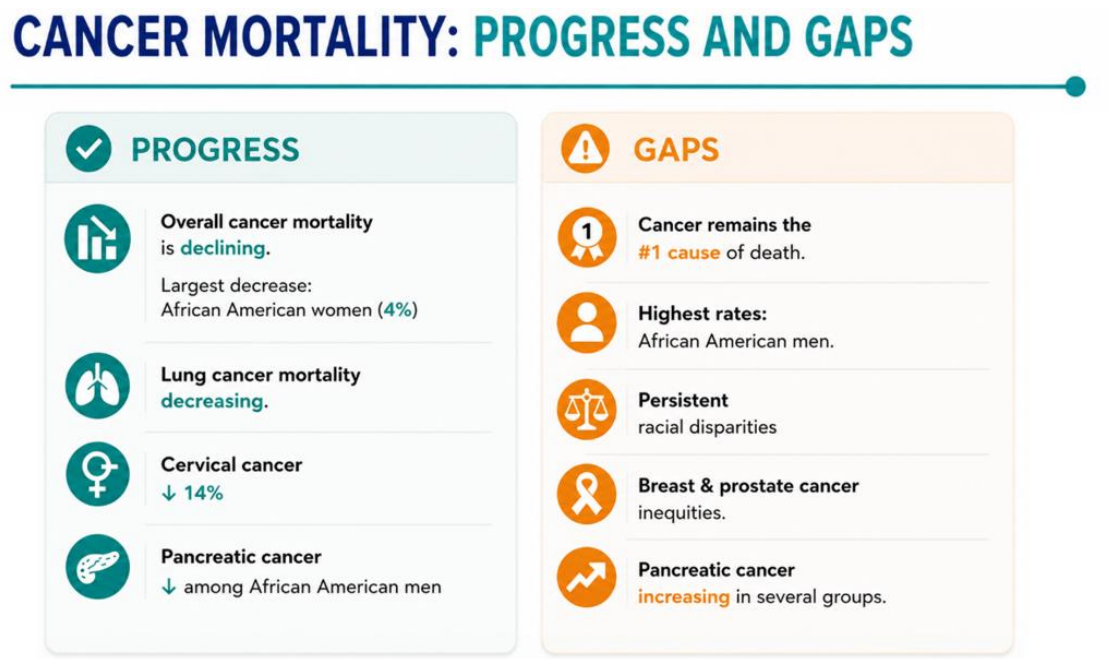
	2016-20	2017-21	2018-22	2019-23	2020-24
African American Women	25.1	23.6	22.3	22.0	22.3
White Women	18.2	17.4	15.9	16.0	15.4
All	18.7	17.8	16.3	16.3	16.0

Meanwhile, colon cancer was the fourth leading cause of cancer death in Wake County from 2020 to 2024. There was a persistent gap between African American and White populations. The most recent concern was a 5% increase in White men and 9% increase in White women. African American men had a 7% decrease while the rate for African American women had remained stable.

Figure 12: Colon/Rectum/Anal Cancer Mortality Rates by Race and Sex, Wake County, 5-Year Average Trend

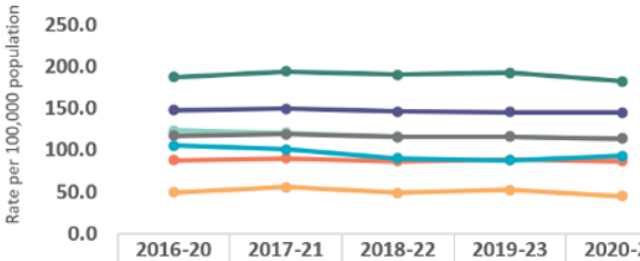


	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	22.0	18.0	17.6	18.9	17.5
White Men	11.3	11.8	10.8	11.5	12.1
African American Women	9.5	9.6	11.7	13.8	13.8
White Women	7.9	7.4	8.0	8.1	8.8
All	10.1	9.8	9.8	10.2	10.7



Next, Ms. Acharya reviewed heart disease. This was the second leading cause of death in Wake County in 2024. Men had higher rates of heart disease than women across all groups, but the rate was higher among African American populations. The overall heart attack mortality had decreased by 6% from 2016 to 2020 and 2020 to 2024.

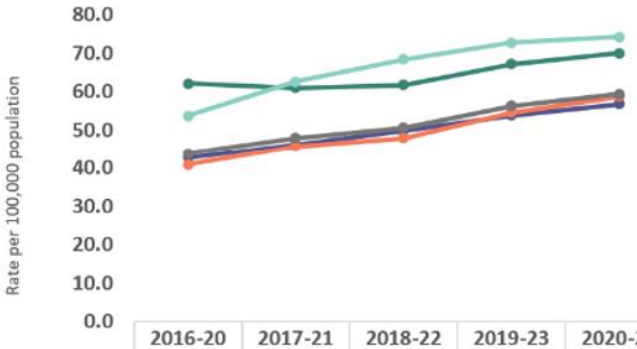
Figure 16: Heart Disease Mortality Rates by Race, Ethnicity and Sex, Wake County, 5-Year Average Trend



	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	187.5	194.1	190.5	192.5	182.2
White Men	147.6	149.4	146.3	145.3	144.9
African American Women	123.6	120.7	116.3	116.1	113.7
White Women	87.8	90.2	86.5	88.3	86.5
Hispanic Men	105.5	101	90.1	87.8	92.8
Hispanic Women	49.1	55.2	48.7	52.2	44.5
All	117.3	118.8	115.4	116.1	113.9

Strokes were the third leading cause of death in Wake County in 2024. Mortality rates increased across all racial groups with a 36% increase overall between 2016 to 2020 and 2020 to 2024. A persistent gap between African American and White populations remains with the highest rates among African American women. Rates continue to rise among all groups with the largest increase being 8% for White women.

