1997-98

INTERIM

JOINT APPROPRIATIONS - HUMAN RESOURCES COMMITTEE

MINUTES

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

October 21-23, 1997
Room 414-Legislative Office Building

Tuesday, October 21 10:00 a.m.
(Full Appropriations meets in Room 643)

(Subcommittee Meeting Begins Approximately 10:30 a.m. in Room 414)

- Welcome — Co-Chairs
- Subcommittee Discussion
  -Goals for Interim Subcommittee Work
  -Planning & Instructions to Staff
- DHHS Organizational Changes & Related Issues — Dr. David Bruton, Secretary DHHS
  -KPMG Peat Marwick Report
  -Key Staff Changes
- DHHS Updates (on legislative initiatives in SB 352) — Jim Edgerton, DHHS
  -NC ACTS and Title IVA-EA retroactive claims)

LUNCH 12:00 - 1:00 p.m.

- DHHS Lawsuits Update — Marc Lodge, DHHS
- Child Welfare Expansion Report & Update — Kevin FitzGerald, DHHS
- Report on Status of ABC's Plan for DHHS Residential Schools — Peter Leousis, DHHS
- Report on Governor's Juvenile Crime Commission — Dr. D. Bruton, DHHS
- Adult Care Homes Report — Lynda McDaniel, DHHS

Wednesday, October 22nd. - 9:00 a.m.

• Caring for Children Program Overview	Kathy Higgins, Acting Director
• Children's Health Insurance	Gordon DeFriese Dr. D. Bruton
• Welfare Reform Report -Overview & Status of Implementation -TANF Block Grant Special Initiatives	DHHS Staff
• Welfare-to-Work Initiative	Pheon Beal, DHHS

LUNCH 12:00 - 1:00 p.m.

Wednesday, October 22nd. - 1:00 p.m.

• Area Mental Health Programs' Audits/Performance Reviews	John Baggett, DHHS
-Division's future plans	Dick Peruzzi, DHHS
-Overview of federal HHS required audits & findings	
• Report on Medicaid & Related Programs/Issues	Dr. D. Bruton, DHHS
-Growth Reduction Plan Report	Dick Peruzzi, DHHS
-Carolina Access, Carolina Alternatives & DSH Update	Allen Gambill, DHHS

Thursday, October 23rd. - 9:00 a.m.

• Report on Re-organization & Incorporation of New Public Health Divisions	Dr. Ron Levine, DHHS
• Future Subcommittee Meetings	

Adjourn

JOINT APPROPRIATIONS SUBCOMMITTEE
ON HEALTH AND HUMAN RESOURCES

OCTOBER 21, 1997

The Joint Appropriations Subcommittee on Health and Human Resources met on Tuesday, October 21, 1997, at 10:00 am, in Room 643 of the Legislative Office Building.

Senator Bill Martin, Cochair presided, welcoming all members and guests present. Cochair's Representatives Gardner, Cansler and Clary also welcomed everyone to the meeting.

Senator Martin begin by looking at the first item on the agenda and suggested the possibility of having some on site meetings in the area.

Senator Phillips expressed his concern for the functioning of regional offices of the Department; what is happening at institutions of the deaf. Constituents continue to voice concerns to him; will kids in the deaf institutions after 7th or 8th grades have somewhere to go to complete 12 years of education?

Representative Gardner stated that there is a report pending that will answer some of Senator Phillips' questions. Mary Ellen Sylvester stated some reports had been placed in the members notebooks. (Material attached to minutes.)

Representative Nye asked when would Medicaid reductions be addressed. Senator Martin asked the staff to tell the Committee some of the things it will be discussing.

Karen Hammonds-Blanks presented a list of subjects to be addressed by the Department during September, October and November meetings. Also grants will be discussed in November or December. She continued with a schedule of when particular items will be discussed.

Senator Martin called on Dr. Bruton for his comments and organizational changes and related issues. (Attached to minutes). Dr. Bruton offered a welcome and expressed how much he had missed his association with legislators. He gave an overview of the organization chart for the Department and proceeded with an overview of the Peat Marwick Study.

Senator Clark asked how the Personnel Office inter-relates with other departments since they report directly to the Secretary. Dr. Bruton requested that Steve Davis from his office get together with Senator Clarke to discuss

Senator Clarke's concerns.

Representative Gardner expressed concerns for $500,000 that has already been spent or a proposal for it to be spent.

Karen had copies of a portion of the report for recommendations by Peat-Marwick made but not mandated. The explanation from this report answered Representative Gardner's concerns. It was determined that the Department chose not to carry out this particular task as it was not mandated. (Handout attached to minutes.)

Senator Martin requested a meeting of Cochairs and the Department to determine which items were chosen to implement and which were not.

Senator Martin suggested that one thing that would be helpful relative to key staff changes in the Department would be for the Secretary to give a review of changes after lunch, and Dr. Bruton agreed to do this.

Representative Adams inquired about the diversity of the organizational chart and changes. Secretary Bruton cited some diversity between race and gender, however, he kept the same Assistant Secretaries.

Jim Edgerton gave a presentation on 4 AEA (Emergency Assistance). He proceeded to give an overview of where the Department is with their ACTS program, (Automated Collection and Tracking System). The federal people will come to the Department in November and December to certify the program. Jim called on Randy, with the Department, to expound on Rollouts and implementation of ACTS.

At the request of Senator Dannelly, Randy explained the meaning of Rollout relative to ACTS. She explained it meant going on line one county at a time. Senator Dannelly commended the Department for doing a great job of implementing ACTS. North Carolina is the only state to have completed implementation of ACTS and it came in $6 million under the budget.

Senator Martin asked if the Department had any state available to make a comparison with on what the situation was before, prior to Rollout. Randy stated it would be the next calendar year before they would have collected accurate statistics to make the comparison. Representative Gardner also congratulated the Department on a job well done.

Secretary Bruton reiterated Senator Dannelly's comments relative to giving the Department credit for putting the system into place before any other state in the union and said that the Department has contracted with a company to maintain a database of new hire reports. Randy said that the new hire directory will help to spot folks.

Representative Hurley asked if law enforcement agencies have access to this information in new hire. Randy stated, not at the present time.

The meeting adjourned for lunch at 12:30 p.m.

The meeting reconvened at 1:35 p.m.

Peter Leosis presented an overview on the State Board of Education's ABC plan in its residential schools.

Senator Phillips asked why was there a restriction of 120 days? Peter explained that this is what the special provision called for. Senator Martin explained further, stating that it was also to lend itself to continuity as it relates to training schools.

Mark Lodge gave an update on the law suits involving the Department According to the Office of Administrative Hearings there are 350 open cases, mostly child support enforcement cases. He further explained and gave a review of four significant law suits. (Handout attached to minutes).

Senator Martin asked about the changes that have taken place within the Department since adjournment of the session , regarding Adam, Barker and Caleb vs. State. Mark suggested that Peter Leosis could answer that question but he had already left for another meeting.

Senator Phillips stated relative to looking at the aforementioned cases, he feels that the state should take responsibility for child protection entirely.

Senator Dannelly asked if there are any other states in the same situation or any worse. Kevin Fitzgerald said that there are 14 other states experiencing the same circumstances, at least those who are operating with the same state/county relationship that we are.

Representative Watson posed a question regarding a case she was directly involved with that she had Julia Howard to follow up on in her absence.

Kevin assured Representative Watson that he had staff working on it presently and that they would discuss the status privately. She also expressed concern for constituents feelings that they are not being served by her or the Department and she wanted to know if they need additional staff to expedite processes.

Representative Gardner said that when it comes to children and elderly being protected, she feels that it is the responsibility of the state to do whatever it takes to make them feel secure.

Senator Dannelly said he believes it to be the responsibility of the legislators to see to it that the Department has staff and funds to carry out the job it takes to guarantee the safety of these folks.

Dr. Bruton gave an overview of the report on the Governor's Juvenile Crime Commission. He believes we have to continue intensive care of these children because they don't receive it at home and public schools don't want them because of their history of disruption.

Senator Martin asked Dr. Bruton if he anticipated that the recommendations would end up being a balanced package of punishment and prevention. Dr. Bruton affirmed this question. Senator Martin stated he also assumes there will be discussion of preparation for a job possibility. Dr. Bruton said that he did not think so at least from this spectrum.

Lynda McDaniel, DHHS gave an overview of Adult Care Homes Report. (Handout attached to minutes).

Representative Adams asked how North Carolina compared to other states in case management that applies to one hour and thirty minutes per month. The average is a higher case load in North Carolina. North Carolina is lacking 48 minutes of time per case and needs to address a personnel issue.

Representative Cansler asked in respect to cost report is there any analysis being done of adult care homes in terms of private pay as opposed to special assistance in relation to quality care. Lynda replied that such an analysis is not available presently but it is in the works.

Lynda proceeded with a report on the adult care bed vacancy report. (Handout attached to minutes).

Senator Martin asked for any ideas any one might have on site visits.

The meeting adjourned at 4:25 p.m.

Senator William Martin, Cochair
Joint Subcommittee on Health and Human Resources

Sarah J. Murphy, Acting Committee Clerk (From tapes)
Joint Subcommittee on Health and Human Resources

10/21/97

Reporting Requirements, Senate Bill 352

SECTION XI. Department of Human Resources

Section	Topic	Committee	Due Date
11.2	Reorganization Plan	Appropriations	Ongoing
11.4	IVA-EA Funding	Appropriations	May 1998
11.5	Proposed Health Care Standards	General Assembly	4/1/98
11.5	Children's Health Insurance Plan	General Assembly	May 1998
11.6	Human Services Grants	Jt. Gov. Ops.	Prior to Award
11.7	Provider Reimbursement Rate Study	Appns./FRD	
	Status Report		2/1/98
	Final Report		2/1/99
11.10	Medicaid Growth Reduction Plan	Appropriations	
	Report on intended actions affecting 1998-99		9/1/97
	Plan through 2001		4/1/98
11.21	Adult Care Homes Annual Report	Jt. Gov. Ops./FRD	10/1/97
11.27	Caring Program for Children Annual Report	Jt. Gov. Ops.	5/1/98
11.28	Quarterly IRMC Review of ACTS	Appns./FRD	9/30/97
11.34	Carolina Alternatives Progress Rpt.	Gen'l Assembly/FRD	5/1/98
11.35	Willie M. Reports	FRD	Periodic
11.36	Thomas S. Progress Report	General Assembly	4/1/98
11.37	Thomas S. Cost Containment Measures	Appns./FRD	12/1/97 & 5/1/98
11.40	Special Alzheimer's Units Reports	Appns./FRD	3/1/98
11.42	Study of Substance Abuse Treatment Programs	Jt. Gov. Ops.	Unspecified

11.44	Efficiency Study of Psychiatric Hospitals	Appns./FRD	4/1/98
11.47	Whitaker School Replacement Facility Status Report	Appns./FRD	5/1/98
11.49	Study Downsizing of MR Centers	Appns./FRD	3/2/98
11.51	Annual Reports on Wilderness, Coach Mentor Training, and Gov.'s 1-on-1 Programs	Jt. Gov. Ops.	10/1/97
✓11.55	Smart Start Progress Reports	Jt. Gov. Ops.	Quarterly
11.57	State Child Fatality Review Team		
	Activity Report	Appns./FRD	Quarterly
	Final Report	General Assembly	5/18/98
✓11.60	ABC's Plan for DHR Schools	Jt. Leg. Ed. Oversight	
	✓Interim Report		10/1/97
	Final Report		4/1/98
11.61	Div. of Svcs. for the Blind Performance Audit	Appns.	1/1/98
11.69	Study of Adult Care Home Bed Vacancy Rates	Appns.	2/1/98
11.71	Adult Day Health Care Medicaid Study	Appns.	5/1/98
11.71	Comparison of Medicaid Eligibility Requirements for In-home and Institutional Care Services	Appns./Aging Comm.	3/1/98
11.73	Study of Alt. Living Arrangements	Appns./ Aging Comm./FRD	5/1/98

PART V. DHR Block Grant Provisions

Report on Special Children Adoption Fund	Appropriations	5/1/98
Report on Use of TANF and SSBG Funds for Substance Abuse Services and Reduction in Out-of-Wedlock Births	Appropriations	1/1/98

DEVELOPMENT OF REORGANIZATION PLAN 10/21/97

Section 11.2. (a) The Department of Health and Human Services shall, using the report of KPMG Peat Marwick, L.L.P. to the General Assembly dated March 20, 1997, develop and begin implementing a plan to reorganize the Department of Human Resources. The reorganization plan shall be designed:

(1) To structure planning, management, and service delivery around a strategic shared mission and long-range vision for the Department;

(2) To better achieve a consolidated family-center services orientation that facilitates identification of gaps in services, improvement of efficient and effective access to services, and reduces fragmentation of leadership, management, and service delivery;

(3) To facilitate a system of incentives within the Department and within local agencies that will reinforce personnel efforts at integrated services delivery; and

(4) To enable assessment of program performance in terms of actual client outcomes, effective and efficient service delivery, and the impact services and departmental functions are having in the lives of clients, rather than in terms of process measures.

(b) With funds from within the Department, and in consultation with the House and Senate Appropriations Subcommittees on Human Resources, the Department of Health and Human Services shall engage an entity with proven expertise to provide the Department leadership and management with the knowledge and tools needed to ensure a change in departmental culture that creates an environment:

(1) Where there is an understanding and appreciation for a departmental mission and primary goals that portray a coordinated system of services, rather than a group of independently operating group of services;

(2) Where, although the Department delivers few direct services, a client needing multiple services can have them delivered in a coordinated manner through local governing entities and by local service providers;

(3) Where counties have the opportunity, where practicable, to develop approaches to service delivery that work best for them;

(4) Where the Department can restructure around functions rather than programs; and

(5) Where the Department can develop an internal management capacity for strategic planning, program planning and evaluation, and formal senior management reviews, on a regular basis, of client needs, program performance, and issues related to resource allocation and risk assessment.

(c) The Department of Health and Human Services shall give very strong consideration to establishing the following service delivery functions: services, regulation, institutional management, education, and health care financing.

(d) The Department of Human Resources shall give very strong consideration to establishing the following coordination and infrastructure functions: information services and performance services.

KPMG Peat Marwick LLP

Report to the Commission on the Reorganization of the Department of Human Resources

Key Points & Recommendations

1. DHR must fundamentally change its role as a regulatory and program management agency.

2. Counties should be allowed to fashion a human services delivery structure that meets local needs and conditions.

3. DHR must reorganize itself in ways that promote integrated program policy, partnerships with local service deliverers, and an outcomes-based approach to
measuring results.

4. Develop a focused mission that is clearly understood by all players in North Carolina's human services delivery system.

5. Coordinate services internally to model an integrated approach to service delivery.

6. Remove program silos by restructuring around functions, rather than programs.

7. Align related services along functional lines through creation of five divisions.

8. Create a local services coordination unit that provides a "single face" of DHR to the state's service providers.

Key Points & Recommendations (continued)

9. Develop an information technology infrastructure that supports that state's entire human services delivery system.

10. Create a DHR "to-be" Organizational Model that reflects the principles and structures incorporated in the recommendations in this report.

Specifically KPMG recommended five service delivery functions:

- ***Division of Services:*** To develop program policy, deliver services and coordinate the delivery of services by local providers directly to the citizens of North Carolina.

- ***Division of Regulatory Services:*** To provide regulatory guidelines, licensing services, and program integrity assurance.

- ***Division of Institutional Management:*** To coordinate the management of DHR institutions, especially with regard to common functions, such as building, maintenance, and food.

- ***Division of Education Services:*** To provide program policy and manage the blind and deaf schools and the educational components at the training schools and mental health institutions.

- ***Division of Health Care Financing Services:*** To carry out administrative and regulatory tasks associated with the North Carolina Medicaid program.

