Introduction:

From 2012 to 2013, more than 129,000 children in North Carolina were referred to local Department of Social Services agencies for suspected abuse or neglect. Of these, more than 36,000 children were recommended to receive additional services. In 2012, 28 children died as a result of abuse or neglect by a parent or caregiver. The negative impact of toxic stress on the developing brain has been demonstrated by over 30 years of neurodevelopmental research. In addition to the effects of abuse and neglect on children's well-being, child maltreatment has a significant financial impact on our medical and social services systems, with total lifetime costs for one year of child maltreatment estimated at approximately $124 billion nationwide, and $210,000 per victim. Even more than these impressive numbers, adverse childhood experiences impacted the childhood of 53% of North Carolina adults, according to a 2012 household telephone survey. The impact of adverse childhood experiences on adult health has been well documented by 20 years of epidemiologic research, demonstrating the lasting consequences of child maltreatment.

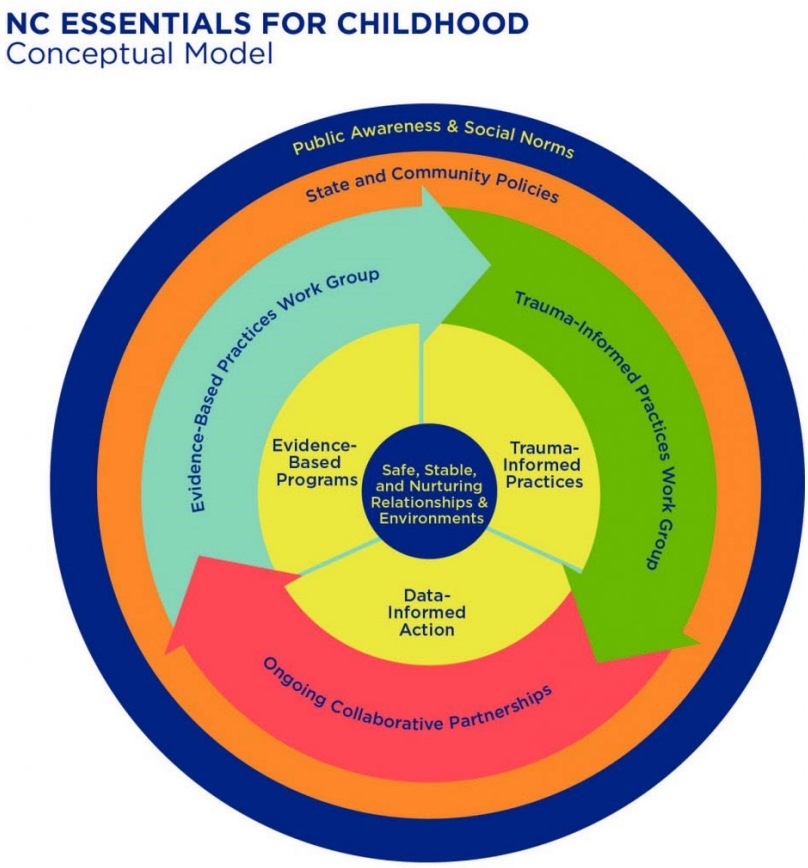
In early 2014, the NCIOM, in collaboration with Prevent Child Abuse North Carolina and the North Carolina Department of Health and Human Services Division of Public Health (NC DPH), convened a statewide Task Force on Essentials for Childhood, tasked with studying and developing a collaborative, evidence-based, systems-oriented, public health-grounded initiative to address the issue of child maltreatment prevention and family well-being in North Carolina. The Task Force laid the groundwork for a multi-year collective impact process to follow.

Since September 2016, with support from the North Carolina Department of Health and Human Services, Division of Public Health, the NCIOM has served as the Backbone Organization for the implementation of the Task Force recommendations. Using the principles of collective impact, the NCIOM supports the implementation of the recommendations of the Task Force on Essentials for Childhood under the direction of a statewide steering committee. NCIOM staff provides guidance and support to the steering committee, working groups, and additional partners, ensuring alignment with and support for the Essentials for Childhood initiative's goals.

This report focuses on activities conducted by NCIOM as backbone organization for North Carolina Essentials for Childhood throughout 2017, and next steps and strategies for 2018 and beyond.

Vision/Mission

One of NCIOM's initial tasks and goals when taking on the backbone organization work was to work with the Steering Committee to refine the vision and mission of North Carolina's Essentials for Childhood initiative. Over a series of 3 meetings in early 2017, NCIOM staff developed an action-oriented, collaborative vision and mission statement to drive the work:



Vision: Children, youth, and families thrive in safe, stable, nurturing, and healthy relationships and environments and are able to reach their full potential within their community.

Mission: Promote child and family well-being in North Carolina by implementing the collective statewide strategic plan for preventing child maltreatment and securing child and family well-being developed by the 2014 Essentials for Childhood Task Force.

Key Goals:

- Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment
- Use data to inform action
- Create the context for healthy children and families through norms change and evidence-based, trauma-informed programs
- Create the context for healthy children and families through policies

The steering committee also identified as an additional goal to support improved agency coordination and across-state alignment.

Throughout the collective impact work, NCIOM staff uses the vision, mission, and goals to structure and drive stakeholders' priorities and strategies.

This report is structured according to each of the goals above, and subdivided by the Task Force recommendations aligned with each goal. In each section, Task Force recommendations are listed and backbone organization activities related to each are described. In addition, backbone organization activities that fall under each goal, but do not pertain directly to a specific recommendation, are described.

Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child maltreatment

Recommendation 3.1: Establish coordinated state leadership efforts to address Essentials for Childhood through a collective impact framework.

Partially implemented

Backbone organization activities:

Steering Committee:

The Essentials for Childhood collective impact initiative is guided by a small steering committee, comprised of members who were instrumental in shaping the original Task Force process and recommendations and are committed to moving this work forward. Please see Appendix A for steering committee members.

In 2017, the NCIOM conducted monthly conference calls with the Steering Committee to update on working group activities, identify strategies for moving additional recommendations forward, discuss new stakeholders with whom to connect, and identify ongoing priorities for the Essentials for Childhood initiative.

NCIOM also held quarterly in-person meetings with the Steering Committee:
February 24, 2017. Full agenda and meeting summary here.
July 7, 2017. Full agenda and meeting summary here.
October 16, 2017. Full agenda and meeting summary here.
January 4, 2018. Full agenda and meeting summary here.

Children's Cabinet Convening:

On July 28, 2017, NCIOM convened a group of over 30 state stakeholders to develop a shared understanding of the advantages and disadvantages of a statewide leadership body to lead policy decisions for child and family serving agencies and organizations, a shared vision for the optimal structure for North Carolina, and consensus on next steps of the discussion.

Meeting highlights:

Michelle Ries, NCIOM Project Director, welcomed everyone to the meeting and gave a brief introduction to the work of the Essentials for Childhood initiative and how it prompted the NCIOM to host a facilitated discussion regarding the potential of a children's cabinet or similar leadership body in North Carolina.

Adam Zolotor, NCIOM President and CEO, reviewed research compiled by Catherine Joyner, PCANC, and NCIOM staff on children's cabinet models that have been implemented in other states.

Michelle Ries led the group through an environmental scan exercise, reviewing existing or pending groups and/or legislation that have similar or overlapping goals. The three groups discussed included: (1) the Child Well-Being Transformation Council established by S.L. 2017-41 / H630; (2) the Juvenile Jurisdiction Advisory Committee proposed by H280; and (3) the B-3 Interagency Council established by S.L. 2017-57. The Early Childhood Leadership Group was also raised for discussion.

Participants discussed the need for a children's cabinet or similar cross-system leadership group to help reconcile fragmentation between systems, agencies, and existing workgroups. Participants discussed the need for improved alignment for organizational missions, policies, outcome measures, investment, and the service interface for children with complex needs.

NCIOM staff facilitated small group discussions, using guided questions about the benefit, role, structure, and charge of a potential children's cabinet, as well as how it fits in the context of existing groups.