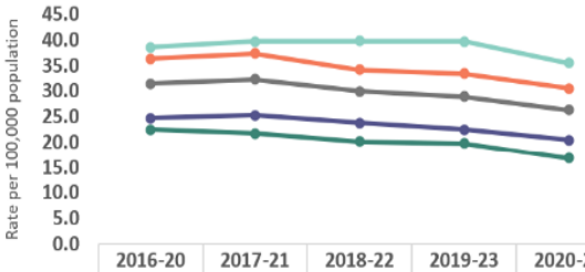
Figure 18: Cerebrovascular Disease Mortality Rates by Race and Sex, Wake County, 5-Year Average Trend



	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	62.1	61.0	61.7	67.1	69.9
White Men	42.7	46.2	49.8	53.8	56.8
African American Women	53.7	62.6	68.4	72.7	74.2
White Women	40.8	45.7	47.9	54.5	58.7
All	43.8	47.9	50.6	56.2	59.4

Alzheimer's disease was the fifth leading cause of death in Wake County in 2024. Women had higher rates than men with the highest rate among African American women. The overall mortality rate declined by 16% from 2016 and 2020 to 2020 and 2024. The higher mortality among women reflects a national pattern and disparity.

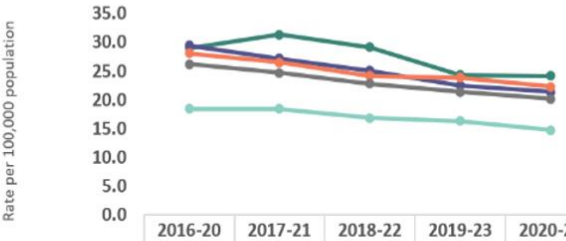
Figure 19: Alzheimer's Disease Mortality Rates by Race and Sex, Wake County, 5-Year Average Trend



	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	22.4	21.7	20.1	19.7	16.7
White Men	24.7	25.2	23.7	22.4	20.4
African American Women	38.5	39.6	39.7	39.6	35.4
White Women	36.3	37.3	34.1	33.4	30.5
All	31.4	32.2	29.9	28.9	26.3

Chronic lower respiratory disease was the sixth leading cause of death in Wake County in 2024. The highest death rates are among African American men. The overall mortality declined 23% from 2016 and 2020 to 2020 and 2024. The largest decline among African American women by 10% from 2019 to 2023 and 2020 to 2024.

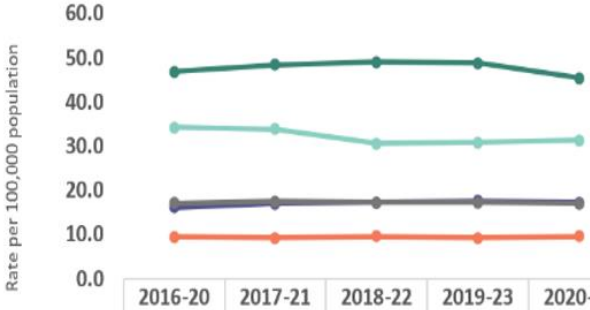
Figure 20: Chronic Lower Respiratory Disease Mortality Rates by Race and Sex, Wake County, 5-Year Average Trend



	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	29	31.3	29.1	24.3	24.2
White Men	29.4	27.2	25.1	22.5	21.4
African American Women	18.5	18.5	16.9	16.4	14.8
White Women	28.1	26.5	24.2	23.9	22.3
All	26.2	24.7	22.8	21.4	20.2

Diabetes was the seventh leading cause of death in Wake County in 2024. There is a persistent gap between the death rates between African American and White populations. The overall mortality rate slightly declined. The largest decrease was among African American men at 7%. Rates increased among women – both African American and White.

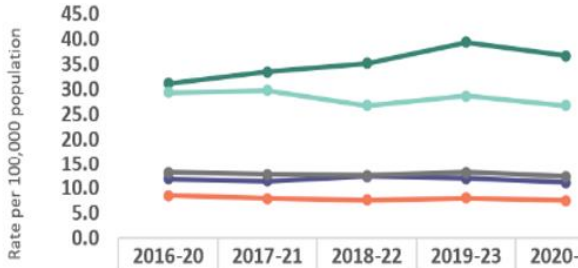
Figure 21: Diabetes Mortality Rates by Race and Sex, Wake County, 5-Year Average Trend



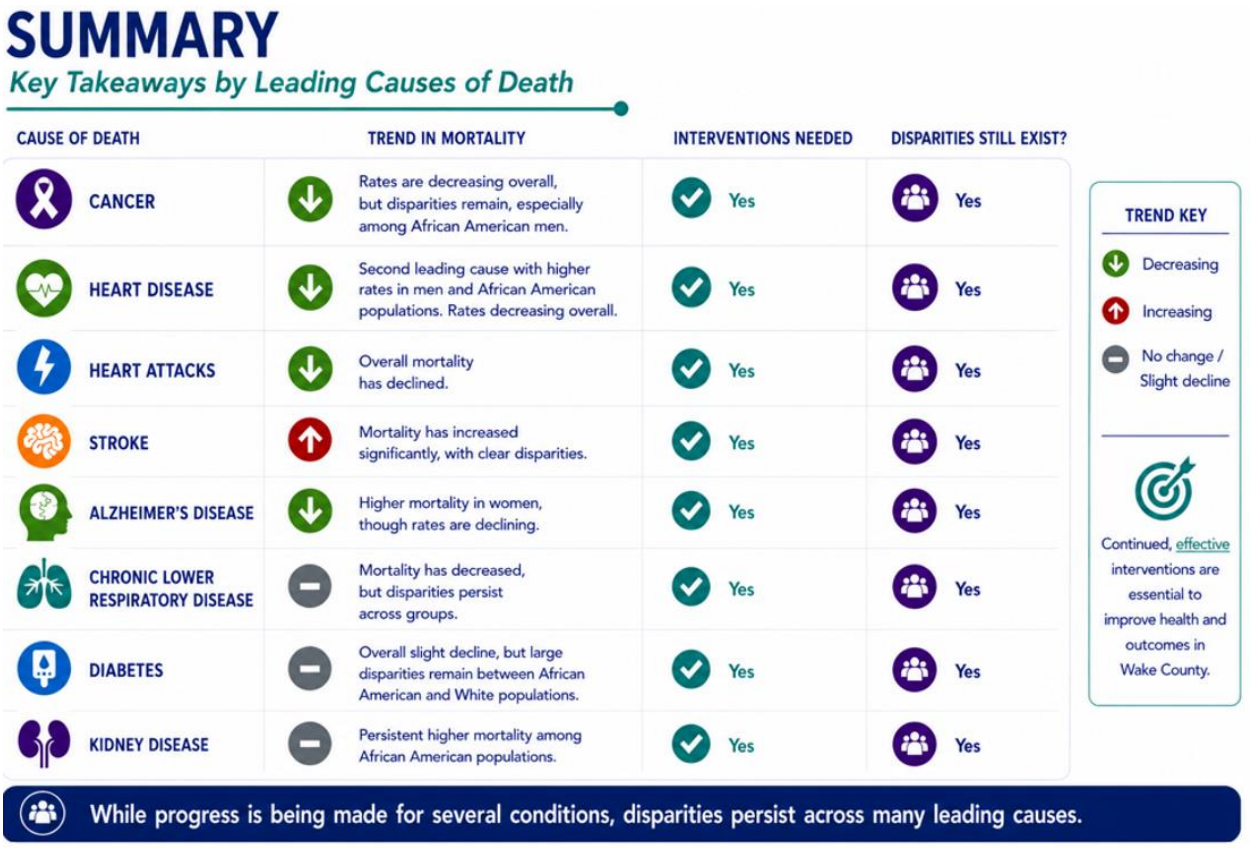
	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	46.8	48.4	49.0	48.7	45.3
White Men	16.1	16.9	17.1	17.5	17.2
African American Women	34.3	33.9	30.6	30.9	31.4
White Women	9.4	9.2	9.5	9.2	9.5
All	17.0	17.4	17.2	17.1	16.9