KPMG Peat Marwick LLP

Report to the Commission on the Reorganization of the Department of Human Resources

Key Points & Recommendations (continued)

In addition, KPMG recommended the establishment of two coordination and regulatory functions:

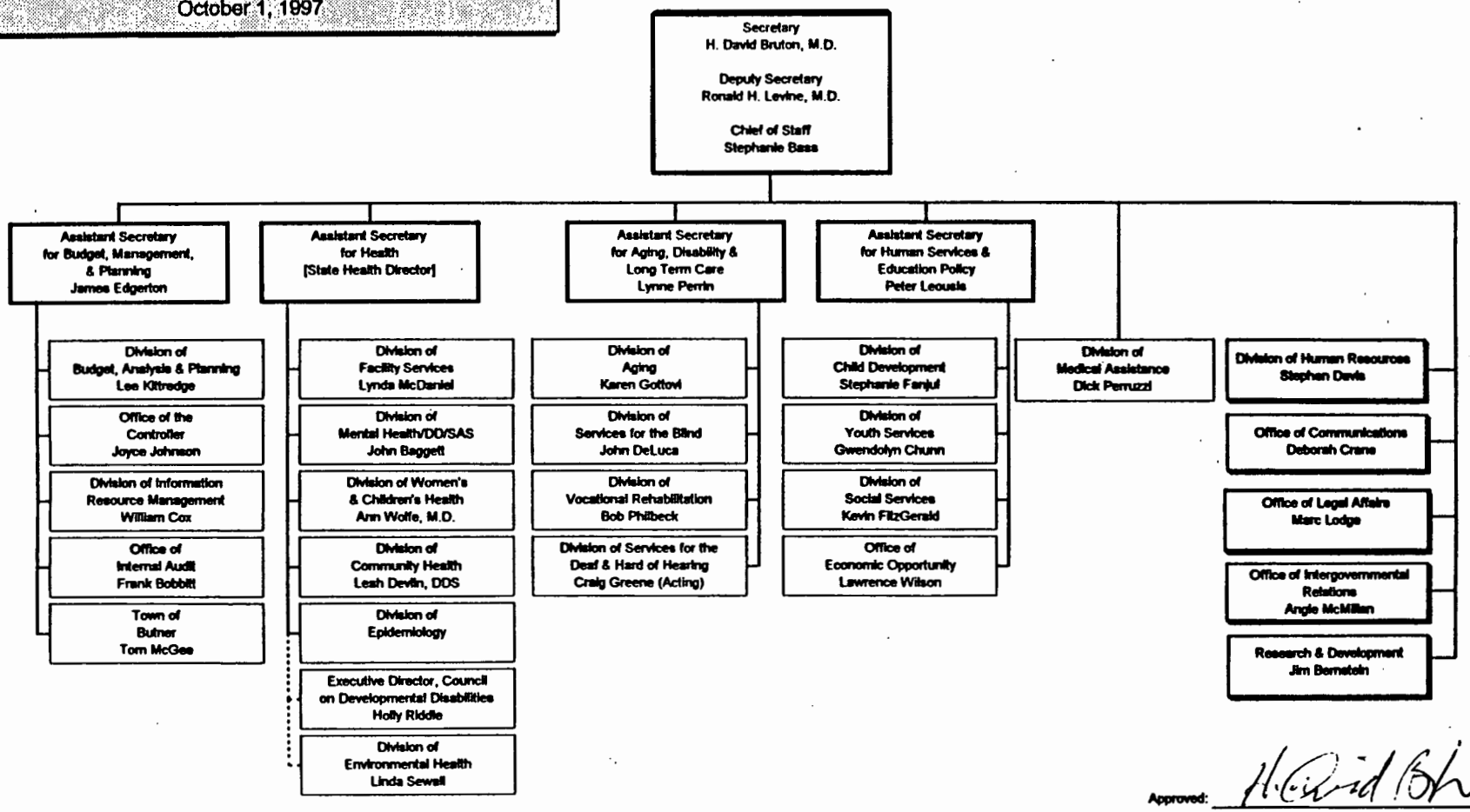
- ***Information Services:*** To develop the information technology infrastructure necessary to support program service delivery.

- ***Performance Services:*** To evaluate program performance and identify opportunities for improvements.

Fiscal Research Division
October 21, 1997

N.C. Department of Health and Human Services

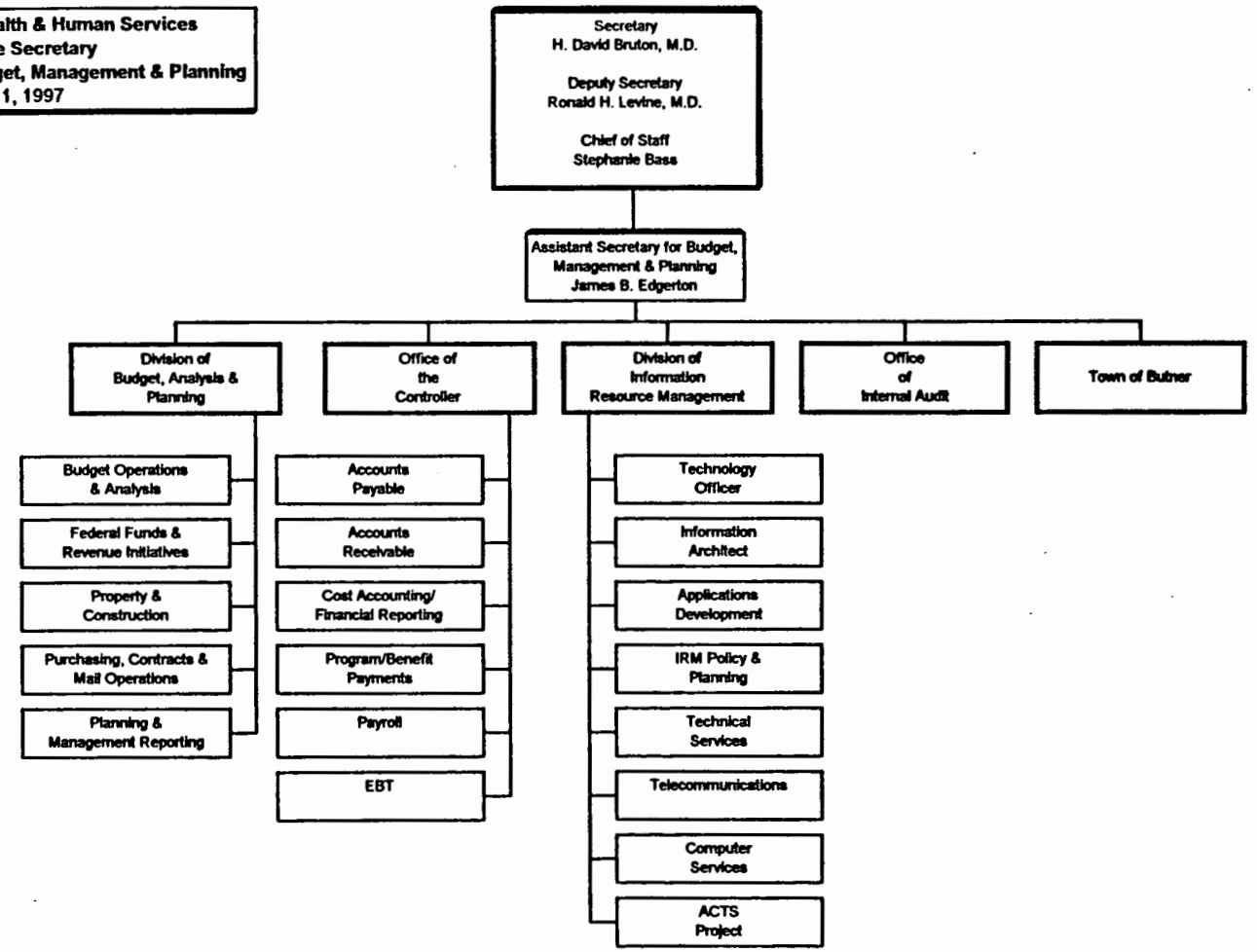
October 1, 1997



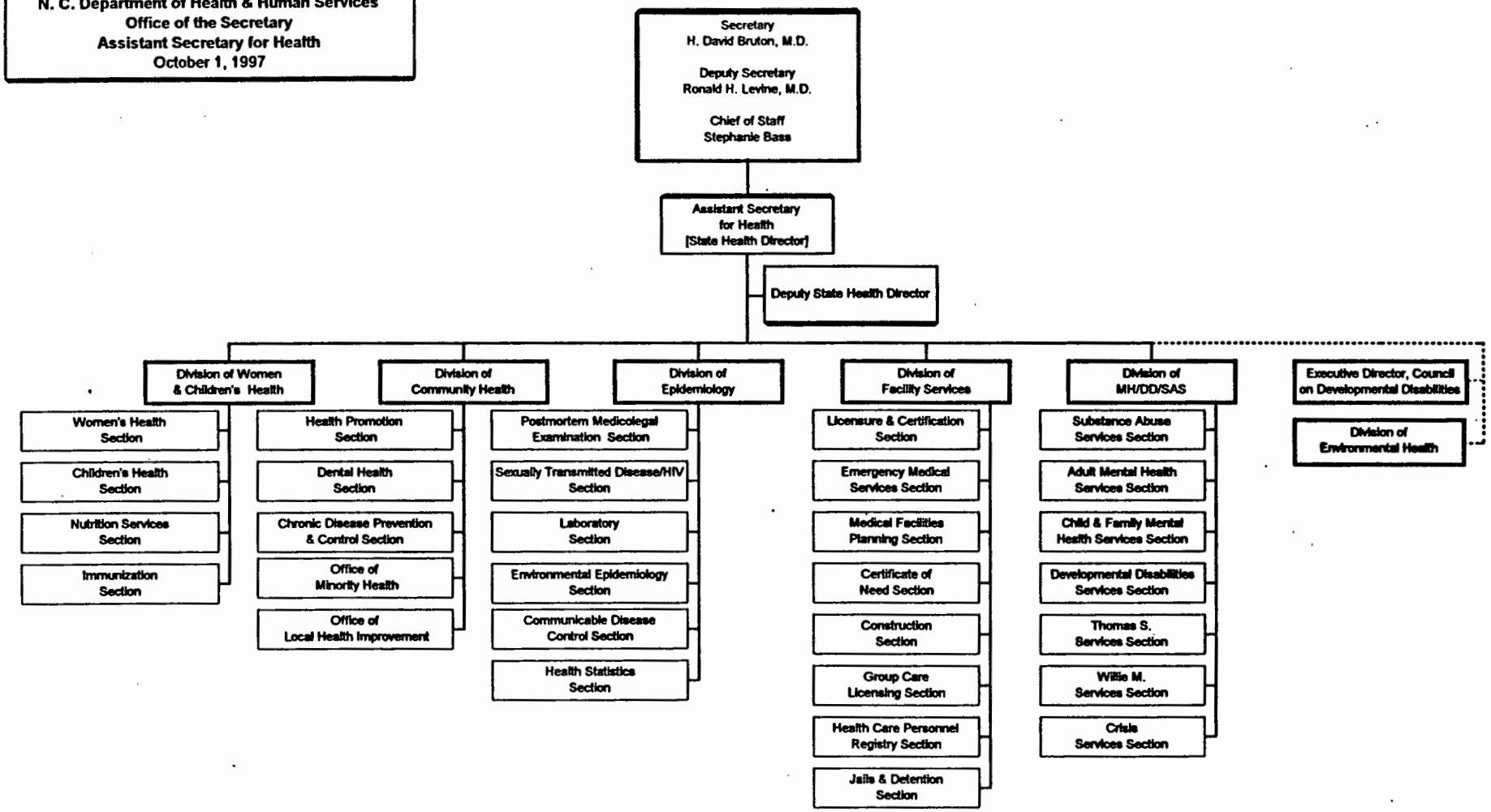
Approved: H. David Bruton

10/21/97

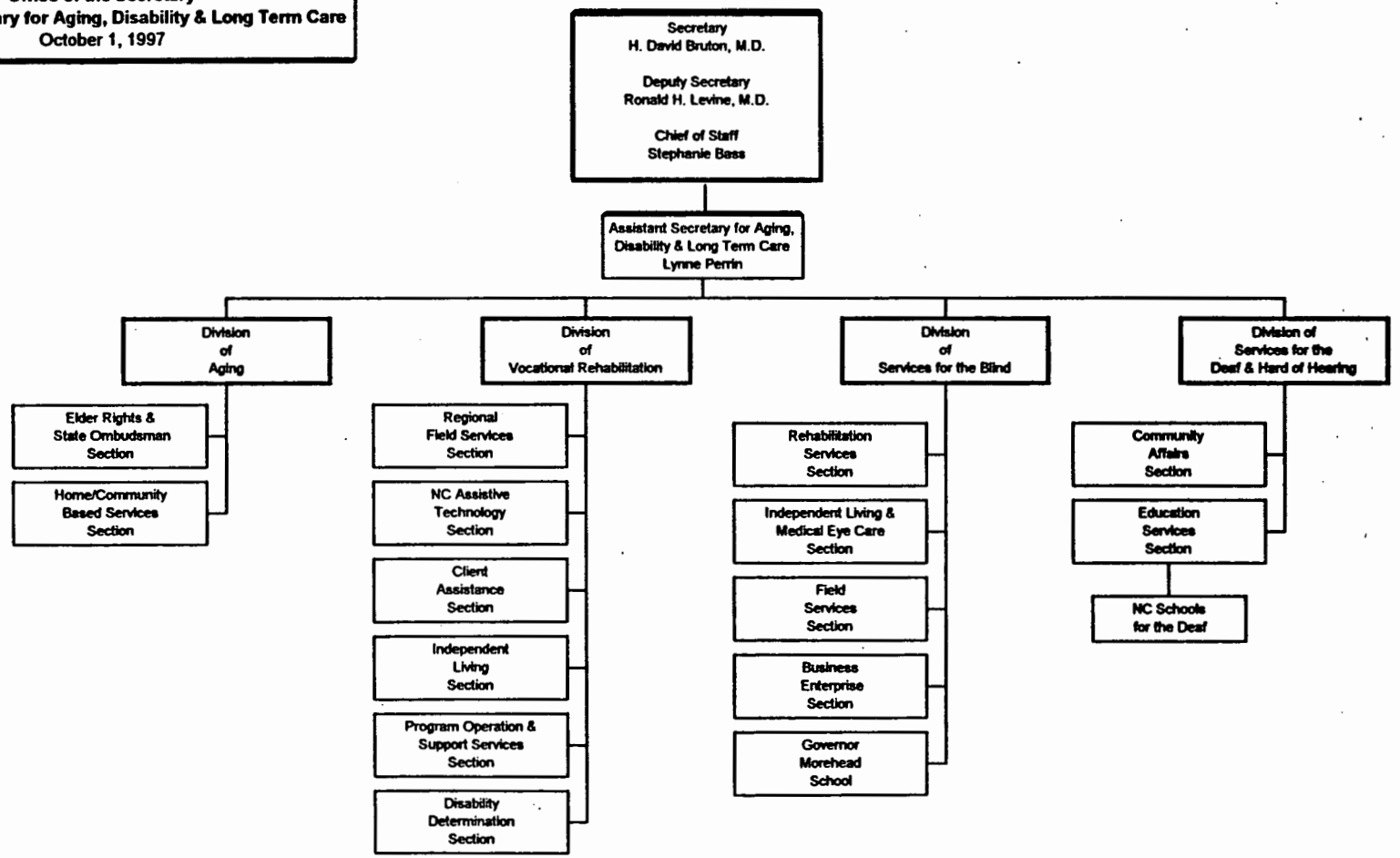
N.C. Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Budget, Management & Planning
October 1, 1997