The Child Well-Being Transformation Council was discussed by all four small groups as a starting point for Cabinet development. In the course of this discussion, participants raised several concerns and suggested considerations for strengthening the Council and clarifying its scope and goals.

Considerations for the Child Well-Being Transformation Council:

The following considerations summarize common themes that emerged as opportunities to build upon the Child Well-Being Transformation Council's vision to promote child and family well-being across the state:

• Common mission and vision: Establishing a mission and vision for North Carolina's children and families, adopted through consensus of the members of the Council, will provide a shared sense of purpose across the distinct agencies and organizations represented on the Council. A shared mission and vision will facilitate cross-system coordination and will communicate the Council's purpose to other stakeholders.

• Defined scope of work and flexible action plan: Child well-being involves many interrelated factors and coordinated, comprehensive infrastructure is required to meet the needs of children and families. The Council should consider defining a consistent scope of work, establishing short and long-term goals, prioritizing strategies for achieving these goals, and developing an action plan to achieve desired outcomes. The council should be explicit in regard to its focus on overall child well-being and prevention.

• Suggested membership: Including additional members on the Council will add to the diversity of experience and perspectives relevant to child services and well-being. Giving more flexibility in making appointments to both the Governor and General Assembly will enhance the strength of partnership between branches of government. Additional membership may include:

- Representatives of the faith community
- Representatives of higher education
- Representatives of geographically diverse areas of the state (including a mix of urban and rural)
- Representation from youth and families.
- Representatives of the business community

• Process for involving local communities: As many decisions affecting the delivery of services in communities are made at the state level, a process for ongoing community participation in determining the goals and strategies of the Council will strengthen efforts to improve service delivery and coordination. This may include creating work groups for specific initiatives or goals, and involving organizations such as county Smart Start Partnerships, Child Fatality Prevention Teams, or other community child serving groups. A conduit for bi-directional communication should be established.

• Dedicated staff: Qualified, full-time staff will play a vital role in determining the capacity and effectiveness of the Council. Coordinating across multiple agencies and organizations will require a variety of skills including facilitation, project management, research, and presentation skills, as well as the ability to build a sense of urgency around issues affecting children.

Following this meeting, representatives from Benchmarks, the Department of Public Instruction, and the Department of Public Safety agreed to work with legislators to discuss

potential changes to this legislation to reflect these considerations, in advance of the 2018 Legislative Session. As of August 2018, plans were underway for the Council to be run through the UNC School of Government (starting in Dec. 2018), with NCIOM as a founding member, representing Essentials for Childhood and other NCIOM initiatives.

Early Childhood Action Plan: Our state currently has a unique opportunity for alignment of Essentials for Childhood and the goals of the SAP with other statewide and local initiatives. NCDHHS, under Secretary Mandy Cohen, is undertaking a significant strategic focus on early childhood (the Early Childhood Action Plan; ECAP), through which NCDHHS will align work and programs across divisions of NCDHHS to implement upstream approaches to ensure optimum health and well-being for our state's young children. NCDHHS outlines the ECAP in three categories: safety, health, and development and education. As a result of convening the Essentials Task Force again in May 2018, NC DHHS will use the NCEfC SAP as its priority strategies to meet the outcomes listed below. NC DHHS includes foster care, adoption, and child protective services in this category. Category outcomes (by 2025) include: decrease the rate of CAN, increase % of children in foster care who obtain family permanency and increase in social-emotional well-being and resilience in young children.

<u>Other implementation activities:</u>

Governor Cooper named new members of the Early Childhood Advisory Council in February 2018. Essential for Childhood steering committee will be discussing how to align our goals and leadership structures with this group.

Other leadership bodies continued or established include the Birth to Three Interagency Council and the Child Fatality Task Force, both of which provide opportunity to stakeholders to work together to develop policy and identify resource needs.

Recommendation 3.2: Support the Establishment and Continuation of Trauma-Informed Practices and Communities (PRIORITY RECOMMENDATION)

A working group, as convened by the Leadership Action Team, should be established to examine research on brain development, the impact of trauma on development and behavior over the lifespan, and ways in which other states and communities have established trauma-informed practices in communities, schools, and among health care providers. The working group should explore additional strategies to disseminate knowledge of brain development, trauma, and adverse childhood experiences. Potential strategies may include social marketing and public awareness campaigns around brain development and trauma; work with professional associations in multiple fields,

including health, education, first responders, faith community, justice system, and social and community services; focused training for these groups and others in trauma-informed practices and community development; and support for integrated behavioral and mental health services.

Fully implemented.

Backbone Organization Activities:

The Trauma-Informed Practices work group is structured according to the above recommendation.

NCIOM staff facilitated discussions with the Steering Committee and outside experts to narrow the focus of this recommendation and determine which aspects would be best for the work group to focus on. In our planning and strategy-setting for this work, we have decided to focus the group's work on trauma-informed schools and initiatives to support learning about trauma and its impact on children and development within school and early care and education settings. The basic goals of the group are: 1) sharing innovative practices; 2) reaching consensus on language about trauma; 3) producing a comprehensive literature review to inform the conversation; 4) determining next steps for dissemination and development of evaluation process for trauma-informed practices in school and early care and education settings.

George (Tripp) Ake, III, Ph.D., Associate Professor at Duke University Medical Center, Center for Child and Family Health chaired this working group and provided expertise and guidance for the working group. Full list of work group members can be found in Appendix A.

Through the course of two 3-hour meetings in fall 2017, group members shared best practices, identified challenges and brainstormed potential strategies in developing trauma-informed language, and discussed dissemination and evaluation of strategies. Through spring 2018, NCIOM staff is developing a literature review, to be edited by the working group members and disseminated in summer/fall 2018.

Meeting materials, including agendas, presentations, and meeting summaries, can be accessed at the links below:

Thursday, October 5, 2017

Thursday, November 9, 2017

Other implementation activities:

A lot of trauma-informed care work throughout the state, including through DCDEE and DPI. The Duke Center for Child & Family Policy is building a professional development program for people who work with young children to learn how to identify the signs of toxic stress and promote resilience.

In addition, in 2018 short legislative session, HB986 made various changes to education laws, including a provision to establish a mental health training program that includes youth mental health, suicide prevention, substance use, sexual abuse prevention, and sex trafficking prevention. The state House convened an interim committee on school safety, and several committee recommendations received funding. Total package of $35 million (p. 35-37), including $10 million in personnel block grants (school counselors, nurses, psychologists, social workers); $3 million in trauma/stress training for community partners, and $2 million for grants to community partners for crisis services – all non-recurring.

Other backbone activities related to Goal 1:

NCMJ Issue

The NCIOM and the Duke Endowment co-publish the *North Carolina Medical Journal.* The journal is published 6 times per year and is read by a wide range of health care professionals, policy makers, government officials, business executives, educators, researchers, and interested lay people. Each issue of the journal has a topical focus referred to as the policy forum. The policy forum is introduced by an extended issue brief that provides an overview of key issues related to the focal topic. The issue brief is followed by commentaries and sidebars written by persons with special expertise or perspectives on various aspects of the topic. The policy forum is complemented by a regular series of departments—Tar Heel Footprints in Health Care, Spotlight on the Safety Net, Running the Numbers, and Philanthropy Profile—that highlight important people, agencies, and data in areas within the scope of the policy forum.

Issues also include a collection of peer-reviewed articles featuring original research on topics relevant to the health of North Carolinians.

The March/April 2018 issue of the *NCMJ* will focus on Responses to Adverse Childhood Experiences. In this issue we will cover various topics, including building resilient communities, trauma-informed juvenile justice, and considering poverty as an ACE. Our guest editors are Susan Kansagra and Kelly Kimple of NC DHHS. Articles and authors for this issue are listed in appendix X.

NCIOM/*NCMJ* staff have also been working with Essentials for Childhood stakeholders to identify ways to cross promote the Journal issue, using specific articles to boost advocacy efforts, enhance messaging on trauma and adverse childhood experiences, and raise

awareness of strategies to ensure safe, stable, and nurturing relationships and environments.