Kidney disease was the ninth leading cause of death in Wake County in 2024. There was a persistent gap between African American and White populations. The highest death rates were among African American men. Mortality rates declined across groups with an overall decrease of 6% from 2019 and 2023 to 2020 and 2024. Declines were observed with both African American and White populations.

Figure 22: Kidney Disease Mortality Rates by Race and Sex, Wake County, 5-Year Average Trend



	2016-20	2017-21	2018-22	2019-23	2020-24
African American Men	31.1	33.4	35.1	39.3	36.6
White Men	11.8	11.4	12.3	11.9	11.1
African American Women	29.3	29.7	26.7	28.6	26.7
White Women	8.5	7.9	7.6	8.0	7.5
All	13.1	12.7	12.5	13.1	12.3



Disparities persisted among many of the conditions reviewed, but the decreasing trend among some of the death rates indicated progress. However, work was still needed to ensure all groups benefitted from these declining rates equally. To do this, there must be a focus on populations most affected while identifying emerging trends. Expanded screenings, strengthened disease management, and culturally responsive and available care were all actions that could be taken to reduce chronic disease disparities. System change occurred when social determinants were addressed, barriers to care were reduced, and partnerships and data-driven action addressed the concerns.

Ms. Acharya closed her part of the presentation by reviewing the Wake County Public Health programs that drive chronic disease prevention efforts, listed below.

- Breast and Cervical Cancer Control Program (BCCCP)
- WISEWOMAN
- Safe Routes to School (SRTS)
- Tobacco Prevention and Control (TPC)
- Medical Nutrition Therapy (MNT)
- Movin' and Groovin'
- Couch to 5K
- Public Health Education Campaigns
- Minority Diabetes Prevention Program (MDPP)
- Farmer's Market
- Summer Food Service Program
- Drug Overdose Prevention Initiative

To help bring these metrics and results to life, Ms. Howell began by highlighting success stories and testimonials to show differences in lives of those served.

- BCCCP
    - BCCCP provides free breast and cervical cancer screenings and follow up services to eligible women in Wake County.
    - Each year, the BCCCP partners with WakeMed during Breast Cancer Awareness Month to ensure uninsured, low-income women receive timely follow-up imaging after abnormal results from the WakeMed Free Mammography Screening event.
    - The following timeline highlights the journey of one woman supported by the Wake County Public Health BCCCP Nurse Navigator. Her experience demonstrates the impact of timely care, strong coordination, and effective partnership across the healthcare continuum.
        - Timeline of Care
            - 11/4/2025 – The WakeMed Breast Imaging Navigator provided the patient's abnormal screening report to the Wake County Public Health BCCCP Navigator, who contacted the patient to determine eligibility and obtain program consent.
            - 12/9/2025 – The Wake Radiology Navigator requested BCCCP approval for diagnostic imaging and a breast biopsy.
            - The BCCCP Navigator approved coverage the same day and obtained the necessary referrals from the patient's primary care provider (PCP).
            - 12/11/2025 – The patient received a BCCCP-covered left breast biopsy.
            - 12/12/2025 – Biopsy results confirmed a left breast invasive ductal carcinoma, stage 1b. The BCCCP Navigator secured a referral from the patient's PCP for a new patient breast cancer consultation at the North Carolina Surgery Center at UNC Rex, also covered by BCCCP.
            - 12/13/2025 – The BCCCP Navigator facilitated the patient's transition to oncology care and requested that a UNC Rex Oncology Nurse Navigator be assigned. The Oncology Navigator assisted the patient with applying for UNC Financial Assistance for treatment coverage, as she did not qualify for NC Breast and Cervical Cancer Medicaid.
            - 12/17/2025 – The patient began her cancer treatment journey with an evaluation at the Breast Surgery office and the development of her treatment plan.
            - 1/7/2025 – The UNC Financial Navigator notified the patient of her approval for UNC Financial Assistance.
    - Throughout her journey, the patient expressed deep gratitude for the support provided by the Wake County Public Health BCCCP Navigator, noting that timely diagnostic services enabled her early stage diagnosis and connection to treatment. She also valued the breast cancer education she received from both BCCCP and UNC Rex Oncology Navigators.