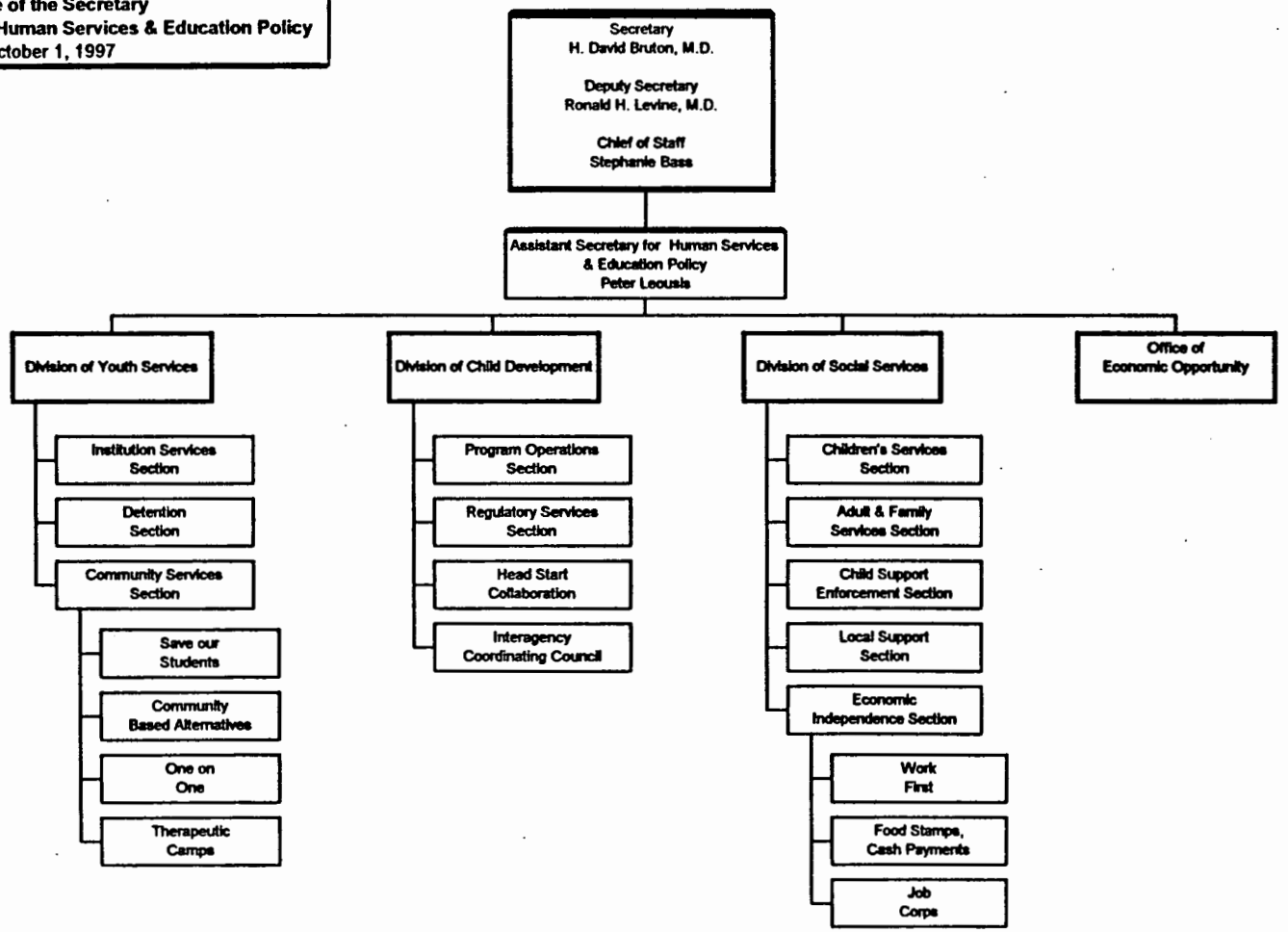
N. C. Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Health
October 1, 1997



Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Aging, Disability & Long Term Care
October 1, 1997



Department of Health & Human Services
Office of the Secretary
Assistant Secretary for Human Services & Education Policy
October 1, 1997



North Carolina Child Support Enforcement

ACTS

Automated Collection and Tracking System

6/21/97

ACTS Implementation

- Statewide implementation completed 9/15/97
- 413,000+ cases
- $25-30+ Million per month in disbursements
- Responding to 750+ calls to ACTS Help Desk
- Full functionality based on 1988 FSA
- Current with all 1997 PRWORA requirements
- Request for Certification Review sent 9/17/97
- Collections Jan - Aug 1997 up 9.5% over 1996

ACTS Implementation

- Pilot Operations (Wilson & Duplin) - Aug 95
- Two stage implementation
  - Data conversion/clean up (2-3 months)
  - Full cutover
- Rollout 1 - Nov 96 Feb 97 (14 offices)
- Rollout 2 - Jan 97 April 97 (14 offices)
- Rollout 3 - Mar 97 June 97 (16 offices)
- Rollout 4 - May 97 Aug 97 (13 offices)
- Rollout 5 - July 97 Sept 97 (25 offices)

ACTS Implementation

Actual Costs Thru 7/31/97

Total Cost	$59.7 M
Planning	.4 M
Personnel	19.7 M
Contract Labor & Hardware	31.6 M
SIPS etc.	7.4 M
Other Misc	.6 M
Federal Share	$49.7 M **
State Share	$10.0 M **

(** Retro 80% match -> Fed = $50.5, State = $9.2M)

ACTS Implementation

Estimated Costs Thru 9/30/97

Total Cost	$62.8 M
Planning	.4 M
Personnel	20.8 M
Contract Labor & Hardware	32.7 M
SIPS etc.	8.3 M
Other Misc	.6 M
Federal Share	$52.9 M
State Share	$ 9.9 M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Status of

KPMG Peat Marwick Recommendations

October 21, 1997

10/21/97

Status of
KPMG Peat Marwick Recommendations

RECOMMENDATION	STATUS
• DHR should implement an ongoing, comprehensive planning process clearly understood by all who are involved in the human services delivery system.	DHHS has established a planning function within the Division of Budget, Analysis and Planning. We are currently restructuring and continuing to integrate our planning processes.
• DHR should consider legislation that would rename DHR to the Department of Human Services (DHS).	Department was renamed Department of Health and Human Services (DHHS).
• DHR's executive staff should be structured with an orientation toward strategic issues and high-level decision making.	We have established an executive management team made up of all direct reports to the Secretary. This is the team that the Secretary uses for strategic issues and high-level decision making. This is also the mechanism for achieving enterprise-wide integrated decision-making.

RECOMMENDATION	STATUS
• DHR should create an executive management team that includes the Secretary, an Assistant Secretary for Administration and Finance, and a new Assistant Secretary for Operations.	Same as above.
• Establish a single Services Division for service policy development and delivery coordination.	Extra level not needed - service delivery and policy development coordinated at Executive Committee level
• Consolidate North Carolina's economic programs into an Economic Services Section to promote a holistic approach to delivering financial support services.	Assistant Secretary for Human Services and Education Policy (Peter Leousis) will be responsible for coordinating these functions which are located within the Divisions under him.

RECOMMENDATION	STATUS
• Combine the program planning and policy component of Children's Services and the front-end Youth Services to create a Child and Youth Services Section.	Same as above. The Governor has appointed a Juvenile Crime Commission that will be looking at these issues.
• Combine the Division of Aging and DSS's Adult Services section to form an Adult and Aging Services Section	Study currently being conducted to determine the appropriate way and time to implement.
• DHR must fundamentally change the nature of its internal and external relationships, moving from a role as a regulator and program manager.	We are currently working to implement these recommendations through the new organization structure. We also plan to delegate more service to the local levels.

RECOMMENDATION	STATUS
• DHR must establish a new role that focuses on policy development, leadership, and collaboration to create an integrated system that facilitates service delivery through outcomes-based performance.	The Department is currently reviewing and improving its outcome measures, and we will begin a management reporting process in November. With the devolution of responsibilities, we plan to use outcome measures to measure performance. This is exactly the direction of our reorganization.
• DHR should create a Policy Coordination and Service Delivery Section to coordinate DHR policy across Service Domains and provide a single face of DHR.	The Department will use the Assistant Secretaries and the Executive Management Committee to coordinate DHR policy across Service Domains. No new bureaucracy needed.
• DHR should use regional teams of consultants to represent DHR to local service deliverers in assigned regions which are consistent across programs.	The Department is just beginning to look at its regional structure now that the public health programs and the former DHR Divisions have been combined into a new DHHS.

RECOMMENDATION	STATUS
• Counties should be allowed to fashion a human services delivery structure that meets local needs and conditions.	We will support any human services delivery structure the counties fashion. We will encourage coordination and integration.
• The population minimum law set by the General Assembly for service delivery redesign should be rescinded.	We will encourage combining services where that makes geographic and economic sense.
• DHR should deliver state-administered services through a regional approach that facilitates coordination of services in groups of counties which are the same across all programs.	Under study.
• Create a local educational agency (LEA) under a DHR Division of Education Services to administer DHR schools.	Education policy will be the responsibility of the Assistant Secretary for Human Services and Education Policy. A cross-Department education management team has been established to assist him.

RECOMMENDATION	STATUS
• DHR should build on recent funding and budgeting changes within and external to DHR by institutionalizing information system policy and priority-setting mechanisms that address cross-Division system issues and supporting service delivery consistent with the Guiding Principles.	Currently being implemented based upon Automation Plan that was presented to the 1997 General Assembly. We are taking an enterprise-wide view of automation. Probably the most important effort underway in DHHS.
• DHR should begin planning a DHR systems infrastructure and application systems that build on common core business needs and support the entire human service delivery structure.	Currently being implemented. High-level steering team has been established which includes members from the Executive Management Committee, County Commissioners' Association Division, and local DHHS Directors.

RECOMMENDATION	STATUS
• DHR should implement system support for an integrated services delivery strategy through an "adaptive" systems approach that breaks large projects into multiple smaller ones within an overall project vision. These "adaptive" project components should be funded separately.	Currently under implementation. This is how we are developing future automation.
• DHR should implement a management plan for obtaining and maintaining needed information technology resources and skills.	Currently being developed.

file: kpmgrec.doc

Reinventing How We Serve the Citizens

Future

SEAMLESS DELIVERY

Employment

Housing

Child Care

Nutrition

Mental Health

Volunteers

Faith Community

Public Health

Referrals/
Placements

Smart Start

Medical Assistance

Technology Integrated Service Delivery

10/21/97

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

October 7, 1997

TO: Mary Ellen Sylvester
Fiscal Research Division

FROM: Lee Kittredge, Director
Division of Budget and Analysis

SUBJECT: Response to Your Request Regarding Status of Title IV-A Emergency Assistance Claims

The status of the above referenced appeal has changed since our last correspondence. The appeal has been heard and some decisions remain. The action and status as described below has occurred.

The appeal has been heard before the Departmental Appeal Board in Washington, D.C. and a decision rendered on September 19, 1997. There were four points on which the appeal was based and we succeeded in three of the four in contention. The Board ruled in favor of the State on secure facility, the cost allocation plan, and the issue regarding Deloitte and Touch's role. The Board ruled in favor of the Agency for Children and Family on the application/prior eligibility determination issue.

The State has thirty days from the date of the decision to document its expenditures for services which were provided to children after they were determined to be eligible for EA in order to receive a portion of the federal funds the State has claimed. The Division of Youth Services is currently documenting such and the Department will meet this deadline. We do not yet know the dollar amount the State will receive as a result of this documentation. Because the State won on three of the four points, we are now eligible to receive some portion of these funds once we complete the documentation.

A last option is for the State to take this case into U.S. District Court to further pursue the prior eligibility determination issue. A decision has not yet been made to pursue this avenue; however, we are researching and discussing this with the attorneys

who represented the Department at the Board and also with counsel from the Office of the Attorney General. We will know in the next few weeks what our action will be.

If you have further questions please let me hear from you.

BA/sb

cc: James B. Edgerton
Nina Yeager

10/21/97

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

SUMMARY OF SIGNIFICANT DHHS LAWSUITS

October 21, 1997

***Thomas S. v. Bruton,* C-C-82-0418-M (W.D.N.C)**

Mentally retarded adults who received treatment in state psychiatric hospitals.

***Willie M. v. Hunt, et al.,* C-C-79-294-M (W.D.N.C.)**

Children under 18 who suffer from emotional, mental, or neurological handicaps accompanied by violent or assaultive behavior.

***Adam, Burke, and Caleb v. State of North Carolina, et al,* 5:96-CV-554-BR (E.D.N.C)**

Children in Division of Youth Services custody alleging non-compliance with IDEA educational requirements.

***Alexander, et al v. Bruton, et al.,* C-C-74-183-M (W.D.N.C.)**

AFDC and Medicaid recipients regarding timely processing of claims by Departments of Social Services.

Cases under the *"Gammons"* theory.

Tort claims against State for alleged negligence of local Child Protective Service Workers.

10/21/97

DIVISION OF SOCIAL SERVICES
CHILD WELFARE SYSTEM IMPROVEMENTS
UPDATE - OCTOBER, 1997

1. Meet minimum staffing standards (CPS, Foster Care, Adoptions) in every county

Progress to Date: The Division of Social Services has surveyed all 100 county Departments of Social Services to identify staffing needs and has distributed the results. We are currently finalizing the schedule of county staff allocations.

The Division has also submitted a formal revision to our Title IV-E State Plan to expand the definition of activities that are reimbursable by the federal government under Title IV-E (Foster Care and Adoption Assistance) of the Social Security Act. With approval of the amended State Plan, we can begin claiming additional federal reimbursement for allowable child protective services activities that are meant to prevent foster care placement.

Next Steps: (1) Finalize the staff allocation by county; (2) Obtain federal approval of the amended IV-E State Plan; (3) Train county staff on changes in reporting their time. *Projected Implementation:* December 1, 1997.

2. Develop Comprehensive Training System for Children's Services Staff

Progress to Date: The Division of Social Services has informed all county DSS agencies of mandatory pre-service and in-service training for children's services social workers and supervisors effective January 1, 1998. It is planned that four regional training centers will be developed in Greenville, Greensboro, Charlotte and Asheville. Division staff have met with various University, Community College and AHEC Staff to determine the availability of space and to develop critical partnerships. Job descriptions for the new trainer positions have been written and we expect the positions to be posted in the very near future.

Next Steps: (1) Finalize the location and key partners for the 4 training centers; (2) Hire and train staff for the training centers. *Projected Implementation:* Jan. 1, 1998

3. Implement the Special Needs Adoption Fund

Progress to date: A committee composed of representatives from the North Carolina Association of County Directors of Social Services, six private adoption agencies, and the Division of Social Services met on October 9th to define guidelines for use of the Special Adoption Fund. The group was able to reach consensus on the critical issues: definition of "special needs," rate of payment, and methodology to establish a baseline for each county DSS and private adoption agency. Dr. Lynn Usher from UNC-CH, who was present at the meeting, will analyze data to help establish the baseline.

Next Steps: (1) Establish baselines for all 100 counties and participating private adoption agencies; (2) Inform all agencies of how the Fund will operate and of the number of Decrees of Adoption required to meet their baseline; (3) Finalize methodology for payment system; (4) Closely monitor payments to assure that funds are used as intended; (5) Provide regular reports to agencies and legislators on use of funds; (6) Evaluate the impact of the Special Adoption Fund. *Projected Implementation:* Payments to begin by Jan. 1, 1998.

4. Implement Comprehensive Child Fatality Review Process

Progress to date: The Division of Social Services has implemented a comprehensive child fatality review process using a multi-disciplinary team approach. The reviews are conducted following the fatality of a child who received child protective services from a county DSS agency within 12 months preceding the death. Job descriptions have been completed for the 2 new staff positions who will develop particular expertise in this area of work.

Next steps: (1) Hire and train fatality review specialists. *Projected Implementation:* December 1, 1997.

5. Competitive Grant Program for Community Child Protection Teams

Progress to date: The Division has finalized plans to administer the grant program. A CCPT can apply for a grant not to exceed $50,000 annually.
There will be a two year limit on funding, with the second year extension contingent on the evaluation of the program for the first year.

Next steps: Submit RFPs. *Projected Implementation:* July 1, 1998.

6. Ensure Professional Liability Insurance

Progress to date: Division staff have met with representatives of the Attorney General's Office and the Dept. of Insurance to identify alternative approaches to this issue.

Next Steps: Continue to identify and compare alternative strategies. *Projected Implementation:* July 1, 1998.