Essentials for Childhood Newsletter

NCIOM staff has produced a quarterly newsletter for Essentials for Childhood. Staff contacts Essentials stakeholders in advance of the newsletter publication and requests submissions of recent work and initiatives to highlight in the newsletter. Newsletter also includes updates on legislation, summaries of work group activities, and other recent work of interest. The newsletter is distributed to approximately 150 Essentials for Childhood partners and child advocates. Newsletters can be found here:
January 2017
April 2017
August 2017
December 2017

Website and Social Media

As backbone organization, NCIOM also created and maintains an Essentials for Childhood website. This website has a description of the collective impact initiative, links back to original Task Force membership and report/recommendations, meeting summaries and materials for all work group meetings, and all Essentials for Childhood newsletters. NCIOM also actively promotes Essentials for Childhood goals, strategies, and partners activities through social media (Twitter and Facebook). www.nciom.org

Goal 2: Use data to inform action

Recommendation 4.1: Establish a Child Data Working Group of the Leadership Action Team to Identify and Support Data Collection and Collaboration

a) The Leadership Action Team should establish a child data working group composed of experts from the North Carolina Division of Public Health (DPH) (e.g. Office of the Chief Medical Examiner, State Center for Health Statistics, Women and Children's Health Section, and Injury and Violence Prevention Branch; Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Division of Social Services; Department of Public Instruction; State Bureau of Investigation; local police departments; North Carolina Partnership for Children; NC Child; Prevent Child Abuse North Carolina; academia; and others. The child data working group should be tasked with:

1) Identifying existing data systems in North Carolina for measuring the physical, socio-emotional, and mental health of children and families.
2) Making recommendations on improving and sustaining these systems.
3) Exploring options for integrating existing systems or developing new functional, interoperable data systems for tracking and evaluating children's and families' well-being.
4) Identifying data critical to assessing child well-being that are not currently measured and developing a plan to collect these data.

b) The Leadership Action Team should designate staff from the Chronic Disease and Injury Section of DPH to lead the child data working group and report back to the Leadership Action Team at regular intervals.

c) The child data working group should identify indicators from the CDC's indicators of impact report as well as additional data from the North Carolina Child Fatality Prevention Program data; Child Protective Services reports; emergency department and hospital discharge data; vital records; and criminal justice data to be included in the Leadership Action Team's annual report on Essentials for Childhood.

d) The child data working group should monitor the progress of the Wake County Child Maltreatment Surveillance System and, if successful, make recommendations to the Leadership Action Team on steps to expand the system to include all 100 counties.

e) The child data working group should monitor the progress of the Early Childhood Integrated Data System (ECIDS) and explore the possibility of expanding the ECIDS to include data on older children and other data sets relevant to child maltreatment surveillance.

f) The child data working group should examine existing case management operations and explore how data can be used at the population health level to improve services and child welfare. The data working group should examine ways to utilize child maltreatment surveillance data to improve case management services and child well-being at the population level.

Partially implemented.

Backbone Organization Activities

Data Working Group: Pathways to Grade-Level Reading:

At the beginning of the collective impact initiative, the Essentials for Childhood steering committee determined that the data work group, as described in the recommendation below, had overlapping and aligned goals, as well as similar stakeholders, with a North Carolina Early Childhood Foundation initiative, Pathways to Grade-Level Reading. As such, the steering committee, in conjunction with the NCECF, decided that the Pathways to Grade-Level Reading initiative would serve as the data working group, in order to meet the recommendation's goals.

Pathways to Grade-Level Reading has as its primary goal: People, agencies, and organizations working collaboratively towards a common goal, agreeing on how to measure progress, coordinating strategies that take into account all aspects of children's healthy development, and aligning policies and practices along the developmental continuum, starting at birth, to maximize each child's potential.

Pathways Phases:

Phase 1 (spring 2016): Data Action Team engaged in a landscape survey of existing national birth-to-eight indicators and those indicators being used by NC state-level organizations.

Phase 2 (fall 2016): Learning Teams assessed trends and identified data gaps.

Phase 3 (2017): Design Teams will build strategies around key factors that impact third grade reading outcomes, including children's social-emotional health, high quality birth-through-age-eight early care and education, and regular school attendance.

NCIOM and other Essentials for Childhood stakeholders were key participants in each of these phases, serving as various team co-chairs and assisting with meeting facilitation as needed.

Through fall 2017, NCIOM staff was engaged by NCECF to strategize and develop a work plan for a new phase of the Pathways work. As part of Essentials, NCIOM will be convening a revised Data Action Team to review the existing data and collection methods of the Pathways indicators and identify data gaps and new resources needed to improve data quality and collection methods. NCIOM will be facilitating this process to inform both Essentials' data goals and the next phases of the NCECF Pathways to Grade-Level Reading work. Please see Appendix C for full work plan.

In addition, NCIOM facilitated exercises with the Essentials for Childhood steering committee to map the indicators identified in Pathways with the data goals and recommendations from the Task Force and to the short- and long-term outcomes identified by the CDC for the Essentials for Childhood initiative. This work is ongoing.

Additional Data Work:

An initial data development working group was convened in June 2015. This working groups' original focus was to addresses gaps in data, monitors progress on data development items, and is focused on implementing data recommendations from the NCIOM E4C Task Force. However, because this group was particularly interested in ensuring efficiencies and non-duplication of efforts they began to focus on the goal of the development of a single data group to meet the data needs of multiple initiatives and grants. It was comprised of representatives from the following organizations: UNC, NCPC, DPH, DSS, and NC Child, and attempted to strategically increase members and partnerships with other organizations which are knowledgeable about the many distinct sources of data available in NC. However, membership fluctuated due to employment changes and the group had limited success gaining interest in a single data group to meet multiple initiatives. This group met to determine the feasibility data sharing agreements for NC TOPPS data. The group determined that it was feasible, but that the that this work was better suited for the Cross Systems Work Group as it would require division and departmental actions.

The work group did not think it had the expertise to tackle recommendations related to the Kindergarten Health Assessment (KHA) or the Kindergarten Entry Assessment (KEA).

During the backbone transition period in fall 2016, this workgroup was dissolved with the understanding that the new backbone organization would determine the feasibility of a new data work group, which would focus on the NCIOM E4C Task Force data recommendations which were not being addressed through the Pathways initiative. The Essentials for Childhood Steering Committee has identified as a strategy convening a sub-group of data experts to provide guidance on parts C through F of Recommendation 4.1. This work has not begun.

<u>Other implementation activities:</u>

None

Recommendation 4.2: Gather Data on Social Norms around Children and Parenting
The child data working group should explore and identify the most appropriate mechanism and funding source by which to measure public opinion and social norms around parenting, children, and families, and report back to the Leadership Action Team. This work should assess attitudes and knowledge about parenting; punishment and discipline techniques; safety net programs including Medicaid and nutrition programs; and risk and protective factors for child maltreatment. Once identified, the survey mechanism should:

1) Include baseline and follow-up surveys to be completed at five year intervals.

2) Produce results to be used by the North Carolina Division of Public Health, the North Carolina Early Childhood Foundation, and community organizations to inform social norms approaches to increasing safe, stable, nurturing relationships and environments.

Fully implemented.

Backbone Organization Activities

DPH received the Awareness, Commitment, and Norms Survey data from the CDC in May 2016 (more below). The project evaluator and a UNC graduate student completed further analysis of the data to assist the steering committee and workgroups in better understanding how this data could be utilized most effectively. The Awareness, Commitment, and Norms Survey data was presented to the Public Awareness workgroup at the July 2016 meeting to determine the utilization in messaging. Based on questions from the workgroup, the project evaluator did some further analysis on parenting seeking help and how responses may differ between parents and non-parents. Stakeholders have been very interested in this data and it has been shared widely. It seems there is the clearest and most interesting story or pattern is for political affiliation and reasons children struggle that are related to society and further analysis is being completed. The NCE4C steering committee continue to explore routes for further dissemination and utilization of this data.