    - This case demonstrates how skilled navigators and their efforts can lead clients to early detection of breast cancers and positively influence survival outcomes.
- MDPP
    - MDPP is a free year-long program that aims to prevent and reduce type II diabetes in communities of color. The program includes screenings, lifestyle classes, and community conversations. MDPP helps people prevent type II diabetes by making changes to their health behaviors and offers education sessions led by trained lifestyle coaches.
    - Participant A (Class of 2025)
        - Before enrolling in the MDPP, the participant was increasingly aware that their blood sugar levels were trending in the wrong direction. They understood the medical implications of pre-diabetes, yet knowledge alone had not translated into consistent behavioral change.
        - The program introduced disciplined routines that made prevention practical. Regular weigh-ins, food logs, activity goals, and open group dialogue reinforced daily decision-making. Tracking intake and movement shifted the participant's approach from occasional effort to steady, measurable progress.
        - What stood our most to the participant was the renewed confidence they gained. The course reframed pre-diabetes as a condition responsive to informed lifestyle choices rather than an unavoidable outcome. The participant noted that this clarity strengthened their commitment to long-term health stewardship.
    - Participant B (Class of 2025)
        - When this participant entered the MDPP, they carried a strong personal motivation: both of their parents lived with diabetes and they did not want to continue that pattern. Their annual physical showed rising numbers which created urgency.
        - The program's structure, the participant shared, helped them turn determination into sustained habits. Consistent sessions, goal setting, nutritional awareness, and increased physical movement required accountability beyond that the participant had maintained on their own. They became more attentive to portion sizes, more intentional about exercise, and more disciplined in tracking their progress.
        - Completing the program strengthened the participant's resolve to protect their health. They now felt prepared with practical strategies to reduce risk and maintain stability. The experience, according to the participant, had been empowering and deeply worthwhile

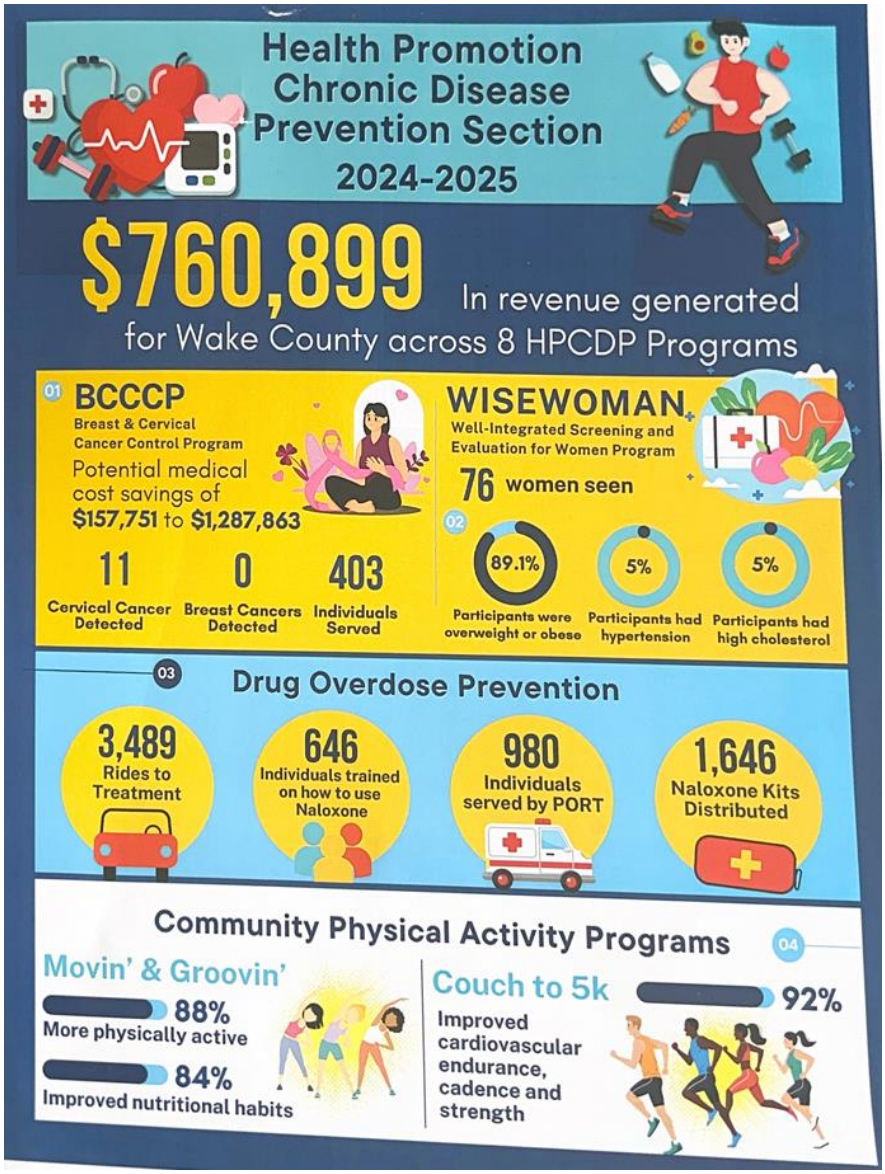
Ms. Mulvihill then shared the remaining success stories.