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Grounds for Termination of Parental Rights (HB 896) Changes to NCGS: 7A-289.32(3), (7)	• Amends ground for TPR so that the required efforts within 12 months of child's placement are focused on parents' efforts rather than DSS efforts. • Amends ground for TPR based on parental incapability to include substance abuse. • Changes time frame for TPR for incapability from "child's minority" to "the foreseeable future."	• Facilitates termination of parental rights in cases in which parents are not making progress toward reunification, are habitual substance abusers, or are otherwise incapable of providing a safe, nurturing environment for the child. Continues requirement that poverty is not ground for termination. • *Agencies should re-evaluate children who have been in foster care for more than 12 months to determine if termination of parental rights would be appropriate to meet the child's need for a safe, permanent home.*
Reasonable Efforts and Safety (HB 896) Changes to NCGS: 7A-517 (25a), (25b) 7A-577 7A-657	• Defines "reasonable efforts" as the diligent use of preventive or reunification services when a juvenile's remaining home or returning home is consistent with achieving a safe, permanent home for the juvenile within a reasonable length of time. • Defines "safe home" as one in which a child is not at substantial risk of abuse or neglect. • Allows court to discontinue reunification efforts at any hearing if reunification would be futile or is inconsistent with juvenile's safety.	• Facilitates safe, permanent placement for children when agency reunification efforts are inconsistent with the best interests of the child. • *The child's safety is primary in considering continued efforts toward reunification. It is appropriate to recommend to the court at any hearing that reunification efforts be discontinued when these efforts have been futile or are inconsistent with the child's safety.*
Timely Court Reviews (HB 896) Changes to NCGS: 7A-657	• Establishes two new required court hearings: 1) 2nd custody review six months following 1st custody review; and 2) permanency planning hearing within twelve months of placement. • Requires court to provide notification of the hearing and, if the child is not returned home, to enter an order as to the best plan of care to achieve a safe, permanent home for the juvenile within a reasonable period of time.	• Provides for more timely court reviews during a child's critical first year of foster placement. • *Agencies should be considering options for permanent placements for children removed from their homes throughout agency involvement with family, and be prepared to make recommendations at the permanency planning hearing which is held within 12 months of placement.*
Missing Parent (HB 896) Changes to NCGS: 7A-577	• Requires court to inquire about parent missing from hearings at every nonsecure custody hearing; authorizes judge to require specific efforts to locate missing parents.	• Should result in increased participation by parents in nonsecure hearings; • Places increased responsibility on DSS to ensure parental involvement in hearings. • *The judge may order specific efforts on the part of DSS to locate the parents.*

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Relative Placement (HB 896) Changes to NCGS: 7A-576 7A-577 131D-10.6A	• Requires judge, at every non-secure custody hearing, to consider and give priority to placement with a relative who is willing and able to provide proper care and supervision in a "safe home". • Allows review hearings to be waived if child is in stable relative or kinship placement for one year and relative/kin has been designated custodian or guardian of the person of the juvenile. • Allows provisional foster care licensure for six months for persons who have not completed training requirements.	• Should result in increased placement of children with relatives when appropriate care and supervision will be provided. • *Relatives should be given priority as potential placement resources for children in care when suitable.* • *Relatives may be approved for provisional licensure as foster parents prior to completing mandated training.* • *Reviews may be waived in stable, legally secure, permanent placements with relatives or other kin in which the relative/kin has been designated custodian or guardian of the person of the juvenile.*
Investigations of All Children in Home (HB 896) Changes to NCGS: 7A-544	• Requires DSS to ascertain immediately after a report is received whether other children live in the reported child's home and, if so, initiate an investigation on all children in the home. • Requires judge to inquire about status of other children remaining in home at every nonsecure custody hearing.	• Requires more immediate assessment of all children in home and will help to ensure that other victim children are identified earlier in the investigative process; • Ensures that the needs of all children in a household are addressed in court. • *All children living in the same household (including group homes and multi-family households) with the alleged victim child at the time of the report must be opened for a CPS investigation. Investigations on "other children living in the home" must be initiated within 24 hours for reports of abuse, or within 72 hours for reports of neglect or dependency. Children who come into or are born into the home during an open investigation must be evaluated as victim children.* • *If a report is investigated in a residential facility with more than one living unit, only those children exposed to possible maltreatment by the alleged perpetrator/caretaker should be opened for investigation.*
Neglected Juvenile Definition (HB 896) Changes to NCGS: 7A-517	• Amends the definition of "neglected juvenile" to state that in determining whether or not a juvenile is neglected, it is relevant whether he or she lives in a home in which another juvenile in the home has been subjected to abuse or neglect.	• Provides the legal basis for including other children in the home in a neglect petition. • Should result in more children being assessed for their need for protective services.

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Guardian of the Person (HB 896) Changes to NCGS: 7A-585 7A-657	• Defines rights and responsibilities of a juvenile's guardian of the person appointed by the juvenile court. • Clarifies that appointment of guardian of the person of the juvenile is also an option for judges at the conclusion of review hearings.	• Clarifies guardianship as an option for legal permanence for children in foster care and specifies the legal rights that guardianship of the person of the juvenile entails. • Specifically authorizes persons so named to sign for a child to marry, to enlist in the armed forces, to enroll in school, and to receive needed remedial, psychological, medical or surgical treatment • *This law will increase options for permanence for children*
State Authority to Intervene in County DSS Service Delivery (HB 896) Changes to NCGS: 108A-74	• Establishes procedures through which the State can intervene in child welfare services in counties that do not provide those services in accordance with State law and applicable rules. If such circumstances pose a substantial threat to the safety and welfare of children in the county, the State may assume control and provide child welfare services through contract or direct operation.	• Provides safeguards for children by providing immediate state-level assistance and oversight to struggling county child welfare programs. • *If the Secretary of DHHS determines that a county agency is not providing Children's Services in accordance with law and rule, or fails to demonstrate reasonable efforts to do so, he/she may institute corrective action, withhold Federal and State funding, and/or assume control of the agency*
Legislative Study Commission on Children and Youth (HB 896) Changes to NCGS: 120-208 to 120-210	• Creates legislative study commission to study and evaluate the system of delivery of services to children and youth and to make recommendations to improve service delivery.	• Resulting recommendations could affect requirements for services.
Dependent Juvenile Definition (HB 153) Changes to NCGS: 7A-517(21)	• Amends definition of dependent juvenile by deleting reference to "physical or mental incapacity" as the cause of the parent's inability to provide for a child; applies to adjudications of dependency made on or after October 1, 1997.	• Broadens the legal basis for declaring a child dependent.

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Disclosure of Information After Fatalities or Near Fatalities (HB 949) Changes to NCGS: 7A-675.1	• Requires public agencies, upon request and under certain conditions, to provide a written summary of findings and information following a child fatality or near fatality resulting from suspected abuse, neglect, or maltreatment. • Sets parameters for disclosure of information.	• Allows agencies to disclose information to the public following a child fatality or near fatality when a person is criminally charged. • Agencies can disclose a written summary of actions taken by the agency regarding that child, the results of the Child Fatality Review, confirmation of prior reports regarding the victim child, a description of the conduct of the most recent investigation and services rendered, and a statement of the basis for the department's decision. • Agencies are not required to disclose information if disclosure would cause danger or harm to a child in the deceased or injured child's household; would jeopardize the State's ability to prosecute the defendant; would jeopardize the defendant's right to a fair trial; would undermine a criminal investigation; or is not authorized by federal law. • Persons requesting disclosure may apply to superior court for an order compelling disclosure if the agency has refused to provide the information.
Interagency Sharing of Information (HB 949) Changes to NCGS: 7A-675(h)	• Requires chief district court judge to issue an administrative order naming the agencies designated to share information relevant to cases in which abuse, neglect, or dependency petition was filed.	• Facilitates more sharing of information among service providers. • *Should result in more consistent, relevant services to the child and family and should reduce inappropriate duplication of services.* • *This law does not apply to information in which confidentiality is protected by federal law.*
Criminal Records Checks (SB 207) Changes to NCGS: 131D-10.2 131D-10.3A 114-19.4	• Narrows definition of foster parents to only those adults licensed as foster parents; • Requires criminal records checks of all persons over 18 who reside in the family foster home; • Requires criminal record check for in-home care aides; forbids change of current employee from out-of-home position to in-home position if they refuse a criminal history check.	• Clarifies existing requirements for foster family homes. • 18 year olds must have a criminal record check if they are residing in the home at the time of the license. • Closes potential legal loophole for in-home caregivers who were on staff in another capacity.

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Waivers on Licensed Facilities (SB 1023) Changes to NCGS: 131D-10.6	• Requires form to request waiver of Commission licensing rules. • Requires waiver decision within 10 business days. • Requires study re: procedures for granting or denying licensure or waivers to Commission rules.	• Formalizes and expedites waiver request process. • Requires study of waiver/denial actions and report to General Assembly on or before 5/1/98. • *DSS staff will need to inform prospective foster parents of waiver procedures and provide a form to request a waiver.*
Changes to Adoption Laws (SB 162) Changes to NCGS: 48-2-502 48-2-503 48-2-604 48-3-702 48-9-102 48-9-303 48-2-601 48-3-603 48-3-201 48-3-602 48-1-101(8) 48-2-501 48-2-206 48-3-302 130A-108	• Information in adoption report to the court in an agency adoption must not lead to identification of former parent or family member; existing records should be screened and revised.. • Specifies when court can dismiss petition to adopt a child at any point between filing of petition and final order. Requires formal notice of dismissal. • Requires agency to give written acceptance of relinquishment of parental rights. • Extends confidentiality to the special proceedings index. • Removes "parent for whose child a guardian has been appointed" from list of those not requiring consent to adopt and adds Standby Guardians to guardian definition. • Allows waiver of court reports in stepparent adoptions in some situations. • After six months gestation, allows mother of unborn child, adoptive parents, or the agency to initiate a special proceeding to determine whether or not the consent of the biological father of the fetus is required to consent to adoption. Procedures outlined. • County DSS must prepare preplacement assessment if prospective adoptive parent has identified child they wish to adopt and cannot afford the cost of a preplacement assessment. • Provides that relinquishment shall become void if before placement with a prospective adoptive parent occurs, the agency and person agree to rescind the relinquishment. • Provides that the signing of a relinquishment no longer terminates the duty to support a child.	• Conforms statute to existing administrative rule. Report is required to be given to adoptive parent. • Adds procedures for dismissal of petition. • Written vs. oral acceptance • Makes clear that the final decree and the index are confidential. • Achieves consistency with new standby guardian statute. • Could lessen number of required reports to court. • Expected to be used primarily in private, independent adoptions. *However, this could impact DSS adoptions of very young children.* • Self-explanatory. • Clarifies that "unable to obtain" includes financial constraints. *Allows more time for prospective adoptive parents to be approved for a specific child Could increase # of preplacement assessments by DSS.* • Provides a mechanism to void a relinquishment similar to present provision to void consent. *No longer needs to be added to relinquishment form to be used.* • Returns to past position on support: duty to support only ends upon entry of *final decree of adoption.*

Summary
Child Welfare Legislative Changes
1997

DESCRIPTION	ACTION	POLICY IMPACTS / PRACTICE GUIDANCE
Allocation to Add Additional Child Welfare Staff (Special Provision)	• Additional appropriation to county DSS's to hire or contract for additional CPS, foster care, and adoption workers • Requires no local funding match for SSBG allocation	• Will ensure that every NC county will have enough children's services staff positions to meet national and state caseload standards.
Special Children Adoption Fund (Special Provision)	• Establishes a fund to provide additional money for participating licensed and private adoption agencies.	• Ensures that more funds are available to support children in adoptive placements.
State Child Fatality Review Team (Special Provision)	• Provides funding for two fiscal years to establish and maintain a multidisciplinary state child fatality review team to review deaths of children recently involved with DSS.	• State level, in depth reviews of child fatalities will lead to recommendations of improved coordination of services and reduction of the number of child deaths. • *There will be more comprehensive reviews of child fatalities by the State multidisciplinary review team.*
Required Pre-Service Training for Child Welfare Staff (Special Provision)	• Establishes pre-service training requirements for all child welfare staff hired on or after 1/1/98.	• Requires all new DSS children's services workers and supervisors to receive training prior to service delivery and annually thereafter. • *Agencies will need to plan for coverage until staff is trained and ready to assume duties.*
Professional Liability Insurance for Child Welfare Staff	• Allocates funds to purchase liability insurance for county child welfare staff.	• Will help to attract and retain qualified staff.
Grants to Community Child Protection Teams	• Allocates funds to increase the outreach capacity of the Community Child Protection Teams.	• Provides funds for CCPT's to establish creative outreach services in the community that will reduce risk to children. • *There is now a state coordinator for CCPT's in the Division of Social Services.*

Exhibit 14. Comparisons Between NC Domiciliary Care Residents and Residents in the ASPE 10-State B&C Home Study: Physical Functioning, Continence, Cognitive Status, and Age

AREA OF FUNCTIONING	ASPE B&C (1993)	NC DOM (1994)
Physical Functioning in ADLs		
Received *any* help from a person in dressing	21%	39%
Received *any* help from a person in locomotion/getting around inside	9%	26%
Received *any* help from a person in cutting food, buttering bread, opening cartons	8%	13%
Received *any* help from a person in eating**	5%	11%
Received *any* help from a person in transferring (e.g., from bed to chair)	8%	23%
Received *any* help from a person in toileting	12%	24%
Received *any* help from a person in bathing	45%**	66%
Received "hands-on"/physical help in one or more of Five ADLs*		
0 ADLs	78%	59%
1-2 ADLs	15%	21%
3-5 ADLs	7%	20%
Incontinence		
Bladder	23%	39%
Bowel	13%	23%
Moderately To Severely Cognitively Impaired	39%	64%
Bedfast/Chairfast (in room in bed or chair 22+ hours per day because of health problem)	7%	12%
Age:		
18-64	22%	30%
65-84	44%	46%
85+	34%	24%

* *Defined as including "hands-on" assistance with any of the following ADLs (excluding supervision/cueing): dressing, locomotion, toileting, transferring, or eating [but not merely cutting food or bathing].*

** *The data presented here are estimates, based on samples of homes and residents. In Appendix A, the estimates for each item are presented with the standard errors for the estimate.*

Exhibit 15. Comparisons Between NC Domiciliary Care Residents and Residents in the ASPE 10-State B&C Home Study: Selected Health Conditions and Assistive Devices**

Health Condition	*ASPE B&C 10-State Study (1993)*	*NC DOM CARE (1994)*
Self-reported "Mental, emotional or nervous condition"	33%	51%
Mental retardation/developmental disabilities*	11%	23%
Diabetes	11%	14%
Arthritis or rheumatism	42%	41%
Hypertension/high blood pressure	28%	26%
Asthma, emphysema or COPD	11%	12%
Multiple Sclerosis	1%	0.4%
Parkinson's	3%	3%
Cancer	7%	6%
Stroke last 12 months	6%	5%
Heart attack last 12 months	3%	2%
Fell during last 12 months	32%	34%
Use of Assistive Devices		
Cane	19%	13%
Walker	23%	14%
Wheelchair	15%	28%
Continence pads/briefs	15%	25%
Pressure relieving devices	6%	14%
Pureed diet/mechanically altered diet	0.6%	5%

* *ASPE and NC DOM Care sample of homes excludes homes licensed by Divisions of Mental Health or Developmental Disabilities; thus it does not include group homes for persons with MR/DD or homes specifically licensed for persons with mental illness.*

** *The data presented here are estimates, based on samples of homes and residents. In Appendix A, the estimates for each item are presented with the standard errors for the estimate.*

10/21/97

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt, Jr., Governor

H. David Bruton, M.D., Secretary

September 30, 1997

The Honorable Harold Brubaker, Speaker
North Carolina House of Representatives

The Honorable Marc Basnight, President Pro Tempore
North Carolina Senate
Legislative Building
Raleigh, North Carolina

Dear Representative Brubaker and Senator Basnight:

In accordance with Section 11.21 A of Chapter 443 of the 1997 Session Laws, I am submitting the enclosed annual adult care homes report. This report describes the status of the following: (1) rate-setting and financing of adult care homes; (2) quality assurance and enhancement of adult care homes; and (3) the process for the evaluation of the Adult Care Home Financing and Quality Assurance Program.

Questions regarding rate-setting and financing and the process for the evaluation of adult care home financing are to be addressed to James B. Edgerton, Assistant Secretary for Budget and Management. Questions regarding the remaining portions of the report are to be addressed to Lynne M. Perrin, Assistant Secretary for Aging and Special Needs.

Sincerely,

H. David Bruton, M.D.

HDB:db

cc: Tom Covington
Karen Hammonds-Blake
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ADULT CARE HOMES REPORT

FOR SFY 1996-97

PRESENTED TO

JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS AND FISCAL RESEARCH

PREPARED BY THE
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
October, 1997

INTRODUCTION

Section 11.21 A of Chapter 443 of the 1997 Session Laws (Senate Bill 352) requires the Secretary of the Department of Health and Human Services to report annually to the Joint Legislative Commission on Governmental Operations and the Fiscal Research Division of the Legislative Services Office on the planning and status of the following:

1. Rate setting and financing for adult care homes, including the use of Medicaid funds for personal care services;

2. Quality assurance and enhancement of adult care, including case management for residents with special care needs, monitoring of adult care facilities and specialized training of direct care staff; and

3. The process for the evaluation of the Adult Care Financing and Quality Assurance Program.

This report provides a summary of the progress for the state fiscal year of July 1, 1996, to June 30, 1997. Below are highlights of the year's activities, followed by sections addressing the areas noted above.

HIGHLIGHTS FOR SFY 1996-97

- Adult care homes submitted cost reports for the period of October 1, 1995 to September 30, 1996. As of June 30, 1997, 76 facilities failed to submit cost reports or request an exemption. These facilities were sent warning letters. Letters of intent to revoke licenses were sent to facilities that still failed to submit reports. (As of September 30, 1997, 28 facilities had not submitted cost reports and action on their licenses is pending.)