Other Implementation Activities:

The CDC, in collaboration with the evaluators from the five (5) funded states, developed a 69-item survey to gather baseline data for North Carolina. With funding from the CDC, YouGov interviewed 1128 respondents in North Carolina between January and March 2016 who were then matched down to a sample of 800 to produce the final dataset. The respondents were matched to a sampling frame on gender, age, race, education, ideology, and census region. The frame was constructed by stratified sampling from the full 2010 American Community Survey (ACS) sample with selection within strata by weighted sampling with replacements (using the person weights on the public use file). Data on voter registration status and turnout were matched to this frame using the November 2010 Current Population Survey. Data on interest in politics and party identification were then matched to this frame from the 2007 Pew Religious Life Survey. The matched cases were weighted to the sampling frame using propensity scores. The matched cases and the frame were combined and a logistic regression was estimated for inclusion in the frame. The propensity score function included age, gender, race/ethnicity, years of education, voter registration, marital status, non-identification with a major party, and ideology. The propensity scores were grouped into deciles of the estimated propensity score in the frame and post-stratified according to these deciles. The final weights were post-stratified to match current estimates of employment, and a full stratification of gender, four category race, four category age, and four category education.

Recommendation 4.3: Create an Online Data System for an Expanded Kindergarten Health Assessment

a) DPI, Department of Health and Human Services (DHHS), North Carolina Pediatric Society, North Carolina Academy of Child Psychiatrists, North Carolina Academy of Family Physicians, and partners should develop an online data system for the KHA that could be shared between health providers, schools, and parents or guardians and integrated into the Child Profile generated by the KEA. Investment in the new system may be supported by the RTT-ELC, but development of the system and ongoing maintenance will require DPI and DHHS investment or legislative appropriations.

b) To improve our knowledge of the well-being of children as they enter school, DPI and DHHS should expand the KHA's comments section to include prompts for addressing specific concerns, including developmental, behavioral, social-emotional, and health-related concerns, as well as provide space for physicians to detail specific recommendations for teachers and school staff on addressing individual children's needs appropriate to their scope of practice. To be effectively utilized, DPI and DHHS will need to invest in educating health care providers and school personnel in the use of the KHA as an essential communication tool between health homes, schools, and families.

Not implemented.

Backbone Organization Activities:

None – In 2016, The Data Development working group reviewed this recommendation but did not believe it had the expertise to tackle this recommendation. A number of other groups were contacted but none assumed leadership on this recommendation. Additionally, House Bill 12 (School Health Assessment) requires every child entering the K-12 school system for the first time to have a health assessment. Because of this HB13, the KHA has been replaced with the School Health Assessment.

Other implementation activities related to Goal 2:

2018 North Carolina Child Health Report Card
The NCIOM, in collaboration with NC Child (formerly Action for Children North Carolina), produces the Report Card annually to assist health administrators, legislators, and child and family advocates in their efforts to improve the health and safety of children statewide. The 2018 North Carolina Child Health Report Card tracks key indicators of child health and well-being in four areas: Healthy Births, Access to Care, Secure Homes and Neighborhoods, and Health Risk Factors. The report provides data on such health concerns and risk factors as asthma, teen births, infant mortality, poverty, and child deaths.

NCIOM and NC Child focused the 2018 Report Card on family financial security and impacts on health, highlighting data on the high percentage of children living in low-income homes and neighborhoods and the number of ways in which family income intersects with other child health indicators.

The 2018 Child Health Report Card received substantial media attention highlighting the impacts of poverty on children's health and other featured data. Media coverage included WUNC, the News and Observer, the Asheville-Citizen Times, the Winston-Salem Journal, and others.

The 2018 North Carolina Child Health Report Card can be found here: http://nciom.org/2018-north-carolina-child-health-report-card/

Violence Against Children Survey

In May 2017, NCIOM and other stakeholders participated in a meeting held by the DPH Injury and Violence Prevention Branch to explore the feasibility of North Carolina's participation in developing a domestic, state-based adaptation of the Violence Against Children Survey (VACS), currently fielded internationally by the Centers for Disease Control and Prevention (CDC). At this meeting, investigators from the CDC presented on the VACS work and facilitated a discussion on opportunities to partner with North Carolina and leverage key capacity and expertise.

Following the May meeting, CDC held an expert consultation meeting in Atlanta in July to discuss methodology, ethical considerations, questionnaire adaptation, and conducting a pilot / feasibility study. One of the main take-aways from this expert meeting is that a pilot implementation of a VACS would be needed to assess the methods adaptations. Some of the key adaptations that were also discussed and recommended included:

- Audio Computer-Assisted Self-Interview (ACASI) administration is likely the best fit for a domestic implementation. This would allow sensitive information to be collected privately and anonymously, which may improve disclosure and maximize respondent safety.
- There would be a need to embed a method for respondents who have or are currently experiencing violence to self-select if they would like a referral into services. In addition, protocols to consider mandatory reporting procedures and requirements would need to be refined.
- Incentives would likely be needed to encourage participation.
- A pilot study would need to evaluate methods of selecting and contacting households.

The next steps for CDC partners included reaching out to funding organizations to seek out funding for a pilot study, refining the objectives, and developing a methodology.

In October 2017, NCIOM held further discussions with CDC investigator Greta Massetti to discuss alignment with Essentials for Childhood, and how North Carolina can be involved in

VACS. From this discussion, we learned that CDC is looking to identify North Carolina partners to take the lead in this work going forward, including an agency that can collect pilot data and field a survey. While this scope of work is not appropriate for the NCIOM, we discussed potential connections with DPH and/or the UNC Injury and Violence Prevention Center. The CDC also identified the need for organizing programmatic and policy stakeholder input to address preliminary questions including use case for VACS, questionnaire content, what data gaps would the VACS data fill. This work is more appropriate for the NCIOM and for the Essentials initiative overall. NCIOM agreed to assist with this work as needed through the end of the 2018 Essentials contract period. Beyond then, we would remain interested and willing to help, but the extent of that help would depend on their need and our resources.

Goal 3: Create the context for healthy children and families through norms change and programs

Recommendation 5.1: Promote Positive Community Norms Around Child Development and Parenting (PRIORITY RECOMMENDATION)
The North Carolina Early Childhood Foundation should continue and expand their work on changing social norms through the First 2,000 Days campaign.

Not implemented.

Backbone Organization Activities:

None specifically regarding First 2000 Days.

Other Implementation Activities:

Much of the work of the Pathways to Grade Level Reading initiative promotes community norms for child development, promoting healthy children and families, and early childhood investments.

PCANC is the main partner working on social norms, through various campaigns focused on the protective factors, resilience, and ACEs awareness.

Recommendation 5.2: Foster Community Support for Healthy Children and Families

The North Carolina Department of Health and Human Services (DHHS), North Carolina Department of Public Instruction, Prevent Child Abuse North Carolina, and North Carolina Partnership for Children should partner with the Center for the Study of Social Policy to identify steps for implementing the Strengthening Families Framework in North Carolina and work towards incorporating the Strengthening Families Framework in state and local child maltreatment prevention efforts.

Partially implemented – ongoing

Backbone Organization Activities:

None.

Other Implementation Updates:

In response to the state child welfare program improvement plan, the DSS, in conjunction with NC State University, launched the NC Child Welfare Leadership Model Implementation work group in October 2016. This work group is composed of partners who have experience or interest in advancing family leadership and family engagement and includes parents, caregivers, youth, in addition to agency representatives from DPH, DSS, PCANC, Families Untied, Wake County Human Services, UNC, and NC State University. This working group met over the next 12-18 months and will inform the development and implementation of a sustainable model for family leadership in North Carolina.