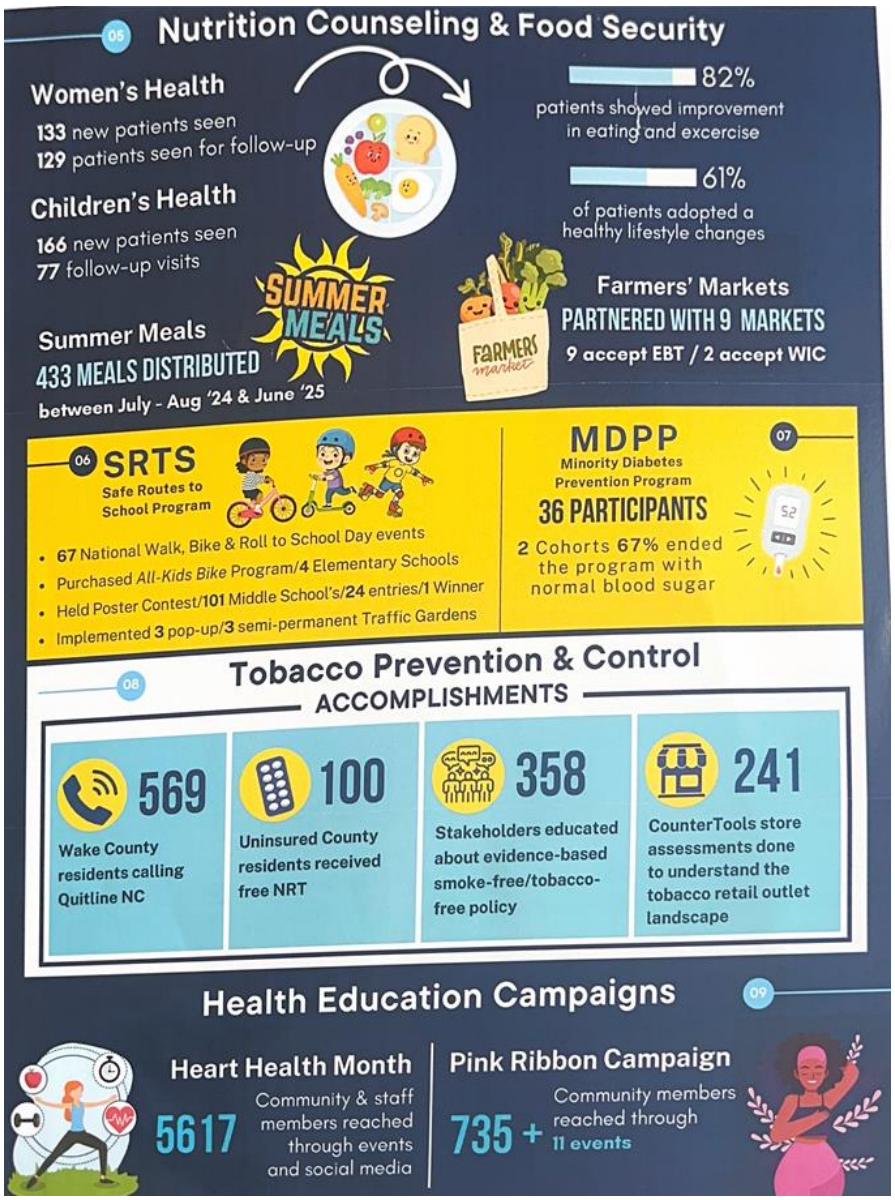
- MNT
    - Health Promotion's Registered Dietitians provide individualized nutrition assessments and MNT to patients referred through Public Health's Women and Child Health clinics.
    - Patient B was a 34-year- old Hispanic female with obesity and type II diabetes mellitus. Her initial weight was 224 pounds with a body mass index (BMI) 43.91. Five months later, she was 209 pounds with a BMI of 40.97. This was a decrease of 15 pounds or 6.6% in her weight.
    - "I feel better since I started with a nutritionist. I have more energy and learned to exercise and eat healthier and the results I have been having with my weight I like to thank you, Beth." (MNT patient quote, thanking Beth, one of the nutritionists)
- Community Exercise Programs
    - Participant B
        - This participant was part of the Movin' and Groovin' – a partnership with the City of Raleigh Parks and Recreation Department at Spring Forest Road Park.
        - "To the Wake County Health Education program, I am so grateful to have the opportunity to express myself about the classes and events that are put together

by Elizabeth Spender-Smith [Health Promotion and Chronic Disease Prevention – Public Health Educator] and the whole Health Education program, I have to say that I was reluctant to attending the exercises classes at first but my wife asked me to go with her and even though I was not sure how I was going to fit in, I went and I have never looked back, I really enjoy the classes, I never thought I was going to enjoy exercising with a group of people at the park, the ladies are great motivators, sometimes you arrive at the park with little energy but before you know it, you are moving all over the place, I hope the programs keep going because it really gives you a reason to go out and exercise, I now look forward to all the events offer by Wake County, thank you all for such a great service to the community, it really has make a difference in my health and my wife's. Thank you."

- Couch to 5K Participant
  - Couch to 5K is also a partnership with the City of Raleigh at a facility at Buffalo Road Park.
  - "A few years ago I knew I needed some fitness in my life. I googled what exercise could I do that took no special equipment, could be done any time of day and anywhere, at no cost, and Google said running. I tried to run around my block and couldn't make it to end of my street. And then I saw the Couch to 5K program in the City of Raleigh's Parks and Recreation Leisure Ledger. I signed up. And sure enough, I was about to go from my Couch to a 5K. Any they gave me a medal on race day for doing it. The only time I have ever received a medal in my life. Now I have 6 medals, and I've been able to convince work colleagues and family members to join me on some runs. I keep signing up for the Couch to 5K sessions for a few reasons, to keep me running, to keep me stretching (which I am not good at on my own), and not that I turned 50, to see if I can outrun someone a decade or two younger."
  - Ms. Mulvihill shared that this participant, indeed, did outrun individuals younger just as they had hoped.

Handouts were also provided, included below, with Health Promotion highlights.


Health Promotion
Chronic Disease
Prevention Section
2024-2025
$760,899
In revenue generated
for Wake County across 8 HPCDP Programs
01
BCCCP
Breast & Cervical
Cancer Control Program
Potential medical
cost savings of
$157,751 to $1,287,863
11
Cervical Cancer Detected
0
Breast Cancers Detected
403
Individuals Served
WISEWOMAN
Well-Integrated Screening and
Evaluation for Women Program
76 women seen
02
89.1%
Participants were overweight or obese
5%
Participants had hypertension
5%
Participants had high cholesterol
03
Drug Overdose Prevention
3,489
Rides to Treatment
646
Individuals trained on how to use Naloxone
980
Individuals served by PORT
1,646
Naloxone Kits Distributed
Community Physical Activity Programs
04
Movin' & Groovin'
88%
More physically active
84%
Improved nutritional habits
Couch to 5k
92%
Improved cardiovascular endurance, cadence and strength



Contact information was provided in closing:

- Akanksha Acharya – Akanksha.Acharya@wake.gov
- Shamika Howell – Shamika.Howell@wake.gov
- Michelle Mulvihill – Catherine.Mulvihill@wake.gov

Mr. Irv Trust asked how staff tracked success rates of their program graduates. Ms. Howell stated that there was an alumni cohort actually established by participants. MDPP was a yearlong program but it was only intensive for sixteen weeks. The group met biweekly and then monthly. Even those anxious to come at first soon found themselves becoming close in the cohort. These participants run together outside of the program. Even when from different walks of life, they seek to stay connected. The cohorts allow for long term care and evaluation of actions plans for sustainable goals moving forward. The alumni cohort was still in the pilot phase with the group meeting once a month. This now creates a support system for those new to MDPP. Vice Chair Wanda Hunter commended the pilot alumni cohort noting that the participants' want to continue to connect spoke volumes of their advocacy for their needs and continued benefits of the program.