- The Adult Care Home Chart of Accounts for the period of October 1, 1996 to September 30, 1997, was revised with input from adult care home providers, advocates, the Fiscal Research Division and selected members of the General Assembly.

- The Department selected a sample of 110 cost reports of facilities that were licensed for six or fewer beds to perform agreed upon procedures for the period ending September 30, 1995. The Department selected a sample of 20 cost reports of facilities that were licensed for six beds or fewer to perform agreed upon procedures for the period ending September 30, 1996.

- The Department also reviewed a sample of 69 Agreed Upon Procedures Reports submitted by independent accountants and CPAs for the period ending September 30, 1995. Of these 69 reports, 15 were selected for a review of the independent accountant's or CPA's work papers which supported the findings in their reports. As a result of this review, all accountants who perform agreed-upon procedures engagements must participate in a peer review program for the 1998 cost reporting period.

- The agreed-upon procedures for the 1996 cost report audits were developed and distributed in October, 1996.

- The Department reviewed and approved applications from individuals, agencies, and organizations across the state to provide the required adult care home personal care training and/or competency training in addition to the training provided by community colleges.

- Adult care home licensure consultants conducted 522 annual surveys of adult care homes and 233 follow-up or expanded surveys, utilizing the staff pharmacists, dietitians and nurse for follow-up surveys and consultation with facilities experiencing compliance problems in particular licensure areas.

- Heavy care residents received case management services from county departments of social services and area mental health programs in 89 counties. 96% of the heavy care residents received case management services from the county departments of social services at expenditures of $2,255,533, and the rest from area mental health programs.

- A total of 132 case managers provided case management services in 82 county departments of social services with reported results of improved continence, nutrition, performance of activities of daily living, socialization and stimulation, and continuity of care.

- Total Medicaid expenditures for basic and enhanced personal care services was $61,383,798 and the monthly average number of residents receiving Medicaid reimbursable personal care services was 18,026 residents.

- The Division of Medical Assistance began a post-payment review regarding facility compliance with Medicaid policies for receiving enhanced personal care payments and developed "prior approval" procedures for case managers authorizing enhanced personal care payments and facilities billing for enhanced care payments.

I. COST REPORTING AND RATE SETTING

A. Cost Reporting and Audit Requirements

G.S. 131D-4.1-4.3 requires all adult care homes, including mental health group homes, which receive funds through State/County Special Assistance for Adults Program (S/C SA) to submit annual cost reports to the Department of Health and Human Services. Those homes which do not receive funds through S/C SA are exempt from the cost reporting requirements. The law also places audit requirements on adult care facilities which are required to submit annual cost reports.

Below is a summary of the adult care cost reporting and audit requirements established by G.S. 131D-4.1-4.3.

Licensed Bed Capacity	Annual Cost Report Required	Cost Report Required to be Audited
21 or more beds	Yes	Annually
7 to 20 beds	Yes	EveryTwo Years
6 or fewer beds	Yes	Not Required *

* To ensure quality of data, the Department has the authority to conduct audits (G.S. 131D-4.2(f)) and has implemented a process where samples of adult care facilities' ($\leq$ 6 beds) cost reports are selected for review by Department personnel.

In order to meet the audit requirements of G.S. 131D-4.1-3, while at the same time contain the cost incurred by the facilities, the Department developed agreed-upon procedures to be performed by independent accountants and Certified Public Accountants (CPAs). The procedures should be performed in accordance with Statement on Auditing Standards (SAS) No. 75; *Engagements to Apply Agreed-Upon Procedures to Specified Elements, Accounts, or Items of a Financial Statement.* In layman's terms, "agreed-upon procedures" describe specific analytical procedures to be performed by the independent accountant/CPA on an agency's accounting records for verifying the accuracy and validity of reported costs and revenues.

Responsibility for the Cost Reports, Chart of Accounts, and rate-setting has been delegated to the Department's Controller's Office. Responsibility for developing the agreed-upon procedures to be performed by all independent accountants and CPAs in verifying the accuracy and validity of reported costs and revenues has been delegated to the Department's Office of the Internal Auditor. The Department's Office of the Internal Auditor and the Controller's Office have coordinated the adult care facilities' cost report audits.

B. Cost Reports and Chart of Accounts

The Adult Care Home Chart of Accounts and Cost Report, with instructions, were developed for the twelve month period October 1, 1995, through September 30, 1996, with input from industry providers and advocates. The chart of accounts was mailed to providers in February, 1996, and the Cost Report format with instructions were mailed to providers in October 1996. Fiscal Research and selected members of the General Assembly also

provided input on the Cost Report and its instructions. Training sessions for providers were held.

Cost Reports for October 1, 1995-September 30, 1996 Reporting Period
Status as of June 30, 1997

2,159	Adult Care Home (ACH) facilities as of September 30, 1995
307	ACH facilities exempt from reporting
78	ACH facilities not required to report because facility closed or sold
1,774	ACH facilities required to submit cost reports
3	ACH facilities submitted unacceptable cost reports
76	Facilities failed to submit cost reports or exemption request

(Note: The facilities which failed to submit a cost report or submitted an unacceptable cost report were sent warning letters. Subsequently, 51 facilities submitted reports. As of September 30, 1997, 28 facilities had not reported and were being sent notices of intent to revoke their licenses.)

The Adult Care Home Chart of Accounts for the period October 1, 1996 through September 30, 1997, was revised with input from industry providers, advocates, Fiscal Research and selected members of the General Assembly. The updated Adult Care Home Chart of Accounts was mailed to providers in October 1996.

C. Rate Setting

The Department's Controller's Office drafted rules establishing a methodology for determining annual rates for homes which serve State/County Special Assistance residents. The Department shared the rate setting methodology with industry groups and has started the rule-making process. The rules are expected to become permanent in August 1998.

During March, 1997, the Research Triangle Institute, under contract with the Division of Facility Services, conducted a study in 92 adult care homes to learn more about the types of residents who have "heavy" care needs and require considerable staff time. This information, along with cost report data, will be used to evaluate the current payment to adult care homes, including Medicaid payment for personal care. The results of the study will be available in October, 1997.

D. Cost Report Audits

1. 1995 Cost Report Audits

The agreed-upon procedures (consistent with Statement on Auditing Standards (SAS) No. 75: *Engagements to Apply Agreed-Upon Procedures to Specified Elements, Accounts, or Items of a Financial Statement)* for use in the facility 1995 cost report audits were mailed to all adult care facilities with a licensed bed capacity of greater than six beds on January 31, 1996. These procedures were utilized by the accountants/CPA's in the performance of the agreed-upon procedures engagements

for those facilities. ("Engagements" are contractual arrangments between an independent accountant or CPA and a facility to perform services.) The Office of the Internal Auditor provided technical assistance to the accountants/CPA's performing the 1995 agreed-upon procedures engagements throughout the year.

As of January 1, 1996, there were 926 adult care facilities that were licensed for six or fewer beds. The Office of the Internal Auditor selected a sample of Cost and Revenue Reports submitted by one hundred and ten (110) adult care facilities for the nine month period ending September 30, 1995 to perform agreed-upon procedures. The Office of the Internal Auditor completed agreed-upon procedures engagements on seventy (70) facilities for the nine month period ending September 30, 1995. The Office of the Internal Auditor was unable to perform agreed-upon procedures on the remaining forty (40) facilities for the following reasons:

a) The facility did not maintain an adequate accounting system to track revenues and expenses;

b) The facility did not maintain any worksheets, schedules and/or calculator tapes that recapped the detail transactions which supported the reported amounts on the Cost and Revenue Report;

c) Invoices were not maintained by the facility to support/document the costs that were reported; or

d) The facility did not maintain an adequate filing system for its invoices.

The Office of the Internal Auditor reviewed a sample (10%) of the Agreed-Upon Procedures Reports that were submitted by independent accountants/ CPA's for the nine month period ended September 30, 1995. As of July 31, 1996 there were seven hundred and seven (707) adult care facilities that were required to have Agreed-Upon Procedures Reports. Seventy one (71) adult care facilities were selected and a review was completed on sixty nine (69) of the Agreed-Upon Procedures Reports submitted for the nine month period ended September 30, 1995. Two facilities were exempted from having to obtain agreed-upon procedures reports.

Of the 69 reports, a sample of fifteen (15) Agreed-Upon Procedures Reports that were submitted by independent accountants/CPA's were also selected for a review of the independent accountant's/CPA's workpapers which supported the findings in their reports. The review revealed that the Agreed-Upon Procedures Reports submitted by seven out of nine accountants should be deemed unacceptable for various reasons. As a result of the review, the Department will require all accountants who perform agreed-upon procedures engagements to participate in a peer review program for the 1998 cost reporting period. The North Carolina Society of Accountants has agreed to implement a peer review program for all of its members who perform agreed-upon procedures engagements.

2. 1996 Cost Report Audits

The Office of the Internal Auditor developed the agreed-upon procedures for use in the facility 1996 cost report audits. These procedures were mailed to all adult care facilities with a licensed bed capacity of greater than six beds on October 25, 1996

and were utilized by the accountants/CPA's in the performance of the agreed-upon engagements on those facilities.

The Office of the Internal Auditor has provided technical assistance to the accountants/CPA's performing the 1996 agreed-upon procedures engagements throughout the year. In addition, the Office of the Internal Auditor participated in workshops held throughout the State to help educate accountants/CPA's in the performance of agreed-upon procedures.

The Office of the Internal Auditor and the managment of two sixty bed adult care facilities entered into a mutual agreement for the Office of the Internal Auditor to prepare the facility's 1996 Cost and Revenue Report and to perform an agreed-upon procedures engagement. The Office of the Internal Auditor has completed the engagements and issued Agreed-Upon Procedures Reports on both facilities.

The Office of the Internal Auditor, in accordance with a request from DHR Management, selected a sample of family care homes' 1996 Cost and Revenue Reports which had been received by the Department as of January 1, 1997 to perform agreed-upon procedures engagements. In order to comply with DHR Management's request that the fieldwork be completed by February 28, 1997, the Office of the Internal Auditor selected a sample of twenty (20) 1996 Cost and Revenue Reports. The Office of the Internal Auditor has completed the fieldwork on all twenty facilities and issued Agreed-Upon Procedures Reports to the facilities and the Department.

II. QUALITY ASSURANCE AND CARE ENHANCEMENT

A. Licensure Rules

Adult care home licensure rules on staff training and competency, resident assessments and care plans, licensed health professional support, and case management cooperation, that had been adopted as temporary rules as mandated by Chapter 449 of the 1995 Session Laws, were adopted in October, 1997, as permanent rules by the Social Services Commission with some changes. Most of the changes were of a technical nature for clarification purposes. The more substantive changes were the addition of the requirement that the resident care plan be signed and dated by the resident's physician within 15 days of completion of the assessment and the exclusion of over-the-counter medications in the more than 10 medications administered to a resident that would require quarterly review by a registered nurse. An objection by the Rules Review Commission to the rule on training and competency content and approval was met by inclusion of standards the Department uses to approve training and competency programs. The effective date for the permanent rules was May 1, 1997.

B. Staff Training and Competency Evaluation

Training for adult care home personal care aides and those directly supervising them is provided through two sources: community colleges and individuals, organizations or agencies who are approved as training providers by the Division of Facility Services according to standards established in licensure rules.

1. Training through Community Colleges

The 58 community colleges were sent curriculum guidelines for the 20-, 40- and 75-hour training developed through the collaborative effort of the Division of Facility Services and the Department of Community Colleges for implementation under their continuing education departments.

The following data pertains to community college training based on a survey conducted by the Department of Community Colleges in July, 1997, that covers a five-quarter period from the spring of 1996 when community colleges could first offer the adult care home staff training.

20-Hour Training
17 community colleges have offered the training
36 courses scheduled
18 courses taught
142 students completed course

40-Hour Training
35 community colleges have offered the training
107 courses scheduled
75 courses taught
589 students completed course

75-Hour Training
15 community colleges have offered the training
59 courses scheduled
48 courses taught
570 students completed course

The Nurse Aide I program has been used to meet the training requirement but data is not available regarding numbers of adult care home staff so trained.

The difference between the number of courses scheduled and actually taught reflects that each community college requires there to be a certain number of students enrolled before the class can be taught. The availability of students for these training programs depends on a variety of factors including use of private providers of training, i.e., contracting with a registered nurse approved to provide training; numbers of staff who are eligible, based on experience, for competency evaluation for training exemption; and staff turnover rates (this is a one-time training requirement but staff are to be trained within six months of hire).

2. Training and Competency Evaluation through State-Approved Private Providers

Many facilities have arranged to get a state-approved training or competency evaluation program to be provided "in-house", either through a nurse on staff or on a contractual basis. Curriculum guidelines for each training program and applications for training approval have been distributed upon request to prospective applicants.

The same applies to those interested in providing the competency evaluation for exemption from the training for staff meeting the 12-months experience requirement established in rule. (Note: Community colleges do not provide competency evaluation only because there is no training component involved.) Many of the approved competency evaluators do, however, offer refresher training prior to the competency evaluation. The Division of Facility Services approves training program and competency evaluation providers.

Following is information on the numbers of state-approved training and competency evaluation providers.

Training

Total number of approved providers of one or more of the training programs (20, 40 or 75 hours) - 90

Total number of approved training providers according to training program:

20-hour training - 42
40-hour training - 79
75-hour training - 42

Competency Evaluation for Exemption Purposes

Total number of approved providers of the competency evaluation for exemption from one or more of the training programs (20, 40 or 75 hours) - 66

Total number of approved competency evaluators according to exemption:

20-hour exemption - 23
40-hour exemption - 31
75-hour exemption - 41

It is the responsibility of the adult homes specialists of the county departments of social services to monitor for facility compliance with the training and competency requirements and issue plans of correction when staff have not been trained and no extension has been granted by the Department. When a plan of correction is required, the administrator must specify on the plan of correction a specific time frame for completion of training and the plan must be approved by the adult homes specialist.

C. Monitoring

During SFY 1996/97, the Division of Facility Services continued to utilize licensure consultants and specialized staff to carry out its mandated monitoring functions in adult care homes. Specialized staff are dietary, pharmacy, and nursing professionals. Through the utilization of these staff, in addition to the regular licensure consultants, and the implementation of an adult care home survey protocol, the section has increased its efficiency and effectiveness in the surveying, consultation and investigation. The current coordinated efforts within the Division enabled the agency to take a lead role in ensuring at least an annual survey in all homes of seven or more beds, or other homes when assessed as seriously non-compliant, and to follow annual visits with additional expanded surveys with staff teams, as needed. Division staff completed 522 annual facility surveys during the year. During the same period, 233 expanded or follow-up (team) surveys were conducted utilizing specialized staff.

Survey staff now have a better opportunity to identify key indicators of compliance (within the selected areas of building safety, staffing and supervision, personal services, health care, and food service), to review care and service outcomes for identified residents, and to address needs for establishing plans to correct significant areas of violations with facilities in timely and effective ways. Where training and consultation needs have been identified as compliance factors, the survey staff has readily responded to assist the facilities with their resources. Staff have issued 263 plans of correction to facilities based on surveys during SFY 1996-97. During the year staff completed 79 provider consultations in the areas of medications, food services, and health services. Where the violations have been of a serious nature that directly affected the health, safety, or welfare of the residents, the Division has taken appropriate regulatory action. Administrative sanctions imposed by the Division during SFY 1996-97 include 2 license revocations, 18 suspension of admissions, 27 provisional licenses, and 1 summary suspension of a license.

The Division continued to provide direction to the county department of social services staff in an effort to improve monitoring skills and an attempt to bring more uniformity to the local monitoring process. Emphasis will be given to reviewing county departments of social services' monitoring activity to ensure quality as well as consistency during the coming year.

III. ADULT CARE HOME CASE MANAGEMENT

Heavy care residents in adult care homes are eligible for Medicaid adult care home case management services. A heavy care resident is an individual who, according to Medicaid criteria, needs extensive assistance or is totally dependent on another person for eating, toileting or both. Case management services facilitate residents' access to Medicaid-covered services, such as skilled nursing services, physical therapy, speech therapy, physician services, medical supplies, durable medical equipment and mental health services; promote appropriate and cost-effective utilization of services; and help assure the quality of care provided to residents.

A. Program Implementation

- For SFY96-97, adult care home case management was provided to residents in 89 of North Carolina's counties by the county departments of social services or area mental health programs. The other 11 counties either have no facilities or have no heavy care residents living in the facilities in their county.
- County departments of social services expended $2,255,533 in support of adult care home case management ($593,584 in state funds, $534,175 in county funds and $1,127,773 in federal funds). Area mental health programs are reimbursed for case management by Medicaid, but the reimbursement made for these case management

activities are not separately identified from reimbursement for other kinds of mental health case management services.