Recommendation 5.2: Foster Community Support for Healthy Children and Families
The North Carolina Department of Health and Human Services (DHHS), North Carolina Department of Public Instruction, Prevent Child Abuse North Carolina, and North Carolina Partnership for Children should partner with the Center for the Study of Social Policy to identify steps for implementing the Strengthening Families Framework in North Carolina and work towards incorporating the Strengthening Families Framework in state and local child maltreatment prevention efforts. The implementation should focus on evidence-based program implementation, mandated reporter trainings, home visiting
models, community-based programs, and other DHHS-wide initiatives that focus on direct services to children and families, as well as efforts aimed at economic security and workforce development.
1) The Division of Child Development and Early Education, in partnership with stakeholders listed above, should convene a working group to examine current family engagement and parent leadership strategies in early care and education, and social services settings. This working group should define best practices and develop a strategy around parent and caregiver engagement.
2) Coordination and planning should include the development of shared outcomes and implementation of evaluation and accountability processes.

Partially implemented – ongoing

Backbone Organization Activities:
None

Other Implementation Activities:

In response to the state child welfare program improvement plan, the DSS, in conjunction with NC State University, launched the NC Child Welfare Leadership Model Implementation work group in October 2016. This workgroup is composed of partners who have experience or interest in advancing family leadership and family engagement and includes parents, caregivers, youth, in addition to agency representatives from DPH, DSS, PCANC, Families United, Wake County Human Services, UNC, and NC State University. This working group has met over the last 12 months and aims to inform the development and implementation of a sustainable model for family leadership in North Carolina.

Recommendation 5.3: Support Implementation of Evidence-Based Programs to Prevent Child Maltreatment and Promote Safe, Stable, and Nurturing Relationships and Environments (PRIORITY RECOMMENDATION)

The Leadership Action Team (LAT) should convene and staff a state Essentials for Childhood Evidence-Based Programs working group, comprised of public and private funders, committed to funding and scaling evidence-based programs. The working group should be charged with coordinating and aligning the implementation infrastructure across those programs, advising the backbone organization and reporting to the LAT on an annual basis. The working group should ensure:

1) *A standard definition of evidence-based and evidence-informed programs and practices and identify high-quality clearinghouses to reference in Requests for Proposals (RFPs).*
2) *Development of an RFP process that operates on a common cycle, with shared outcomes and evaluation requirements. RFPs should be informed by implementation science and should provide multiyear funding with attention to sustainability and fidelity.*
3) *Planning grants to foster and sustain interagency collaboration and collective impact work in local communities. Subsequent grant cycles should give preference to communities that successfully carried out planning process.*
4) *Technical assistance to communities and organizations during planning, implementation, and on an ongoing basis.*

Fully implemented (ongoing)

Backbone Organization Activities:

Evidence-Based Practices Work Group

NCIOM staff worked with co-chairs and group members to clarify priorities and strategies for the work group, originally convened in July 2016. The January 2017 meeting focused on reviewing the group's past discussions and coming to consensus on a primary goal and 1-3 priority strategies to achieve that goal through 2017 and 2018.

Primary Goal: Increase support for aligning evaluation and RFP processes across agencies and organizations and develop proposal for aligned RFP and evaluation process.

Short-Term Outcomes: Private funders could help fund pre-work planning; Identify (develop?) and advocate for a framework for determining community readiness and capacity for EBP implementation; creation of a map of which DHHS & DSS divisions are connected to EBPs and division capacity for additional implementation

Long-Term Outcomes: wiser spending of resources, enabling programs to better serve their clients or serve additional clients, ease data sharing, and encourage broader community attribution.

This group has met 8 times through 2017 and early 2018, focusing on refining strategies and developing recommendations on increasing alignment of evaluation and proposal process for the implementation of child and family-serving evidence-based programs in North Carolina. The group has also explored additional content of relevance to the recommendations and goals, including research on implementation teams, pay for success models.

Meeting materials, including meeting agendas and summaries, available at links below:

January 23, 2017
March 20, 2017
May 4, 2017
June 15, 2017
July 24, 2017
September 6, 2017
October 25, 2017
February 1, 2018

Other Implementation Activities:
None

Recommendation 5.4: Assess Potential Funding Strategies to Ensure Adequate Investment in Evidence-Based Programs to Prevent Child Maltreatment
The Leadership Action Team should study existing alternative funding strategies for evidence-based program investment, examining the experience of South Carolina and other states. Funding strategies should prioritize spending based on community need, determination of scope/reach, best practices, evidence-base of programs' outcomes, and availability of implementation support for such programs. The Leadership Action Team should explore the application of cost-benefit models to inform policymaking and public investments in evidence-based programs, as well as North Carolina's current data capacity to apply such a model.

Partially implemented – ongoing

Backbone Organization Activities:

The work group has also explored additional content of relevance to the recommendations and goals, including research on implementation teams, pay for success models.
In addition, the work group also provide content expertise and guidance to the Division of Medical Assistance as they developed a 2-phase pilot for Medicaid coverage of home visiting services.

Other Implementation Activities:

In December 2017, Governor Cooper announced that North Carolina will join the Pew-MacArthur Results First Initiative. DHHS will be the first state agency to partner with Results First, and the partnership will focus on public health programs to address child and maternal health. As the Essentials Task Force identified Results First as a promising partnership model to be explored by the state as it enhances and expands evidence-based practices for child health and well-being, the NCIOM is following up with policy advisor Darryl Childers in Gov. Cooper's office to learn more about this initiative and how it may align with other Essentials activities.

Recommendation 5.5: Explore Incentivizing Outcomes Resulting from Evidence-Based Treatment Programs (PRIORITY RECOMMENDATION)
The North Carolina Division of Medical Assistance, in collaboration with Community Care of North Carolina, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Division of Public Health should identify opportunities to incentivize payment for outcomes resulting from evidence-based

treatment programs, especially as quality of care is incentivized under reform of Medicaid in North Carolina. Agencies listed above should:

1) Identify evidence-based or evidence-informed child maltreatment and trauma treatment programs, particularly programs that have or could have implementation infrastructure in North Carolina.
2) Define age-appropriate, validated behavioral health and social, emotional, and mental health process and outcome measures on which to tie performance based incentive payments for implementing organizations. These measures should align with those chosen by the child data working group (as described in Using Data to Inform Actions) to measure progress and outcomes around child maltreatment and safe, stable, nurturing relationships and environments for children in North Carolina.
3) Develop value-based Medicaid payments that would provide additional reimbursement to professionals who credential to provide evidence-based or evidence-informed treatment protocols, including models such as Trauma Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy.

Partially implemented – ongoing

Backbone Organization Activities:

The evidence-based practices work group has provided strategic guidance to North Carolina Medicaid as the agency developed a pilot proposal for Medicaid coverage of home visiting models. In July 2018, NC Medicaid launched two pilot home visiting initiatives, in Cleveland and Johnston counties. The pilots use Medicaid funds to pay for home visiting programs; the Cleveland County pilot will use the Nurse Family Partnership model, and Johnston County will use a hybrid model focused on high-risk pregnancies. DHHS has estimated the per-visit cost to Medicaid at $83.72, for a total projected expense in Cleveland County of $251,160, and $92,090 in Johnston county.

Task Force on Health Care Analytics

In 2016, the NCIOM convened a Task Force on Health Care Analytics, at the request of the Division of Health Benefits (DHB) of the North Carolina Department of Health and Human Services, to develop the set of quality metrics that will be used to drive improvement

in population health under North Carolina's Medicaid reform plan. The Task Force, in most cases, selected measures from existing evidence-based federal and state measurement sets and built on previous work by the North Carolina Division of Medical Assistance (DMA), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), and others to define and prioritize quality measures for North Carolina Medicaid.