Ms. Lily Chen pointed out the lack of presence of Asian American and Pacific Islander (AAPI) in the data and asked if this was due to the size of the population being too small to show statistically (as she as seen in her own work). Ms. Acharya explained that the demographic information presented at the beginning of the presentation was for context of the composition of the county. The data presented insofar as the chronic disease report itself reflected its own set of data and reports. Ms. Chen then inquired about the mention of "culturally responsive care" and what this might look like. This was defined as providers from a client's culture. The provider might speak the client's language so that they are better able to verbalize risk factors or share in cuisine to better understand health risks and how to steer towards healthy food that appeals to the client. Ms. Chen thanked Ms. Acharya for her response noting how she had seen the Asian community respond well to Community Health Workers (CHWs) as compared to therapists for mental health issues due to stigma.

Dr. Ojinga Harrison asked about the $760,899 earned in revenue from the Health Promotion and Chronic Disease Prevention programs. Ms. Mulvihill said that these were largely from grants that the programs received. There are agreement addendums with the North Carolina Division of Public Health (DPH) as well as Recovery Court. This is counted as income that can then be put back into the programs.

When asked about mental health not being in the chronic disease report, Ms. Acharya confirmed that mental health was addressed in a separate report done in collaboration with Behavioral Health. These reports would likely be shared in the future. Ms. Howell added that there were conversations specifically in MDPP and BCCCP where staff check in about patients' mental health both in preparation for the programs as well as in part of the evidence-based curriculum endorsed by the CDC. Resources are provided during classes in a way that does not isolate any one client but encourages questions for those who may need extra support. Sometimes this comes as a client sharing why they may be struggling in a program or with losing weight going differently than anticipated. These concerns are specifically reported for MDPP to ensure funding continues (along with other data points for showing program participation). Although it was not highlighted in the presentation, mental health resources were very much available to participants.

Dr. Harrison stressed that many people could appreciate that the presence of a mental health condition could impact a person's mortality and morbidity. He asked how the change in demographics in Wake County impacted the numbers recorded in the data, particularly with the changes of health in the county aligning with trended data. Ms. Acharya explained that there was no definitive way to determine if growing populations have worsened a particular trendline. This data showed five years of risk data and averaged those to address the conditions. This was a balance between individuals coming with preexisting health conditions and even disparities which could shift while a person was living in the county.

Dr. Harrison touched on the changing needs of communities as well – the ability to afford housing, worsening health outcomes, and accessibility barriers – and how these needs could influence efforts. Chair Ann Rollins concurred, stating that after five years of data, it might be prudent to review which conditions were increasing. These might need staff to be employed in a different way to modify supports. Ms. Howell shared that it did, at least, help staff navigate recruitment. Areas that had been underserved in the past were now actively being targeted. Southeast Raleigh was an area that programs had received a number of calls from and staff were purposeful to visit and make resources available. Wake Forest was another such area. Programs do allow staff to provide motivational incentives such as gas cards to help clients participate if they meet eligibility requirements. Staff have also worked to address childcare needs for those meeting requirements all to ensure that their services are made available to those who, according to data and self-reports, are in the most need. Ms. Acharya added that the data did include COVID-19 years and that Wake County was continuing to trend in the right direction overall.

Ms. Rollins commented that the Board was looking for recommendations to make to the Wake County Board of Commissioners (BOC), especially as dollars became tighter and municipalities and staff felt the

pressure to collaborate and place more emphasis on partnerships. Ms. Hunter emphasized the importance of having an environmental scan of the programs and initiatives in Wake County to identify what resources were available and which ones needed to be elevated. She commended such similar work done by Ms. Lechelle Wardell (Population Health Director) with partners for HealthLit4Wake. Organizations may be willing to take on a load of work so that it is not all laid directly upon Wake County. This could be helpful in communities that are more aware of where its residents will show up at for events (such as community centers or other locations that earn high traffic). This could increase the health and quality of health in Wake County not just in Raleigh but in all of the municipalities.

Ms. Howell did share that the BCCCP was open to all twelve municipalities. It was currently in Raleigh but had been in Wake Forest as well as Zebulon. Zip codes received on paperwork were but one way of gathering data to identify areas of high need. Ms. Rollins asked if the Regional Centers were being used to promote the programs. Ms. Howell confirmed that staff worked closely with the Regional Centers to impact communities in those areas. The Northern Regional Center (NRC) in Wake Forest was a particular success with its close affiliation and location to the senior community.

Ms. Rollins asked if there were proactive steps being taken for the growth in the senior population, especially given the unique health concerns this group brought to the county. Ms. Howell stated that there were unique considerations for seniors, especially given the modern burn out that many could experience in addition to health concerns. Staff work to bridge the gap to create opportunities for them to stay healthy while honoring needs and limitations.

Mr. Trust asked how comorbidities came into play with the chronic disease reports, for example how a person who had diabetes might also have or be more likely to have Alzheimer's disease. Ms. Acharya said that this data was not available, unfortunately. Data received was that for morbidity and emergency room (ER) visits. It was very difficult to identify risk factors given all of the history behind even a single case. As Mr. Trust pointed out, even opioid addiction could play a part in these outcomes underlining just how many aspects of life can play into chronic diseases.

Ms. Rollins uplifted the tobacco policies and best practices being picked up by the City of Raleigh with Cary anticipated to be the next in line for active change. Many youth were being outspoken and supportive as well. In addition, there would be a ribbon cutting on June 24th for the first permanent bike rodeo route to do programming across the year with different community partners. Ms. Rollins recognized Ms. Mulvihill who was directly supporting both of these initiatives. This also spoke to the deep commitment of the community with partners very eager to assist in addressing these concerns.

Chair Ann Rollins asked for a motion to approve the Chronic Disease report. There was a motion to approve the report by Mr. Irv Trust. Dr. Ojinga Harrison seconded. The report was unanimously approved.

Public Health Annual Fee Review (Public Health Accreditation Benchmark #33.5, 33.7, and 39.3)
(Presented by Ms. Tisha Adams)
Ms. Tisha Adams (Medical Billing and Coding Manager) presented the Public Health annual fee review. Public Health fees included medical and dental fees, new medical fees, and suggested fee changes. As the Medical Billing and Coding Manager, Ms. Adams did not evaluate the pharmacy fees nor the fees for vaccines as they were both based on the cost of the drug used. This year there were a few new fees and a few suggested fee changes.