- Today 96% of the heavy care residents are receiving case management from the county departments of social services and 4% are receiving the service from the area mental health programs.
- The Department is working with two demonstration projects to learn about the benefits and barriers to county departments of social services providing case management to heavy care residents in adult care homes on a multi-county basis. These projects began in December, 1996, and involve Alexander/Burke/Caldwell and Catawba counties in the west and Camden/Chowan/Currituck /Pasquotank and Perquimans counties in the east. These projects are planned to continue until June, 1998.

B. Staffing and Caseloads for Case Management

The following data is for July through December, 1996, for the 82 county departments of social services providing case management directly.

- 82 county departments are providing case management with a total of 132 case managers representing 48.5 full-time equivalent positions (FTE).
- 15 county departments have designated a full time position to provide case management.
- 67 county departments are using staff to provide case management who also provide other adult services. The average FTE for case management in the 67 counties with part-time staff providing case management is right at a half-time position (.48 FTE).
- For staff who provide case management, in addition to other duties, the most common other assignments include guardianship, representative payee, adult placement services, adult protective services, adult home specialist, intake, and in-home services.
- The number of heavy care residents per county varies widely, ranging from 1 resident up to 166 residents. The median number of heavy care residents in a county is 26 residents.
- The average FTE caseload is 64 heavy care residents per case manager. Each resident is receiving an average of 1 hour 12 minutes per month of case management service. These minutes do not include time not directly attributable to a resident, such as time spent in training, supervisory conferences, travel to see the resident, completing paperwork, etc. The recommended caseload is 40 heavy care residents per case manager. This caseload size allows each resident to receive 3 hours of case management per month.

In all 41 area mental health programs, the case management responsibilities regarding heavy care residents have been met by existing case managers in addition to their regular duties. In a sample survey of area mental health programs representing Wake, Anson, Hoke, Montgomery, Richmond, Moore, Randolph, Cabarrus, Stanly and Union Counties, counties with heavy care residents averaged three per county.

C. Heavy Care Resident Characteristics

Data for SFY96-97 show the following about heavy care residents in adult care homes in the 82 counties in which the county departments of social services are providing case management directly.

- About two-thirds of the heavy care residents need extensive or total assistance with toileting; slightly less than one third need assistance with both toileting and eating; and about two percent need assistance with eating only.
- Heavy care residents are primarily elderly, 88% being over the age of 60. The median age is 81. The mentally ill and developmentally disabled residents who meet the heavy care criteria are somewhat younger with their median age being 67.
- 70% of heavy care residents are female.
- 56% of heavy care residents are white; 30% are African-American; and 14% are Native American and other minorities.

D. Conditions, Services, and Outcomes

The following data describes the types of health conditions that heavy care residents have and some of the care and services they are receiving in adult care homes. Counties providing this information include Buncombe, Cabarrus, Cleveland, Craven, Cumberland, Durham, Franklin, Gaston, McDowell, Mecklenburg, Onslow, Pasquotank and Wayne.

- Primary diagnosis for residents in the sample varies extensively. Common problems include arthritis, diabetes, pulmonary disease, and cardio-vascular problems (stroke and heart disease).
- Mild to severe dementia is noted for *almost all* these residents.
- Virtually all residents receive physician and pharmacy services, in addition to enhanced personal care.
- More than 75% receive nursing services through home health agencies.
- 50% receive physical therapy or occupational therapy.
- Over 50% receive assistance in the form of medical supplies and durable medical equipment.
- Other Medicaid-funded services being provided include hospital care (both inpatient and outpatient), dental care, ophthalmology care, mental health services, and medical transportation.
- Other county department-funded services being provided are placement services, guardianship, representative payee, health support services, and adult protective services.

Case managers have reported the following outcomes, which are expected for additional residents as more case management time is provided to current and future heavy care residents:

- improved assessment and health and medical care
- improved continence
- improved nutrition
- better use of residents' funds
- improved communication between residents, families, facility staff and community providers
- improved performance in activities of daily living
- improved socialization and stimulation
- improved continuity of care
- improved services to other residents

IV. MEDICAID REIMBURSEMENT FOR PERSONAL CARE

When Medicaid's adult care home personal care (ACH/PC) coverage began in August, 1995, the Division of Medical Assistance began to develop and install system controls for claims processing. These controls validate the accuracy of adult care homes' billings. The Division also reviews providers' claims to identify inappropriate billings and modifies billing procedures and claims processing system controls to prevent these. The Division's quality control efforts during SFY 1996-97 are described below.

A category of adult care home residents identified as "disenfranchised" was created when the General Assembly reduced the maximum payment level for Special Assistance (SA) to $844 per month, effective August 1, 1995. "Disenfranchised" residents are individuals whose income was between the old and new eligibility limits. These residents were "grandfathered" for continued coverage under SA and Medicaid, but are ineligible for Medicaid's ACH/PC and case management (ACH/CMS) coverage. In September, 1996, the Division installed a system control to prevent adult care homes from being paid for providing ACH/PC to "disenfranchised" residents. In January, 1997, the Division completed a post-payment review of adult care homes' ACH/PC billings to date for "disenfranchised" residents and identified $575,000 paid in error. As of September 22, 1997, $506,000 has been recovered through voluntary repayments and systematic recoupments.

In September, 1996, the Division began a post-payment review focusing on adult care homes' compliance with Medicaid polices for receiving Enhanced ACH/PC payments. With input from industry representatives and adult care home case managers, the Division has made necessary changes in billing procedures and system controls to better assure compliance. The Division developed "prior approval" procedures for ACH case managers authorizing Enhanced ACH/PC coverage for heavy care residents and adult care homes billing for Enhanced ACH/PC payments. These procedures were implemented on a "pilot" basis in 11 counties on June 1, 1997. An ACH/CMS case

manager must authorize Enhanced ACH/PC payments in the claims processing data base before the adult care home can receive Enhanced ACH/PC payments. Statewide implementation is tentatively set for November 1, 1997. Currently, all Enhanced ACH/PC claims paid to date are being subjected to the new system controls for prior approval. All identified overpayments or underpayments will be adjusted.

The Division of Medical Assistance continued its provider education efforts during SFY 1996-97. Division staff made 40 presentations to adult care homes and ACH case managers at regional and local meetings. The Division also continued ongoing site visits to adult care homes to review service documentation for compliance with Medicaid policies. Individualized follow-up letters were sent to identify areas of non-compliance and recommend corrective actions.

V. EVALUATION

The Division of Facility Services developed a plan for the evaluation of the effects of Senate Bill 864. That bill requires the evaluation to be completed by June 30, 1999. The evaluation of the training, case management and monitoring components of the bill will be based on an evaluation working paper drafted by the Division specifying the process and outcome measures to support the evaluation. The working paper calls for a description of each process and the roles and responsibilities of key players. It also presents a series of evaluation questions about major aspects of each process with evaluation designs for answering these questions. Staff with responsibilities in the various areas targeted for evaluation are in the process of gathering information to respond to the questions. The Division will be contracting for this evaluation to be conducted.

TOTAL MEDICAID ACH/PC EXPENDITURES FOR SFY 96-97:

Medicaid ACH/PC Payment Rate Category of Service	Medicaid ACH/PC PerDiem Rates	Expenditures for Category of Service SFY 96-97	Monthly Average of Recipients Receiving Service in SFY 96-97
Basic ACH/PC	$ 8.07	$ 47,554,538	15,264
Enhanced ACH/PC (extra assistance with eating)	$ 16.00	$ 243,413	42
Enhanced ACH/PC (extra assistance with toileting)	$ 10.87	$ 7,632,780	1,871
Enhanced ACH/PC (extra assistance with eating and toileting)	$ 18.08	$ 5,953,067	849
Total ACH/PC Expenditures SFY 96-97		$ 61,383,798	18,026

*Data from N.C. Division of Medical Assistance Program Expenditure Report (PER)

10/21/97

North Carolina Department of Human Resources

Division of Medical Assistance

P.O. Box 29529 • 1985 Umstead Drive • Raleigh, N. C. 27626-0529

Courier Service 56-20-06

James B. Hunt Jr., Governor
H. David Bruton,M.D., Secretary

Paul R. Perruzzi, Director
(919) 733-2060

August 26, 1997

The Honorable Lanier M. Cansler
The Honorable Charlotte A. Gardner
The Honorable Debbie A. Clary
The Honorable William N. Martin
North Carolina General Assembly
Legislative Building
Raleigh, North Carolina 27601

Dear Appropriations Chairs:

In accordance with the instructions in the Appropriations Act under "Medicaid Growth Reduction," this report sets out DMA's plan for action to meet the budget targets specified by the legislature.

It takes time before program changes or cuts impact the budget. Implementing changes requires studies and analysis, changes in the State Plan, APA, notification to providers, changes in the claims processing system, etc. If there are challenges to the changes, even more time could be lost. Finally, after changes are implemented, it takes several months for the changes to flow through the system and actually result in savings.

To meet the budget targets and ensure a smooth transition from our existing growth in state appropriations to the limit of 8% in SFY 2000-01 we will begin in SFY 97-98 to achieve a reduction in the program's rate of growth by instituting cost containment actions.

Attached is a list of cost containment options. DMA will estimate the cost savings and implications, then meet with appropriate provider associations to get their input and suggestions. After considering provider input, and Medical Care Advisory Committee input, DMA will take the most prudent actions. We intend to take actions to reduce expenditures by an annualized 1.5%. Since these actions will occur at different times this fiscal year the impact on the

97-98 budget may only be in the 1% range. We will be planning for an additional 1.5% reduction that will be implemented in stages during the end of this fiscal year and the beginning of 98-99.

If you have any questions, please contact me.

Sincerely,

Paul R. Perruzzi

PRP/sl
Attachment

cc: H. David Bruton, M.D., Secretary
Jim Edgerton
Nina Yeager
Carol Shaw
Jim Bernstein
Daphne Lyon

Cost Containment Options

Hospital Inpatient-Rebase DRG, reduce DRG payment rate, reduce inflation payment, contract certain services

Hospital Outpatient-Change reimbursement method to a prospective system, reduce inflation rate, change ER reimbursement

Nursing Facilities-Rebase rates, reduce inflation payment, ROE, limit bed coverage, revise admission criteria

Drugs-Change reimbursement rate to AWP-15%, limit reimbursement to the lowest rate offered to any third party payor, prior approval, days supply limit.

In-home Services-Reduce some rates based on cost report data, tighten up medical necessity criteria, introduce controls such as assessment, reassessment and prior approval, reduce inflation payment, require Medicare billing, competitive bid where feasible

CAP Services-Hold to reasonable budgetary limit, adjust rates, limit inflation increase

Public Provider Services-Hold to reasonable budgetary limit.

ACH-Personal Care-Hold inflation payment.

Physician Services-limit crossover payments based on Medicaid rates, reduce rates that exceed Medicare payment rates

Durable Medical Equipment-reduce rates, limit inflation increase, competitive bid

ICF/MR-Reduce inflation increase

Edits-Improve edits in the claim processing system to fail inappropriate claims.

ACCESS-Expand statewide as quickly as possible. Begin ACCESS II demos as quickly as possible.

HMOs-Permit HMOs to compete in select counties

Transfer of Assests-Propose legislation to prevent the transfer of assets to become eligible for Medicaid

8/18/97

10/21/97

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt, Jr., Governor

H. David Bruton, M.D., Secretary

September 30, 1997

The Honorable Harold Brubaker, Speaker
North Carolina House of Representatives

The Honorable Marc Basnight, President Pro Tempore
North Carolina Senate
Legislative Building
Raleigh, North Carolina

Dear Representative Brubaker and Senator Basnight:

In accordance with Section 11.21 A of Chapter 443 of the 1997 Session Laws, I am submitting the enclosed annual adult care homes report. This report describes the status of the following: (1) rate-setting and financing of adult care homes; (2) quality assurance and enhancement of adult care homes; and (3) the process for the evaluation of the Adult Care Home Financing and Quality Assurance Program.

Questions regarding rate-setting and financing and the process for the evaluation of adult care home financing are to be addressed to James B. Edgerton, Assistant Secretary for Budget and Management. Questions regarding the remaining portions of the report are to be addressed to Lynne M. Perrin, Assistant Secretary for Aging and Special Needs.

Sincerely,

H. David Bruton, M.D.

HDB:db

cc: Tom Covington
Karen Hammonds-Blake
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Nina Yeager
Mary Ellen Sylvester
Stephanie Bass

ADULT CARE HOMES REPORT

FOR SFY 1996-97

PRESENTED TO

JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS AND FISCAL RESEARCH

PREPARED BY THE
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
October, 1997

INTRODUCTION

Section 11.21 A of Chapter 443 of the 1997 Session Laws (Senate Bill 352) requires the Secretary of the Department of Health and Human Services to report annually to the Joint Legislative Commission on Governmental Operations and the Fiscal Research Division of the Legislative Services Office on the planning and status of the following:

1. Rate setting and financing for adult care homes, including the use of Medicaid funds for personal care services;

2. Quality assurance and enhancement of adult care, including case management for residents with special care needs, monitoring of adult care facilities and specialized training of direct care staff; and

3. The process for the evaluation of the Adult Care Financing and Quality Assurance Program.

This report provides a summary of the progress for the state fiscal year of July 1, 1996, to June 30, 1997. Below are highlights of the year's activities, followed by sections addressing the areas noted above.

HIGHLIGHTS FOR SFY 1996-97

- Adult care homes submitted cost reports for the period of October 1, 1995 to September 30, 1996. As of June 30, 1997, 76 facilities failed to submit cost reports or request an exemption. These facilities were sent warning letters. Letters of intent to revoke licenses were sent to facilities that still failed to submit reports. (As of September 30, 1997, 28 facilities had not submitted cost reports and action on their licenses is pending.)

- The Adult Care Home Chart of Accounts for the period of October 1, 1996 to September 30, 1997, was revised with input from adult care home providers, advocates, the Fiscal Research Division and selected members of the General Assembly.

- The Department selected a sample of 110 cost reports of facilities that were licensed for six or fewer beds to perform agreed upon procedures for the period ending September 30, 1995. The Department selected a sample of 20 cost reports of facilities that were licensed for six beds or fewer to perform agreed upon procedures for the period ending September 30, 1996.

- The Department also reviewed a sample of 69 Agreed Upon Procedures Reports submitted by independent accountants and CPAs for the period ending September 30, 1995. Of these 69 reports, 15 were selected for a review of the independent accountant's or CPA's work papers which supported the findings in their reports. As a result of this review, all accountants who perform agreed-upon procedures engagements must participate in a peer review program for the 1998 cost reporting period.

- The agreed-upon procedures for the 1996 cost report audits were developed and distributed in October, 1996.

- The Department reviewed and approved applications from individuals, agencies, and organizations across the state to provide the required adult care home personal care training and/or competency training in addition to the training provided by community colleges.

- Adult care home licensure consultants conducted 522 annual surveys of adult care homes and 233 follow-up or expanded surveys, utilizing the staff pharmacists, dietitians and nurse for follow-up surveys and consultation with facilities experiencing compliance problems in particular licensure areas.

- Heavy care residents received case management services from county departments of social services and area mental health programs in 89 counties. 96% of the heavy care residents received case management services from the county departments of social services at expenditures of $2,255,533, and the rest from area mental health programs.

- A total of 132 case managers provided case management services in 82 county departments of social services with reported results of improved continence, nutrition, performance of activities of daily living, socialization and stimulation, and continuity of care.

- Total Medicaid expenditures for basic and enhanced personal care services was $61,383,798 and the monthly average number of residents receiving Medicaid reimbursable personal care services was 18,026 residents.

- The Division of Medical Assistance began a post-payment review regarding facility compliance with Medicaid policies for receiving enhanced personal care payments and developed "prior approval" procedures for case managers authorizing enhanced personal care payments and facilities billing for enhanced care payments.

I. COST REPORTING AND RATE SETTING

A. Cost Reporting and Audit Requirements

G.S. 131D-4.1-4.3 requires all adult care homes, including mental health group homes, which receive funds through State/County Special Assistance for Adults Program (S/C SA) to submit annual cost reports to the Department of Health and Human Services. Those homes which do not receive funds through S/C SA are exempt from the cost reporting requirements. The law also places audit requirements on adult care facilities which are required to submit annual cost reports.

Below is a summary of the adult care cost reporting and audit requirements established by G.S. 131D-4.1-4.3.