The Task Force anticipates measures will evolve based on experience and published evidence and will need to be reviewed and updated on a regular basis. The methodology for measure selection and selected measures are discussed in subsequent chapters of this report. The Task Force considered measures across a broad spectrum of health care, care settings, and populations, including but not limited to public health, population health, whole-person health (integration of mental, physical, and oral health), pediatrics, oral health, key high-cost high-risk subpopulations, mothers and infants, those with chronic illnesses and foster children. The Task Force also considered areas of health disparities, including racial and ethnic disparities and disparities between rural and urban areas. The selected measures address our state's most significant health priorities and are aligned as much as possible with national measures and those of other insurers. In addition, because of the large proportion of North Carolina's Medicaid population who are children (approximately 50%), the Task Force sought to identify cross-cutting measures that would be applicable to both pediatric and adult Medicaid beneficiaries. In addition, the Task Force identified screening for trauma and ACEs and specific quality measurements for foster care children as areas that Medicaid should include in ongoing work on population health improvement.

Other Implementation activities:

The Child Well-Being Steering committee recommendations related to increased availability of evidence-based treatment programs, incentivizing outcomes from evidence-based treatment programs, data collection and utilization, and systems improvements and were closely aligned to many of the NCIOM E4C task force recommendations. Recommendations were presented to DHHS leadership in March 2016 for endorsement. While DHHS leadership was supportive, questions were raised regarding the necessary resources, priority areas, connecting recommendations to existing workgroups (as possible), and the ROI for each recommendation. One conference call was held in June 2016 to begin to answer these questions and make an implementation plan. On that call, the group had trouble seeing a clear path forward primarily because it moved from planning to implementation, and the group did not have the capacity or authority to act on many of the items. At the same time, the group wanted to ensure that the recommendations were implemented. A plan was proposed to shift from the current "facilitator and steering committee" format to a more implementation-focused format of project manager and board of advisors. The steering committee was to meet one additional time to sift through the recommendations and determine which items could be handled by another group entirely, which items should be

spearheaded by the project manager, and which items are far out on the horizon (or require other items to happen first) and put on hold. Then the steering committee would move to an advisory role with the project manager responsible for the work. The project manager would give regular progress reports to the board of advisors and call on them for support when needed but would not meet regularly. However, the then project facilitator was unable to schedule another call or meeting due to conflicting schedules before she left this position. The final meeting of the steering committee never occurred, and a new project manager was never hired despite the availability of private funding. Fortunately, the work was not completely dropped as the recommendations were folded into the work of the newly formed Cross Systems Work Group.

The Child FIRST replication is another opportunity for incentivizing outcomes and evidence-based treatment programs. DMH/DD/SAS and DMA are currently working on a service definition and cost rate.

From 2018 short session: HB403 modifies Medicaid Transformation legislation to specify the parameters of Medicaid behavioral health and intellectual/development disabilities tailored plans.

Recommendation 5.6: Increase Funding for Evidence-Based and Evidence-Informed Programs Implemented by the Smart Start Network (PRIORITY RECOMMENDATION)
The General Assembly should increase appropriations by 5% per year to the Smart Start network to support their work in promoting and implementing a range of evidence-based and evidence-informed programs to support and strengthen families and contributing to improved school readiness, long-term educational success, and lifelong well-being. Appropriation increases should continue until statewide capacity is developed to meet assessed needs.

Not implemented

Backbone organization activities:

None

Other implementation activities:
None. The SFY 15-16 budget directs the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee to study early childhood and family support programs, including the Child Care subsidy program, NC Pre-K and Smart Start. The subcommittee has developed a proposal for a statewide plan that addresses county or regional needs of children which may provide an opportunity for increased funding for the Smart Start network.

Goal 4: Create the context for healthy children and families through policies

Recommendation 6.1: Ensure that Child Care Centers Provide a High Quality, Nurturing Environment (PRIORITY RECOMMENDATION)

Research shows that high quality early care and education is associated with better social-emotional development of children and less maltreatment. The Task Force on Essentials for Childhood strongly believes that the right answer is more AND better early care and education. The long-term goal in early care and education should be that all children from families who want early education can afford it and that it be of high quality. North Carolina should seek to maximize its investment in early care and education initiatives, and leverage federal and foundation resources to enhance the child care workforce and allow more children to attend high quality care and education programs.

a) *The Division of Child Development and Early Education (DCDEE), in partnership with the Child Care Commission and the Department of Public Instruction Office of Early Learning, should continue to re-evaluate its quality star rating system and reimbursement system to identify high quality child care facilities based on updated evidence and best practices. As part of this work, DCDEE should revise the star rating system to include:*
    1) *Criteria that consider the program's focus on learning to support children's social and emotional development, executive function, language skills, and health.*
    2) *Quality measures focused on teacher/child interactions and teacher education and criteria on continuous quality improvement.*

b) *DCDEE should work with the North Carolina Rated License Assessment Project to revise its policies and procedures for implementation of rating scale assessments to reflect these criteria changes.*

c) *The North Carolina General Assembly (NCGA) should enhance child care subsidies by:*

    1) *Adjusting subsidy funding to increase percentage of eligible children receiving subsidies per year by 1% points.*

    2) *Increasing subsidies for infant and toddler care, expanding both the number of available child care slots as well as improving access to and affordability of higher quality care.*

    3) *Allocating additional recurring funding for child care subsidies and, in conjunction with DCDEE and the Social Services Commission, examining eligibility requirements including household income, employment/education, and redetermination periods in order to ensure children's continuity of care and allow parents to remain in the*

workforce, weather family transitions, and increase families' economic security without jeopardizing short-term subsidy eligibility.

4) *Excluding the income of a "non-parent relative caretaker" from the definition of the family income unit so that grandparents and other extended family members can continue to care for their children and support their learning opportunities.*

d) DCDEE, in partnership with the North Carolina Department of Public Instruction, Office of Early Learning and community stakeholders including child care resource and referral agencies, community colleges, Head Start, Smart Start partnerships, and child care providers, should continue to work towards adequate wages and/or wage support, benefits (especially health insurance), education and training, and career advancement opportunities to continue to grow a high quality and well-trained early care and education work force. DCDEE and partner organizations should:

1) Continue ongoing evaluation of professional child care workforce development on a bi-annual basis, using the Child Care Services Association workforce study evaluation model. Evaluation should provide county-specific data.

2) Allocate sufficient funding for statewide WAGE$ salary supplementation for eligible child care workers and other workforce development programs. Funding should also support targeted resources and technical assistance for the workforce, in order to improve early education quality, as well as a continuous quality improvement frame.

Partially implemented – ongoing

Backbone organization activities:
None

Other implementation activities:

In SFY 15-16 the NCGA provided funding for NC Pre-K. The final budget included $2.3M in state funding and an additional $2.7M of lottery funding to retain NC Pre-K slots that would have expired due to a non-recurring allocation in the previous year's budget. The total number of NC Pre-K slots was unchanged. However, in SFY 16-17, NC Pre-K received $1.325 M for 260 new NC Pre-K slots.

The SFY 15-16 budget included a market rate increase for infant and young toddler child care providers who participate in the child care subsidy program and the SFY 16-17 budget included a market rate increase for Tier 1 and Tier 2 counties for children ages 3-5. Additionally, $1.325 M for 260 new subsidy slots was included in the SFY 16-17 budget. As of

June 2016, the statewide waiting list for child care subsidies was 21,784. The Child Fatality Prevention Team recommended implementation of this recommendation to the full Child Fatality Task Force as a child fatality prevention strategy.

In SFY 16-17 two additional studies on early childhood education were included this session. One on the child care subsidy rate setting process and another on the cost and effectiveness of NC Pre-K.

In 2018 budget:
NC Pre-K had $50 million of state funds replaced with $50 million in federal funding

Child Care Subsidies: $9.75 million allocated to increase subsidy reimbursement rates for children in tier 3 counties (age 3-5), with an additional $3.675 million for increased reimbursement in Tier 1 and 2 counties. $19.575 million from federal block grants allocated to reduce child care subsidy wait list by 3,700 slots.

Child Care Quality: Additional provisions direct the Division of Child Development and Early Education to create a new star-rating quality system for children age 0-2.

From DCDEE:
The North Carolina Division of Child Development and Early Education (DCDEE) announced in August 2018 that it will implement five new projects aimed at infant and toddler health, two of which relate directly to the NCIOM's Essentials for Childhood Task Force recommendations.