The Wake County Public Health Center had a total of 151 unique medical procedural codes. In fiscal year (FY) 2027, staff were suggesting a change in price for a total of 13 codes. They were also adding a total of three new medical codes. The Dental clinic had no suggested price changes for FY 2027.

Counseling risk factor reduction and behavior change intervention codes were being added by the Wake County Public Health Center (see below).

New Codes	Description	MCR Allowable	50th Percentile	Proposed Fees
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure) approximately 30 minutes	$62.06	$118.90	$119.00
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure) approximately 45 minutes	$84.75	$136.30	$137.00
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure) approximately 60 minutes	$108.83	$152.49	$153.00

Ms. Adams explained that these codes were primarily used in infectious disease and STI clinics to council clients on changing behaviors so they were not visiting the clinics as frequently. The "level one" counseling code for fifteen minutes had typically been used in the past, but there were longer visits being recorded over time. Therefore, there was a need for additional codes for 30-, 45-, and 60-minute visits, respectively.

Next were suggested fee changes. The Wake County Public Health Center was bringing back the in-house ultrasound procedures previously available between 2018 and circa 2024. Since there was a break in time since the procedures, a review of fees was needed. Below were the previous fees and suggested price changes.

Ultrasound Codes	Code Description	Previous Fee	50th Percentile	Proposed Fee
76801	Ultrasound, less than 14 weeks, single or first gestion	$300.00	$377.40	$350.00
76802	Ultrasound, less than 14 weeks, each additional gestational	$210.00	$228.74	$229.00
76805	Ultrasound, greater than 14 weeks, single or first gestation	$350.00	$435.07	$400.00
76810	Ultrasound, greater than 14 weeks, each additional gestation	$350.00	$345.47	$350.00
76811	US, Fetal Anatomic Survey	$526.78	$682.14	$600.00
76812	US Fetal Anatomic Survey, each additional gestation	$290.15	$416.81	$316.00
76815	Ultrasound, limited, 1 or more fetuses	$260.00	$263.30	$264.00
76816	Ultrasound, follow-up	$300.00	$353.12	$350.00
76817	Ultrasound, transvaginal	$338.00	$299.49	$300.00
76830	US Transvaginal, Gynecologic	$290.15	$386.51	$340.00
76856	US Pelvic Complete	$284.52	$340.57	$335.00
76857	US Transvaginal, Limited (IUD Check) - 76857	$191.56	$211.45	$212.00
76882	US Extremity Limited	$102.35	$141.65	$142.00

Fees are based off a cost analysis performed each year established by consulting the Medicaid cost analysis, fee analyzer, and data from the North Carolina Department of Health and Human Services (NC DHHS) nursing consultants. Ms. Adams combines this data and calculates the median cost. Even with the 50th percentile, some of these had changed a lot since last established in 2018. Staff had to consider the amount that would be charged not only to insurance companies but also to self-pay patients.

Because such a span of time had passed since the prices were last evaluated, Ms. Adams made it a goal not to go above a $50 increase with the fees while still aiming for the 50th percentile.

Note: Ms. Adams clarified that code "76812 – US Fetal Anatomic Survey, each additional gestation" was actually suggested to be $340.00 instead of the $316.00 in the image presented above. This was to keep closer to the 50th percentile (provided in the image above as $416.81).

Mr. Irv Trust asked what percentage of fees were rejected by insurance companies. Ms. Adams said that there was a different contracted rate with each payor. Whatever rate was charged to Medicaid, they would do a reimbursement rate. The same was true of private insurances. Generally, the private insurance rates

are higher, so Ms. Adams tried to raise the prices slightly to even out the payments received. The key to the Medicaid cost study, however, was that it was a study that showed the cost to perform the service. It did not mean that this was the amount that could be received back, but it did show what the actual service cost to perform. This is why a cost study analysis was included in the considerations as it encouraged rates to stay realistic for self-pay clients while still holding insurance companies accountable.

When asked about the new three new fees, Ms. Adams stated that the fee policy required staff to charge the Medicare reimbursement rate for any code added prior to presenting to the Wake County Health and Human Services Board. This rate was usually pretty low. Some insurance companies could pay more than this, but this was the requirement of the policy prior to presentation to the Board.

Vice Chair Wanda Hunter asked what was causing the visits to be longer to the infectious disease and STI clinics. Ms. Adams had heard that this was due to the population being served. Conversations largely sought to be informative with others focusing on social determinants of health (SDoH). Changes in behavior were also a factor with identifying risk factors and then discussing ways to mitigate to improve health and quality of life. Commissioner Cheryl Stallings added that this could have the added benefit of building relationships between the client and clinics as well. Chair Ann Rollins suggested that this could also be used as a prevention effort to ensure the client does not return having been equipped with the knowledge of how to address their condition.

Ms. Hunter maintained that the infectious disease and STI clinics might not be locations to encourage relationship building. Ms. Adams shared that the infectious disease clinic did have primary care services where physicals could be provided as well as care for certain acute services. Many times this provider was the only one that the client was seeing. If this was the case, staff did want to ensure that they were informed of better practices and care. Ms. Rollins spoke to the possibility of needing to caution someone visiting the infectious disease clinic from their ability to infect others which could take more than 15 minutes to properly explain with all the other considerations that go into a visit.

Ms. Hunter asked if a person without a provider was encouraged to see a primary care provider (PCP) or told to come back to the clinics. Ms. Sara Gisler (Deputy Director of Public Health – Clinical Operations) stated that infectious disease and child health clinics both provided PCP services, so these clients would be welcome to return. Other clinics, such as the STI clinic, would encourage the client to find a PCP and would be able to provide resources to help with this search. When asked if clients were also encouraged to apply for Medicaid as appropriate given Medicaid Expansion, Ms. Gisler confirmed that this was also suggested as appropriate. Medicaid services were available in the Public Health building so a comprehensive set of services were available for sign up.

Commissioner Cheryl Stallings asked for an estimate of how many clients were self-pay. Ms. Adams said that when she last requested this number at the end of 2025 (prior to moving into the new Public Health building), self-pay was at 30%.

Chair Ann Rollins asked for a motion to approve the proposed new fees and fee changes. There was a motion to approve the amended fees by Mr. Irv Trust. Dr. Tonya Minggia seconded. The amended fees were then unanimously approved.