Licensed Bed Capacity	Annual Cost Report Required	Cost Report Required to be Audited
21 or more beds	Yes	Annually
7 to 20 beds	Yes	EveryTwo Years
6 or fewer beds	Yes	Not Required *

* To ensure quality of data, the Department has the authority to conduct audits (G.S. 131D-4.2(f)) and has implemented a process where samples of adult care facilities' ($\leq$ 6 beds) cost reports are selected for review by Department personnel.

In order to meet the audit requirements of G.S. 131D-4.1-3, while at the same time contain the cost incurred by the facilities, the Department developed agreed-upon procedures to be performed by independent accountants and Certified Public Accountants (CPAs). The procedures should be performed in accordance with Statement on Auditing Standards (SAS) No. 75; *Engagements to Apply Agreed-Upon Procedures to Specified Elements, Accounts, or Items of a Financial Statement.* In layman's terms, "agreed-upon procedures" describe specific analytical procedures to be performed by the independent accountant/CPA on an agency's accounting records for verifying the accuracy and validity of reported costs and revenues.

Responsibility for the Cost Reports, Chart of Accounts, and rate-setting has been delegated to the Department's Controller's Office. Responsibility for developing the agreed-upon procedures to be performed by all independent accountants and CPAs in verifying the accuracy and validity of reported costs and revenues has been delegated to the Department's Office of the Internal Auditor. The Department's Office of the Internal Auditor and the Controller's Office have coordinated the adult care facilities' cost report audits.

B. Cost Reports and Chart of Accounts

The Adult Care Home Chart of Accounts and Cost Report, with instructions, were developed for the twelve month period October 1, 1995, through September 30, 1996, with input from industry providers and advocates. The chart of accounts was mailed to providers in February, 1996, and the Cost Report format with instructions were mailed to providers in October 1996. Fiscal Research and selected members of the General Assembly also

provided input on the Cost Report and its instructions. Training sessions for providers were held.

Cost Reports for October 1, 1995-September 30, 1996 Reporting Period
Status as of June 30, 1997

2,159	Adult Care Home (ACH) facilities as of September 30, 1995
307	ACH facilities exempt from reporting
78	ACH facilities not required to report because facility closed or sold
1,774	ACH facilities required to submit cost reports
3	ACH facilities submitted unacceptable cost reports
76	Facilities failed to submit cost reports or exemption request

(Note: The facilities which failed to submit a cost report or submitted an unacceptable cost report were sent warning letters. Subsequently, 51 facilities submitted reports. As of September 30, 1997, 28 facilities had not reported and were being sent notices of intent to revoke their licenses.)

The Adult Care Home Chart of Accounts for the period October 1, 1996 through September 30, 1997, was revised with input from industry providers, advocates, Fiscal Research and selected members of the General Assembly. The updated Adult Care Home Chart of Accounts was mailed to providers in October 1996.

C. Rate Setting

The Department's Controller's Office drafted rules establishing a methodology for determining annual rates for homes which serve State/County Special Assistance residents. The Department shared the rate setting methodology with industry groups and has started the rule-making process. The rules are expected to become permanent in August 1998.

During March, 1997, the Research Triangle Institute, under contract with the Division of Facility Services, conducted a study in 92 adult care homes to learn more about the types of residents who have "heavy" care needs and require considerable staff time. This information, along with cost report data, will be used to evaluate the current payment to adult care homes, including Medicaid payment for personal care. The results of the study will be available in October, 1997.

D. Cost Report Audits

1. 1995 Cost Report Audits

The agreed-upon procedures (consistent with Statement on Auditing Standards (SAS) No. 75: *Engagements to Apply Agreed-Upon Procedures to Specified Elements, Accounts, or Items of a Financial Statement)* for use in the facility 1995 cost report audits were mailed to all adult care facilities with a licensed bed capacity of greater than six beds on January 31, 1996. These procedures were utilized by the accountants/CPA's in the performance of the agreed-upon procedures engagements

for those facilities. ("Engagements" are contractual arrangments between an independent accountant or CPA and a facility to perform services.) The Office of the Internal Auditor provided technical assistance to the accountants/CPA's performing the 1995 agreed-upon procedures engagements throughout the year.

As of January 1, 1996, there were 926 adult care facilities that were licensed for six or fewer beds. The Office of the Internal Auditor selected a sample of Cost and Revenue Reports submitted by one hundred and ten (110) adult care facilities for the nine month period ending September 30, 1995 to perform agreed-upon procedures. The Office of the Internal Auditor completed agreed-upon procedures engagements on seventy (70) facilities for the nine month period ending September 30, 1995. The Office of the Internal Auditor was unable to perform agreed-upon procedures on the remaining forty (40) facilities for the following reasons:

a) The facility did not maintain an adequate accounting system to track revenues and expenses;

b) The facility did not maintain any worksheets, schedules and/or calculator tapes that recapped the detail transactions which supported the reported amounts on the Cost and Revenue Report;

c) Invoices were not maintained by the facility to support/document the costs that were reported; or

d) The facility did not maintain an adequate filing system for its invoices.

The Office of the Internal Auditor reviewed a sample (10%) of the Agreed-Upon Procedures Reports that were submitted by independent accountants/ CPA's for the nine month period ended September 30, 1995. As of July 31, 1996 there were seven hundred and seven (707) adult care facilities that were required to have Agreed-Upon Procedures Reports. Seventy one (71) adult care facilities were selected and a review was completed on sixty nine (69) of the Agreed-Upon Procedures Reports submitted for the nine month period ended September 30, 1995. Two facilities were exempted from having to obtain agreed-upon procedures reports.

Of the 69 reports, a sample of fifteen (15) Agreed-Upon Procedures Reports that were submitted by independent accountants/CPA's were also selected for a review of the independent accountant's/CPA's workpapers which supported the findings in their reports. The review revealed that the Agreed-Upon Procedures Reports submitted by seven out of nine accountants should be deemed unacceptable for various reasons. As a result of the review, the Department will require all accountants who perform agreed-upon procedures engagements to participate in a peer review program for the 1998 cost reporting period. The North Carolina Society of Accountants has agreed to implement a peer review program for all of its members who perform agreed-upon procedures engagements.

2. 1996 Cost Report Audits

The Office of the Internal Auditor developed the agreed-upon procedures for use in the facility 1996 cost report audits. These procedures were mailed to all adult care facilities with a licensed bed capacity of greater than six beds on October 25, 1996

and were utilized by the accountants/CPA's in the performance of the agreed-upon engagements on those facilities.

The Office of the Internal Auditor has provided technical assistance to the accountants/CPA's performing the 1996 agreed-upon procedures engagements throughout the year. In addition, the Office of the Internal Auditor participated in workshops held throughout the State to help educate accountants/CPA's in the performance of agreed-upon procedures.

The Office of the Internal Auditor and the managment of two sixty bed adult care facilities entered into a mutual agreement for the Office of the Internal Auditor to prepare the facility's 1996 Cost and Revenue Report and to perform an agreed-upon procedures engagement. The Office of the Internal Auditor has completed the engagements and issued Agreed-Upon Procedures Reports on both facilities.

The Office of the Internal Auditor, in accordance with a request from DHR Management, selected a sample of family care homes' 1996 Cost and Revenue Reports which had been received by the Department as of January 1, 1997 to perform agreed-upon procedures engagements. In order to comply with DHR Management's request that the fieldwork be completed by February 28, 1997, the Office of the Internal Auditor selected a sample of twenty (20) 1996 Cost and Revenue Reports. The Office of the Internal Auditor has completed the fieldwork on all twenty facilities and issued Agreed-Upon Procedures Reports to the facilities and the Department.

II. QUALITY ASSURANCE AND CARE ENHANCEMENT

A. Licensure Rules

Adult care home licensure rules on staff training and competency, resident assessments and care plans, licensed health professional support, and case management cooperation, that had been adopted as temporary rules as mandated by Chapter 449 of the 1995 Session Laws, were adopted in October, 1997, as permanent rules by the Social Services Commission with some changes. Most of the changes were of a technical nature for clarification purposes. The more substantive changes were the addition of the requirement that the resident care plan be signed and dated by the resident's physician within 15 days of completion of the assessment and the exclusion of over-the-counter medications in the more than 10 medications administered to a resident that would require quarterly review by a registered nurse. An objection by the Rules Review Commission to the rule on training and competency content and approval was met by inclusion of standards the Department uses to approve training and competency programs. The effective date for the permanent rules was May 1, 1997.

B. Staff Training and Competency Evaluation

Training for adult care home personal care aides and those directly supervising them is provided through two sources: community colleges and individuals, organizations or agencies who are approved as training providers by the Division of Facility Services according to standards established in licensure rules.

1. Training through Community Colleges

The 58 community colleges were sent curriculum guidelines for the 20-, 40- and 75-hour training developed through the collaborative effort of the Division of Facility Services and the Department of Community Colleges for implementation under their continuing education departments.

The following data pertains to community college training based on a survey conducted by the Department of Community Colleges in July, 1997, that covers a five-quarter period from the spring of 1996 when community colleges could first offer the adult care home staff training.

20-Hour Training
17 community colleges have offered the training
36 courses scheduled
18 courses taught
142 students completed course

40-Hour Training
35 community colleges have offered the training
107 courses scheduled
75 courses taught
589 students completed course

75-Hour Training
15 community colleges have offered the training
59 courses scheduled
48 courses taught
570 students completed course

The Nurse Aide I program has been used to meet the training requirement but data is not available regarding numbers of adult care home staff so trained.

The difference between the number of courses scheduled and actually taught reflects that each community college requires there to be a certain number of students enrolled before the class can be taught. The availability of students for these training programs depends on a variety of factors including use of private providers of training, i.e., contracting with a registered nurse approved to provide training; numbers of staff who are eligible, based on experience, for competency evaluation for training exemption; and staff turnover rates (this is a one-time training requirement but staff are to be trained within six months of hire).

2. Training and Competency Evaluation through State-Approved Private Providers

Many facilities have arranged to get a state-approved training or competency evaluation program to be provided "in-house", either through a nurse on staff or on a contractual basis. Curriculum guidelines for each training program and applications for training approval have been distributed upon request to prospective applicants.

The same applies to those interested in providing the competency evaluation for exemption from the training for staff meeting the 12-months experience requirement established in rule. (Note: Community colleges do not provide competency evaluation only because there is no training component involved.) Many of the approved competency evaluators do, however, offer refresher training prior to the competency evaluation. The Division of Facility Services approves training program and competency evaluation providers.

Following is information on the numbers of state-approved training and competency evaluation providers.

Training

Total number of approved providers of one or more of the training programs (20, 40 or 75 hours) - 90

Total number of approved training providers according to training program:

- 20-hour training - 42
- 40-hour training - 79
- 75-hour training - 42

Competency Evaluation for Exemption Purposes

Total number of approved providers of the competency evaluation for exemption from one or more of the training programs (20, 40 or 75 hours) - 66

Total number of approved competency evaluators according to exemption:

- 20-hour exemption - 23
- 40-hour exemption - 31
- 75-hour exemption - 41

It is the responsibility of the adult homes specialists of the county departments of social services to monitor for facility compliance with the training and competency requirements and issue plans of correction when staff have not been trained and no extension has been granted by the Department. When a plan of correction is required, the administrator must specify on the plan of correction a specific time frame for completion of training and the plan must be approved by the adult homes specialist.

C. Monitoring

During SFY 1996/97, the Division of Facility Services continued to utilize licensure consultants and specialized staff to carry out its mandated monitoring functions in adult care homes. Specialized staff are dietary, pharmacy, and nursing professionals. Through the utilization of these staff, in addition to the regular licensure consultants, and the implementation of an adult care home survey protocol, the section has increased its efficiency and effectiveness in the surveying, consultation and investigation. The current coordinated efforts within the Division enabled the agency to take a lead role in ensuring at least an annual survey in all homes of seven or more beds, or other homes when assessed as seriously non-compliant, and to follow annual visits with additional expanded surveys with staff teams, as needed. Division staff completed 522 annual facility surveys during the year. During the same period, 233 expanded or follow-up (team) surveys were conducted utilizing specialized staff.

Survey staff now have a better opportunity to identify key indicators of compliance (within the selected areas of building safety, staffing and supervision, personal services, health care, and food service), to review care and service outcomes for identified residents, and to address needs for establishing plans to correct significant areas of violations with facilities in timely and effective ways. Where training and consultation needs have been identified as compliance factors, the survey staff has readily responded to assist the facilities with their resources. Staff have issued 263 plans of correction to facilities based on surveys during SFY 1996-97. During the year staff completed 79 provider consultations in the areas of medications, food services, and health services. Where the violations have been of a serious nature that directly affected the health, safety, or welfare of the residents, the Division has taken appropriate regulatory action. Administrative sanctions imposed by the Division during SFY 1996-97 include 2 license revocations, 18 suspension of admissions, 27 provisional licenses, and 1 summary suspension of a license.

The Division continued to provide direction to the county department of social services staff in an effort to improve monitoring skills and an attempt to bring more uniformity to the local monitoring process. Emphasis will be given to reviewing county departments of social services' monitoring activity to ensure quality as well as consistency during the coming year.

III. ADULT CARE HOME CASE MANAGEMENT

Heavy care residents in adult care homes are eligible for Medicaid adult care home case management services. A heavy care resident is an individual who, according to Medicaid criteria, needs extensive assistance or is totally dependent on another person for eating, toileting or both. Case management services facilitate residents' access to Medicaid-covered services, such as skilled nursing services, physical therapy, speech therapy, physician services, medical supplies, durable medical equipment and mental health services; promote appropriate and cost-effective utilization of services; and help assure the quality of care provided to residents.

A. Program Implementation

- For SFY96-97, adult care home case management was provided to residents in 89 of North Carolina's counties by the county departments of social services or area mental health programs. The other 11 counties either have no facilities or have no heavy care residents living in the facilities in their county.
- County departments of social services expended $2,255,533 in support of adult care home case management ($593,584 in state funds, $534,175 in county funds and $1,127,773 in federal funds). Area mental health programs are reimbursed for case management by Medicaid, but the reimbursement made for these case management

activities are not separately identified from reimbursement for other kinds of mental health case management services.

- Today 96% of the heavy care residents are receiving case management from the county departments of social services and 4% are receiving the service from the area mental health programs.
- The Department is working with two demonstration projects to learn about the benefits and barriers to county departments of social services providing case management to heavy care residents in adult care homes on a multi-county basis. These projects began in December, 1996, and involve Alexander/Burke/Caldwell and Catawba counties in the west and Camden/Chowan/Currituck /Pasquotank and Perquimans counties in the east. These projects are planned to continue until June, 1998.

B. Staffing and Caseloads for Case Management

The following data is for July through December, 1996, for the 82 county departments of social services providing case management directly.

- 82 county departments are providing case management with a total of 132 case managers representing 48.5 full-time equivalent positions (FTE).
- 15 county departments have designated a full time position to provide case management.
- 67 county departments are using staff to provide case management who also provide other adult services. The average FTE for case management in the 67 counties with part-time staff providing case management is right at a half-time position (.48 FTE).
- For staff who provide case management, in addition to other duties, the most common other assignments include guardianship, representative payee, adult placement services, adult protective services, adult home specialist, intake, and in-home services.
- The number of heavy care residents per county varies widely, ranging from 1 resident up to 166 residents. The median number of heavy care residents in a county is 26 residents.
- The average FTE caseload is 64 heavy care residents per case manager. Each resident is receiving an average of 1 hour 12 minutes per month of case management service. These minutes do not include time not directly attributable to a resident, such as time spent in training, supervisory conferences, travel to see the resident, completing paperwork, etc. The recommended caseload is 40 heavy care residents per case manager. This caseload size allows each resident to receive 3 hours of case management per month.

In all 41 area mental health programs, the case management responsibilities regarding heavy care residents have been met by existing case managers in addition to their regular duties. In a sample survey of area mental health programs representing Wake, Anson, Hoke, Montgomery, Richmond, Moore, Randolph, Cabarrus, Stanly and Union Counties, counties with heavy care residents averaged three per county.

C. Heavy Care Resident Characteristics

Data for SFY96-97 show the following about heavy care residents in adult care homes in the 82 counties in which the county departments of social services are providing case management directly.

- About two-thirds of the heavy care residents need extensive or total assistance with toileting; slightly less than one third need assistance with both toileting and eating; and about two percent need assistance with eating only.
- Heavy care residents are primarily elderly, 88% being over the age of 60. The median age is 81. The mentally ill and developmentally disabled residents who meet the heavy care criteria are somewhat younger with their median age being 67.
- 70% of heavy care residents are female.
- 56% of heavy care residents are white; 30% are African-American; and 14% are Native American and other minorities.