The new projects include: a training and technical assistance initiative that will help make the places young children spend most of their time healthier and safer; a consultation service program that will provide three regional Registered Nurse Child Care Health Consultants to work with early childhood programs; Infant Toddler Educator AWARD$ to invest in the state's youngest children; a pilot program for intensive infant and toddler technical assistance; and a new team of experts on trauma-informed infant and toddler care.

Recommendation 6.2: Enhance Care and Reimbursement Standards to Promote Children and Families' Mental Health (PRIORITY RECOMMENDATION)

a) Community Care of North Carolina (CCNC), should work with the North Carolina Division of Public Health (DPH), the Division of Medical Assistance (DMA), the North Carolina Pediatric Society, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/ SAS), the North Carolina Medical Society, and the North Carolina Academy of Family Physicians, to establish guidelines for primary care clinicians for expanded screening of families with children for psychosocial

risk factors and family protective factors, using Bright Futures as a model. Guidelines should be applicable to all populations, regardless of payer. Expanded screening guidelines should include/address:

1) *Increased referrals, when appropriate, to existing mental health and social services, and improve care coordination and information sharing among health care (primary care and mental health) and social service providers.*

2) *Ongoing evaluation by DMA, including frequency of and intervals between implementation, quality of existing mental health and social services, and receipt of referred services.*

3) *Evaluation of payment policies to incentivize universal screening and services provided (prenatal, postnatal, children, new parents). DMA should explore the establishment of incentive structure for primary care providers who reach expected goals for screening (i.e. percentage of parents screened), assessment, referral, and treatment protocol for children and families, as well as development of a data collection process by which to track services and outcomes.*

4) *CCNC should ensure transfer of patient information from psychosocial risk screening done as part of pregnancy medical home to infants' pediatric medical provider and other medical services.*

b) DMH/DD/SAS, DMA, the North Carolina Foundation for Advanced Health Programs, CCNC, North Carolina Pediatric Society, and the North Carolina Academy of Family Physicians should support current work to increase integrated behavioral health care under Medicaid reform. DMA and DMH/DD/SAS should build in methods to facilitate and establish integrated behavioral health within their practices (i.e. onsite mental health providers, social workers, etc.).

Partially implemented – ongoing

<u>Backbone Organization activities:</u>

None; however, much of NCIOM's ongoing work with DHHS, especially Medicaid, relates directly to this recommendation.

<u>Additional implementation activities:</u>

TK – update with Medicaid SDOH work, behavioral health tailored plans, quality strategy (and screening incentives), etc. – when plans are released.

Recommendation 6.3: Ensure Economic Security for Children and Families (PRIORITY RECOMMENDATION)

The North Carolina General Assembly (NCGA) should commission a non-partisan economic analysis of the impact of current North Carolina state tax policy on children and families, including impact on economic security, take home pay, and employment rates. This analysis could be conducted by the North Carolina Center for Public Policy Research, the Fiscal Research Division of the NCGA, or a similar non-partisan policy analysis firm. The NCGA should use findings from this analysis to inform future policies to address economic opportunity and security for families and children.

Not implemented

Backbone organization activities:

None; however, in developing new strategies under ongoing E4C funding, NCIOM will subcontract with NC Child and NCECF to support their work on economic mobility and family friendly workplace policies as identified by CDC as appropriate strategies.

Additional implementation activities:

None: No action has been taken by the NCGA to date.

Recommendation 6.4: Enhance Career Training and Education Opportunities to Promote Economic Security for Families

The North Carolina Community College System and local education agencies should work with local industry to enhance career training opportunities consistent with the needs of local industry. These programs should apply best practices from apprenticeship models, job certification programs, and early college integrated programs.

Not implemented as related to Essentials

Backbone organization activities:

None

Additional implementation activities:

None

Other backbone organization activities related to Goal 4:

In order to address the Goal 4 policy recommendations and focus prioritized action on these recommendations, the NCIOM reconvened the Essentials for Childhood Task Force at a 5-hour meeting on May 18, 2018. This meeting brought together members of the Task Force on Essentials for Childhood and the Task Force on the Mental Health, Social, and Emotional Needs of Young Children and their Families. These task forces were convened in 2015 and 2012, respectively, and we brought the members together to discuss progress on each Task Force's recommendations, identify priorities for ongoing work, and identify new opportunities for policy change. The meeting agenda included highlights of community-based approaches to child maltreatment prevention and mental health promotion, and small group discussion on community and state level policy levers of change.

Additional Overall Backbone Organization Activities conducted by NCIOM:

CDC Technical Assistance:

NCIOM, as part of the contract with DPH, participates in many grantee activities conducted by the Centers for Disease Control and Prevention for project staff and backbone staff in each of the five funded states. These activities include quarterly all-state reflection calls, bi-monthly state-specific evaluation calls, technical assistance webinars, and in-person reverse site visits. Through these activities, NCIOM staff has had the opportunity to reflect on the progress, successes, and challenges of the Essentials for Childhood initiative in North Carolina, strategize next steps and priorities, and learn from other states' work.

Alignment with Other NCIOM Work

Through the Essentials for Childhood initiative, NCIOM staff has identified several areas of work with which to align the Essentials goals, messaging, and strategies. These include connecting our partner child advocates' work on paid family leave and other family friendly strategies with caregiver support efforts being undertaken by advocates for aging populations; highlighting messages about trauma and prevention of maltreatment in upcoming NCMJ issue and in work with the North Carolina General Assembly; exploring ACEs screening and quality measurement for children in foster care through our Task Force to identify Medicaid quality metrics; and other overall infusion of the Essentials for Childhood framework.

Evaluation Summary

Thus far, the North Carolina Essentials for Childhood evaluation has included developmental and process evaluations. As the goals of these evaluations differ, they have occurred simultaneously throughout the initiative.

The goal of the developmental evaluation has been to support the advancement of this innovative initiative. During the North Carolina Institute of Medicine Task Force, the evaluator created and implemented a survey that allowed the Task Force members to reflect on their participation to date, including their overall satisfaction, satisfaction with communication from the steering committee, involvement in decision making processes, and how welcomed and included they felt during the Task Force. The results of the survey were shared with the Steering Committee so they could make adjustments to the process as necessary. Additionally, to allow for whole group reflection and discussion, the evaluator shared the results with Task Force members during a meeting. The developmental evaluation has also included working with the Steering Committee and backbone organizations to identify strategies to move the initiative forward when progress in specific areas slows or reaches road blocks. For example, there are a lot of concurrently implemented early childhood initiatives that the Essentials for Childhood initiative was either partnering with, considering partnering with, or tracking the progress of, as their goals are closely aligned with those of the Essentials for Childhood initiative. Additionally, the backbone organization was concerned that there were potentially synergistic activities that they were not aware of and wanted to find a way to systematically identify and track all of these potential and actual partnerships. To address this need, the evaluator researched, recommended, and along with the Steering Committee utilizes a partner mapping tool to allow for documentation of the current and potential partnerships.

The goal of the process evaluation is document the process of implementing the initiative in North Carolina. As such, the focus of the process evaluation has been to track meetings that occur as part of the initiative, including participation, agenda topics, and decisions made during the meetings. This has occurred for meetings of the Task Force, Steering Committee, and each of the Work Groups.

Plans for Sustainability

NCIOM and DPH are in the process of identifying specific goals and strategies for the next phase of this project, with the goal of applying for additional funding when the CDC releases their next request for applications in April 2018. The May meeting will help refine these goals and strategies, and NCIOM will develop a detailed work plan and objectives prior to the start of any

new work. We will focus on prioritizing policy recommendations, improving community-level strategies, and incorporating parent and family partners into this work.