Public Health Update
(Presented by Ms. Sara Gisler)
In the absence of Ms. Rebecca Kaufman (Director of Public Health), Ms. Sara Gisler (Deputy Director of Public Health - Clinical Operations) provided brief updates from the Public Health department.

- Swimming pool season is well underway with 853 of the County's 1,200 public swimming pools being inspected as of last week. Leadership expressed appreciation to Environmental Health and Safety (EHS) and Onsite Water Protection for partnering to complete this work.
- Clinics are collaborating with General Services Administration (GSA) to add some child-friendly artwork to parts of the new Public Health building.
- Clinics are working to set patient satisfaction goals for fiscal year (FY) 2027.
- The Population Health team has received the second Wake Wheels 4 Health bus. Staff are getting it ready and it is on the calendar to attend community events. Both buses were procured during the COVID-19 pandemic and now are wrapped with the new logo and upfitted for day-to-day outreach.
- The Population Health team hosted an "Ask the Doc" townhall this month on maternal child health.
- The Population Health team has been active in the community this month with "Bike to School day" at Chavis Park, hosting a community baby shower, and hosting a "clear the air" menthol awareness event.
- The Workforce team is launching a new training contract and ensuring all staff can benefit.
- The Nursing team has begun their Back-to-School Vaccination clinics which will be held at the Regional Centers as well as additional appointments in the immunization clinic.
- Wake County Public Health is celebrating Nurses' Week this week with a variety of events hosted by Ms. Tina Payton (Nursing Director) and her team.
- The Pharmacy continues to grow their partnership programs with Healing Transitions and the County detention center, filling an unmet need in the community.
- Administration is working with Wake County Security to host a series of training courses on security at the new Public Health building and what staff can expect for clients' experience.

Social Services Update
(Presented by Ms. Sheila Donaldson)
In the absence of Ms. Toni Pedroza (Director of Social Services), Ms. Sheila Donaldson (Deputy Director of Social Services – Programs) provided brief updates from the Social Services department.

- Economic Services was working collaboratively with the state to look at the process flows for eligibility programs to make recommendations to improve efficiency. These meetings also help to identify what is working, what is not, and what staff suggest to improve process flows.
- The Wake County Board of Commissioners (BOC) made a proclamation just that past Monday designating May as Foster Care Month. While there was a daily need for foster care parents, this month allowed for appreciation for those active who put so much effort and love into taking care of their children.
- In June, staff would share more details around World Elder Abuse Awareness Day (WEAAD).

Vice Chair Wanda Hunter asked how many youth were living in the Social Services building. Ms. Donaldson confirmed that, at the time, thirteen were on census. When asked how many of these youth required therapeutic care, Ms. Donaldson said that they likely all needed this level of care. Ms. Hunter asked if the County certified foster parents to care for youth that require therapeutic care. In Wake County, staff are able to license regular foster homes. They did not license therapeutic foster homes. The County contracted with other providers in the community who licensed therapeutic foster families. Staff focused on recruiting "traditional" or "regular" foster families for several reasons. Getting the right match

to a child's needs with a family's strength seriously improved the outcomes for that child. When in scarcity and looking for a bed rather than a proper fit, a child could disrupt from a placement adding another layer of trauma and loss. This then showed up in behavior with youth then needing therapeutic foster care over time. With a robust general pool, all would benefit.

Ms. Hunter shared that this seemed a barrier to getting children into the building into placement as there were people in the community wanting to be foster parents to children with therapeutic needs. These were individuals willing to go through certification and actively wanting to do the work. However, there was no pathway or connection to a third party or navigation to help them. Ms. Donaldson expressed appreciation for this feedback and would take it back to their licensing team to help discuss a warm transition to contract providers. There was a definitive need but also the want to provide the accurate amount of support for these individuals. There was an increase over the last year with individuals with intellectual disabilities entering foster care.

Deputy County Manager Duane Holder shared that he had met with Child Welfare leadership, including Ms. Pedroza and Ms. Donaldson, alongside Healthy Blue leadership to discuss the transition and how things had gone since Healthy Blue took over as the Children and Families Specialty Plan (CFSP) on December 1st, 2025. Healthy Blue leadership had voiced a commitment to work with staff to develop out-of-the-box approaches to assist with placements.

Dr. Ojinga Harrison asked if the number of adolescents waiting in hospitals and emergency rooms (ERs) was published insofar as those who would be entering foster care. While it was not reported even to Wake County, this was something that was reported to the state. Ms. Donaldson said that the Managed Care Organization (MCO – Healthy Blue for North Carolina) has this information and it can be requested. Part of the issue is that there are sometimes two entities – Healthy Blue for those in foster care and Alliance for those in the general community – handling these cases. When a family first brought their child to the ER for mental health assistance, Alliance might step in for support. Once the family chose not to pick up their child, this support transitioned to Healthy Blue. There did need to be additional synergy between the two to support the family and prevent youth from entering custody. Mr. Holder added that Healthy Blue was now the statewide MCO and had a different lens than the County. This could include different hospital systems and process flows that leadership were still discussing.

Ms. Rollins inquired about senior services including a comprehensive coordination there, Mr. Holder confirmed that the Board would be receiving presentations during their June 2026 meeting from Resources for Seniors and Meals on Wheels. Leadership from Central Pines was also anticipated to be in attendance.

Committee Chairs Update

(Presented by Ms. Ann Rollins, Ms. Wanda Hunter, and Mr. Irv Trust)

Chair Ann Rollins encouraged Board members to read the Regional Networks report provided in the Board's agenda packet.

Vice Chair Wanda Hunter shared that the Social Services Committee had received a foster care update and discussed the North Carolina Fatherhood Conference scheduled for June 20th.

Mr. Irv Trust noted that the Public Health Committee had received updates from Ms. Rebecca Kaufman (Director of Public Health) as well as the Public Health Report: Chronic Disease that Ms. Akanksha Acharya (Senior Epidemiologist) had presented that day to the Board. Finally, the Committee had received a drought update from Mr. Mike Ranck (Environmental Health Program Manager – Groundwater). This presentation compared and contrasted historical data with present day trends while providing a primer in water table levels with respect to private and public wells in addition to drought conditions.

Public Comments

- None

Adjournment

The meeting was adjourned at 9:28 a.m.

Board Chair's Signature:  **Date:** 06/25/2026

Respectfully submitted by Brittany Hunt