Appendix A:

Steering Committee Members: Sharon Hirsch
President and CEO
Prevent Child Abuse North Carolina

Catherine Joyner, MSW
Executive Director, Child Maltreatment Prevention Leadership Team
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Mental Health Program Manager
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
North Carolina Department of Health and Human Services

Donna White
Deputy Director and Vice President
North Carolina Partnership for Children, Inc.
Work Group Membership:

Trauma-Informed Practices Work Group

Chair:

George S. Ake, III, PhD
Program Director
UCLA-Duke National Center for Child Traumatic Stress

Work Group Members:

Samone Bullock
Fletcher Fellow
AJ Fletcher Foundation

Suzanne Cotterman
Director, Office of Early Education
Durham Public Schools

Elizabeth DeKonty, MSW
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Public School Forum of North Carolina

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Anna Mercer-McLean, MS
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Seth Saeugling
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Kelly Sullivan, PhD, MEd
Child and Family Clinical Psychologist
Duke Health

Johnnye Waller
Director of Student Resources
Lee County Schools

Evidence-Based Practices Work Group

Co-Chairs:

Jeff Quinn, MPH,
Director of Community Resources, Durham Connects
Duke Center for Child and Family Policy

Tony Troop
Program Manager, Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program
Division of Public Health, Children and Youth Branch

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Appendix B: North Carolina Medical Journal March/April 2018 Issue Table of Contents

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Responding to Adverse Childhood Experiences

Issue Brief: It Takes a Village

Brief overview of ACES, their impact, and then a broader discussion of the public health response to ACES. Lay out where we are as a state in responding to ACES research. Introduce trauma-informed concept and where we are in crafting policies/programs/strategies to incorporate what we now know about ACES. *Authors: Susan Kansagra & Kelly Kimple*

Contact: susan.kansagra@dhhs.nc.gov & kelly.kimple@dhhs.nc.gov

Articles:

1. The impact of childhood experiences on lifelong health and well-being
What are ACEs? How prevalent are ACES in NC (BRFSS data)? What is their immediate impact? What do we know about ACEs impact on lifelong health and well-being? *Author: Anna Austin*

2. Building Resilient Communities

What can be done to mitigate the impact of ACEs at the community level? What is a trauma-informed community? What are the programs, policies, and practices in place? What can be done by communities to reduce the likelihood of ACEs occurring? Buncombe County will serve as the example for this piece. This commentary should also highlight the work of Buncombe DSS in keeping children out of foster care/in their homes. *Author: Joshua Gettinger*

3. What is trauma-informed medical care?
This commentary will answer, "What does a trauma-informed pediatric practice look like?" What needs to be in practices/programs/policies need to be in place to be a trauma-informed medical practice? Are there established best practices? *Author: Marian Earls*

Sidebar: Implementing Fostering Health NC
One component of Fostering Health NC has been to improve recognition, assessment and response to trauma among foster children. What has the Fostering Health team learned about how to make pediatric practices more trauma-informed? What is the real experience of medical practices trying to implement trauma-informed practices? *Author: Dr. Esther Smith*

4. What are schools doing to be trauma-informed?

This commentary should discuss schools that are doing more linkages with LME/MCOs. School districts that can be used as examples include Durham and Watauga counties. *Author: Denise Presnell*

5. Trauma-informed Juvenile Justice

North Carolina's juvenile justice system began transitioning to a trauma-informed system in 2012, with a grant from the MacArthur Foundation. This article will briefly discuss the reason for this move and then focus on what has changed, challenges in shifting the system, and lessons learned for other NC systems moving in this direction. *Authors: Jean Steinberg & William Lassiter*

Sidebar: How do we keep kids out of the justice system, and why?
Author: Lorrin Freeman, Wake Co. DA

6. What does Medicaid cover for children?

This commentary will focus on how Medicaid supports a trauma-informed response to ACEs and should include a discussion of evidence-based programs like CBT, Child First, and PCIT. This commentary will also include the challenges of finding a child psychologist/psychiatrist due to the distribution of providers as well as coverage for parents with mental health and substance abuse issues. Authors should also consider the caregiver component of effective trauma-informed treatments how Medicaid handles this. *Author: Robert Murphy*

Sidebar: Using Medicaid to get Trauma-Informed Care
This sidebar will look at how EPSDT allows for children under the age of 21 who are enrolled in Medicaid to access treatment for trauma in Edgecombe. *Author: Ciara Zachary*

7. Poverty as an ACE

Food insecurity is common throughout NC. This commentary will look at how such factors related to poverty relate to ACEs. The commentary can pull from SWYC and NC Child, and can discuss rules for eligibility for SNAP, as there has been a decrease in enrollment for children 1-5.

Commentary on thesis that poverty is an ACE. *Author: Michelle Hughes*

8. Reconsidering our Domestic Violence Response System
Being exposed to domestic violence is an ACE, but are the systems that respond to domestic violence designed to address the needs of children who have experienced trauma? *Authors: Leslie Starsoneck & Tripp Ake*

Columns
1. Running the Numbers: DV Trauma Screen in NC *Author: Jeanne Preisler*

2. Tar Heel Footprint: Catherine Joyner *Author: Michelle Ries (NCIOM)*

3. Spotlight on the Safety Net: PCA NC prevention Planning *Author: Sharon Hirsch*

Appendix C: Pathways to Grade Level Reading Data Gaps Analysis Work Plan and Timeline

Objectives:

- Facilitate a gaps analysis process that reviews what data we have and what data we are missing. For each missing measure or each measure that has only poor quality data, the Agenda will include:
    - Why it is not available/poor quality
    - How it could be collected/improved
    - Who would collect it/improve it (agency)
    - What that would take (resources – time, money, personnel)
    - What would need to happen to trigger data collection (e.g., legislation, agreement with state agency)
- Make recommendations to the Data Advisory Council on prioritization of data collection/improvement.

Workplan:

- Convene (in-person or virtually, as appropriate) the Pathways Data Action Team members and other data experts to engage them in this process.
- Confirm what is available and what is not, using the What Do We Know document as a starting point.
- Collect additional data if any are found that are not already collected.
- Determine for each missing measure or each measure that has only poor quality data:
    - Refine availability matrix – What is the specific data gap? Why it is not available/poor quality?
    - How it could be collected/improved
    - Who would collect it/improve it (agency)
    - What that would take (resources – time, money, personnel)
    - What would need to happen to trigger data collection (e.g., legislation, agreement with state agency)
- Outline possible themes for prioritization of agenda items (e.g., go after low hanging fruit measures first, improve current data collection before collecting new measures, etc) and share any recommendations on prioritization of data collection/improvement with the Data Advisory Council
- Identify which of above questions/tasks may need to be addressed by next phase, with input/informed by the gaps analysis phase

Timeline:

- Fall 2017 (end of October): Add source information to data matrix (NCIOM)
- Fall 2017 (mid-November): Define data gaps categories (NCIOM and NCECF)

- Winter 2018 (Feb): Invite Data Action Team members and other data experts to participate in the process and introduce them to NCIOM (NCECF)
- Winter 2018 (Feb): Send data matrix and relevant background materials to Data Action Team members and other data experts and ask them to answer key gaps analysis questions (NCIOM)
    - *Looking at data marked unavailable, are there any measures for which we can revisit whether data exists? Do we know of any additional sources, proxy measures, etc.?*
    - *What is the specific type of data gap? (e.g., data is not collected, data is poor quality for x reason, proxy measure does not adequately speak to the outcome)*
- March 2018: Compile responses to produce revised What Do We Know matrix, highlighting gaps (NCIOM)
- April 2018: Convene DAT to answer the following questions, starting first with the top 15 Measures of Success (noted in blue on the Framework):
    - *Why isn't the data available? Could it be collected?*
    - *Who would be the responsible agency/party for data collection?*
    - *What resources (time, money, personnel) would be necessary for collection of data on this measure?*
    - *What would need to happen to trigger data collection? (e.g., legislation, agreement with state agency)*
    - *What are some possible themes for prioritization of Data Development Agenda items?*
- End of April, 2018: Write up interim gaps analysis including items above for the top 15 Measures of Success.
- End of June, 2018: Write up final gaps analysis including items above for all measures and DAT recommendations for next phase.