D. Conditions, Services, and Outcomes

The following data describes the types of health conditions that heavy care residents have and some of the care and services they are receiving in adult care homes. Counties providing this information include Buncombe, Cabarrus, Cleveland, Craven, Cumberland, Durham, Franklin, Gaston, McDowell, Mecklenburg, Onslow, Pasquotank and Wayne.

- Primary diagnosis for residents in the sample varies extensively. Common problems include arthritis, diabetes, pulmonary disease, and cardio-vascular problems (stroke and heart disease).
- Mild to severe dementia is noted for *almost all* these residents.
- Virtually all residents receive physician and pharmacy services, in addition to enhanced personal care.
- More than 75% receive nursing services through home health agencies.
- 50% receive physical therapy or occupational therapy.
- Over 50% receive assistance in the form of medical supplies and durable medical equipment.
- Other Medicaid-funded services being provided include hospital care (both inpatient and outpatient), dental care, ophthalmology care, mental health services, and medical transportation.
- Other county department-funded services being provided are placement services, guardianship, representative payee, health support services, and adult protective services.

Case managers have reported the following outcomes, which are expected for additional residents as more case management time is provided to current and future heavy care residents:

- improved assessment and health and medical care
- improved continence
- improved nutrition
- better use of residents' funds
- improved communication between residents, families, facility staff and community providers
- improved performance in activities of daily living
- improved socialization and stimulation
- improved continuity of care
- improved services to other residents

IV. MEDICAID REIMBURSEMENT FOR PERSONAL CARE

When Medicaid's adult care home personal care (ACH/PC) coverage began in August, 1995, the Division of Medical Assistance began to develop and install system controls for claims processing. These controls validate the accuracy of adult care homes' billings. The Division also reviews providers' claims to identify inappropriate billings and modifies billing procedures and claims processing system controls to prevent these. The Division's quality control efforts during SFY 1996-97 are described below.

A category of adult care home residents identified as "disenfranchised" was created when the General Assembly reduced the maximum payment level for Special Assistance (SA) to $844 per month, effective August 1, 1995. "Disenfranchised" residents are individuals whose income was between the old and new eligibility limits. These residents were "grandfathered" for continued coverage under SA and Medicaid, but are ineligible for Medicaid's ACH/PC and case management (ACH/CMS) coverage. In September, 1996, the Division installed a system control to prevent adult care homes from being paid for providing ACH/PC to "disenfranchised" residents. In January, 1997, the Division completed a post-payment review of adult care homes' ACH/PC billings to date for "disenfranchised" residents and identified $575,000 paid in error. As of September 22, 1997, $506,000 has been recovered through voluntary repayments and systematic recoupments.

In September, 1996, the Division began a post-payment review focusing on adult care homes' compliance with Medicaid polices for receiving Enhanced ACH/PC payments. With input from industry representatives and adult care home case managers, the Division has made necessary changes in billing procedures and system controls to better assure compliance. The Division developed "prior approval" procedures for ACH case managers authorizing Enhanced ACH/PC coverage for heavy care residents and adult care homes billing for Enhanced ACH/PC payments. These procedures were implemented on a "pilot" basis in 11 counties on June 1, 1997. An ACH/CMS case

manager must authorize Enhanced ACH/PC payments in the claims processing data base before the adult care home can receive Enhanced ACH/PC payments. Statewide implementation is tentatively set for November 1, 1997. Currently, all Enhanced ACH/PC claims paid to date are being subjected to the new system controls for prior approval. All identified overpayments or underpayments will be adjusted.

The Division of Medical Assistance continued its provider education efforts during SFY 1996-97. Division staff made 40 presentations to adult care homes and ACH case managers at regional and local meetings. The Division also continued ongoing site visits to adult care homes to review service documentation for compliance with Medicaid policies. Individualized follow-up letters were sent to identify areas of non-compliance and recommend corrective actions.

V. EVALUATION

The Division of Facility Services developed a plan for the evaluation of the effects of Senate Bill 864. That bill requires the evaluation to be completed by June 30, 1999. The evaluation of the training, case management and monitoring components of the bill will be based on an evaluation working paper drafted by the Division specifying the process and outcome measures to support the evaluation. The working paper calls for a description of each process and the roles and responsibilities of key players. It also presents a series of evaluation questions about major aspects of each process with evaluation designs for answering these questions. Staff with responsibilities in the various areas targeted for evaluation are in the process of gathering information to respond to the questions. The Division will be contracting for this evaluation to be conducted.

TOTAL MEDICAID ACH/PC EXPENDITURES FOR SFY 96-97:

Medicaid ACH/PC Payment Rate Category of Service	Medicaid ACH/PC PerDiem Rates	Expenditures for Category of Service SFY 96-97	Monthly Average of Recipients Receiving Service in SFY 96-97
Basic ACH/PC	$ 8.07	$ 47,554,538	15,264
Enhanced ACH/PC (extra assistance with eating)	$ 16.00	$ 243,413	42
Enhanced ACH/PC (extra assistance with toileting)	$ 10.87	$ 7,632,780	1,871
Enhanced ACH/PC (extra assistance with eating and toileting)	$ 18.08	$ 5,953,067	849
Total ACH/PC Expenditures SFY 96-97		$ 61,383,798	18,026

*Data from N.C. Division of Medical Assistance Program Expenditure Report (PER)

10/21/97

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

October 10, 1997

The Honorable Leslie Jane Winner, Co-Chairman
Joint Legislative Education Oversight Committee

The Honorable Jean Rouse Preston, Co-Chairman
Joint Legislative Education Oversight Committee

Legislative Office Building
300 North Salisbury Street
Raleigh, NC 27603

Dear Senator Winner and Representative Preston:

Enclosed is the required interim report on the Department of Health and Human Services plan to implement the State Board of Education's ABC Plan for its residential schools as stated in Senate Bill 352, Section 11.60. This report highlights the joint efforts of the State Board of Education and the Department of Health and Human Services on their progress toward the implementation of the ABC's plan in DHHS residential schools.

Sincerely,

H. David Bruton, M.D.

Michael E. Ward

Enclosures

cc: Stephanie Bass
Peter Leousis
Lynne Perrin

Status of ABC's Plan for DHHS Residential Schools

October 1, 1997

The 1997 General Assembly included a special provision in SB 352, Section 11.60, which directs the Department of Health and Human Services (DHHS) to implement the State Board of Education's ABC plan for its residential schools.

The special provision covers a broad spectrum of issues which have been of concern to DHHS for several years. During that period, DHHS placed renewed emphasis upon its educational programs and institutions and will continue to improve the educational quality of its schools.

The DHHS has high expectations for the children and school staff of the schools. Many child-centered improvements have been made and additional improvements are being planned. The challenging issues of special education are being addressed through strategic planning, such as called for in the ABC Plan.

DHHS programs fall into two basic categories:

1. Traditional schools which have K-12 programs, follow the Standard Course of Study, and whose students are in attendance for a full academic year. The students are placed in these schools primarily for educational purposes.

2. Treatment Programs and Training Schools, most of whose students are in attendance for less than a full academic year. Students are placed in these programs for non-educational reasons.

DHHS has adopted the philosophy of the ABC planning process for the residential schools under the Division of Youth Services, the Division of Services for the Blind and the Division of Services for the Deaf and Hard of Hearing. The students in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) educational programs are served for an average of less than 120 days and are admitted to DMHDDSAS facilities due to serious emotional disturbance or mental illness. Since psychiatric treatment needs must be met before educational programs can be addressed, the appropriateness of the ABC Plan for these programs is under review

Members of the Educational Advisory Committee in DHHS and staff of the Exceptional Children Division in DPI have worked closely over the last year in reviewing the State Board's ABC Plan and discussing how DHHS residential schools can be included. Those meetings have been helpful and productive. Below are examples of activities:

1. Representatives from the DHHS residential schools have met with the Accountability Services Division in DPI to receive information about testing and the ABC model. They discussed how the DHHS schools will be a part of the ABC model.

2. Representatives from the DHHS residential schools have met with DPI's Division of School Improvement to review information about the Assistance Teams and how the DHHS schools will receive assistance.

3. The DHHS is represented on the Exceptional Children Advisory Council. Through this Council DHHS has been kept up-to-date on the planning and implementation of the ABC model.

4. In August, 1997, the Exceptional Children Division invited DHHS representatives to attend their annual State Conference on Exceptional Children. At that meeting there was much discussion related to the ABC results and plans.

5. Lowell Harris and Martha Downing from the Exceptional Children Division were invited to visit the Eastern NC School for the Deaf in Wilson on September 16, 1997 to observe the classes and to discuss issues related to the ABC's Plan with the faculty and the management team.

In October, Peter Leousis of DHHS, Dr. Henry Johnson of DPI, and key staff members from each department will meet to discuss the next steps in this joint effort. Included will be the study of methods of alternative testing and other issues that will enable DHHS schools to further address accountability for providing quality education to students.

Educational issues are complex; all DHHS children are special education students with Individualized Education Plans. The processes which are underway will result in a higher quality education for DHHS special needs children.

ADULT CARE BED VACANCY REPORT AS OF 10/20/97

10/21/97

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals							
COUNTY	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	BEDS IN PIPELINE	APPROVED EXEMPTIONS	TOTAL BEDS AVAILABLE	TOTAL BEDS OCCUPIED	VACANCY RATE
ALAMANCE	780	774	565	4	4	1	29	221	1028	566	44.94%
ALEXANDER	66	66	63	0	0	0	3	0	69	63	8.70%
ALLEGHANY	104	104	59	22	22	14	0	0	126	73	42.06%
ANSON	0	0	0	53	47	39	0	60	107	39	63.55%
ASHE	76	76	45	30	30	29	0	0	106	74	30.19%
AVERY	46	46	43	0	0	0	0	0	46	43	6.52%
BEAUFORT	183	181	169	10	10	10	0	6	197	179	9.14%
BERTIE	75	70	65	38	36	33	0	0	106	98	7.55%
BLADEN	259	259	219	30	29	28	18	6	312	247	20.83%
BRUNSWICK	86	86	63	92	92	74	66	60	304	137	54.93%
BUNCOMBE	1082	1067	872	413	413	333	54	22	1556	1205	22.56%
BURKE	379	354	331	60	60	59	0	86	500	390	22.00%
CABARRUS	623	611	496	54	54	40	253	0	918	536	41.61%
CALDWELL	298	289	268	20	17	14	0	108	414	282	31.88%
CAMDEN	6	6	4	0	0	0	0	0	6	4	33.33%
CARTERET	112	112	44	13	12	5	0	76	200	49	75.50%
CASWELL	252	252	218	0	0	0	12	0	264	218	17.42%
CATAWBA	363	348	313	74	74	73	128	106	656	386	41.16%
CHATHAM	194	194	162	120	113	78	0	0	307	240	21.82%
CHEROKEE	48	48	44	20	20	12	6	12	86	56	34.88%
CHOWAN	60	60	59	30	30	29	0	0	90	88	2.22%
CLAY	12	12	7	20	19	18		0	31	25	19.35%
CLEVELAND	438	412	396	0	0	0	87	42	541	396	26.80%
COLUMBUS	183	183	178	25	25	22	0	0	208	200	3.85%
CRAVEN	466	466	404	33	31	27	0	102	599	431	28.05%
CUMBERLAND	777	762	691	194	174	126	110	103	1149	817	28.89%
CURRITUCK	0	0	0	10	8	8	0	0	8	8	0.00%
DARE	0	0	0	18	18	17	0	0	18	17	5.56%
DAVIDSON	318	318	255	198	186	162	144	6	654	417	36.24%
DAVIE	105	101	83	64	64	56	0	0	165	139	15.76%
DUPLIN	325	325	271	62	52	46	0	72	449	317	29.40%
DURHAM	933	890	772	167	167	138	20	101	1178	910	22.75%
EDGECOMBE	281	280	277	65	59	48	66	0	405	325	19.75%
FORSYTH	1489	1424	1158	253	165	144	126	136	1851	1302	29.66%
FRANKLIN	270	269	225	10	10	10	0	0	279	235	15.77%

ADULT CARE BED VACANCY REPORT AS OF 10/20/97

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals							
COUNTY	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	BEDS IN PIPELINE	APPROVED EXEMPTIONS	TOTAL BEDS AVAILABLE	TOTAL BEDS OCCUPIED	VACANCY RATE
GASTON	531	524	503	214	194	168	0	88	806	671	16.75%
GATES	0	0	0	10	10	4	0	0	10	4	60.00%
GRAHAM	30	30	21	23	23	20	0	3	56	41	26.79%
GRANVILLE	197	190	163	40	40	36	0	0	230	199	13.48%
GREENE	46	46	41	17	17	11	6	0	69	52	24.64%
GUILFORD	1103	1029	862	480	456	417	577	300	2362	1279	45.85%
HALIFAX	172	156	126	45	40	35	0	0	196	161	17.86%
HARNETT	483	465	426	114	57	51	0	0	522	477	8.62%
HAYWOOD	311	311	252	30	30	30	0	18	359	282	21.45%
HENDERSON	358	358	328	40	40	37	0	132	530	365	31.13%
HERTFORD	187	187	173	0	0	0	2	0	189	173	8.47%
HOKE	75	71	58	10	10	9	5	0	86	67	22.09%
HYDE	0	0	0	0	0	0	0	0	0	0	0
IREDELL	583	583	473	170	170	151	81	100	934	624	33.19%
JACKSON	143	143	102	20	20	14	0	0	163	116	28.83%
JOHNSTON	474	471	415	30	28	26	84	0	583	441	24.36%
JONES	6	6	6	20	20	15	6	0	32	21	34.38%
LEE	310	310	253	0	0	0	3	0	313	253	19.17%
LENOIR	286	284	255	0	0	0	6	0	290	255	12.07%
LINCOLN	140	138	138	63	63	55	0	0	201	193	3.98%
MACON	52	52	46	30	23	23	0	0	75	69	8.00%
MADISON	54	54	46	20	20	17	0	0	74	63	14.86%
MARTIN	165	157	147	0	0	0	0	0	157	147	6.37%
MCDOWELL	419	412	346	15	15	13	0	0	427	359	15.93%
MECKLENBURG	940	940	704	628	562	448	467	259	2228	1152	48.29%
MITCHELL	35	35	30	10	10	7	0	0	45	37	17.78%
MONTGOMERY	167	166	154	10	10	10	36	0	212	164	22.64%
MOORE	275	257	239	86	85	72	116	192	650	311	52.15%
NASH	235	233	223	149	143	130	0	48	424	353	16.75%
NEW HANOVER	661	660	526	170	50	31	78	20	808	557	31.06%
NORTHAMPTON	211	211	176	0	0	0	19	6	236	176	25.42%
ONSLOW	391	391	312	8	8	8	4	0	403	320	20.60%
ORANGE	196	195	158	127	127	120	86	0	408	278	31.86%
PAMILICO	0	0	0	8	8	8	40	0	48	8	83.33%
PASQUOTANK	190	190	177	0	0	0	0	76	266	177	33.46%

ADULT CARE BED VACANCY REPORT AS OF 10/20/97

	Freestanding Adult Care Beds			Adult Care Beds in Nursing Homes/Hospitals							
COUNTY	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	LIC CAPACITY	BEDS AVAILABLE	BEDS OCCUPIED	BEDS IN PIPELINE	APPROVED EXEMPTIONS	TOTAL BEDS AVAILABLE	TOTAL BEDS OCCUPIED	VACANCY RATE
PENDER	103	103	57	23	23	20	0	0	126	77	38.89%
PERQUIMANS	64	64	53	0	0	0	0	0	64	53	17.19%
PERSON	73	73	61	5	5	5	0	0	78	66	15.38%
PITT	494	491	362	50	50	42	84	68	693	404	41.70%
POLK	38	35	30	74	74	54	0	0	109	84	22.94%
RANDOLPH	315	315	293	68	67	53	268	0	650	346	46.77%
RICHMOND	287	287	178	10	10	10	0	0	297	188	36.70%
ROBESON	631	629	527	47	25	24	36	30	720	551	23.47%
ROCKINGHAM	359	359	295	39	39	37	76	80	554	332	40.07%
ROWAN	510	504	456	207	207	175	84	118	913	631	30.89%
RUTHERFORD	515	506	455	100	100	97	0	76	682	552	19.06%
SAMPSON	173	160	138	60	59	56	53	0	272	194	28.68%
SCOTLAND	158	153	135	20	20	20	0	0	173	155	10.40%
STANLY	55	55	52	52	52	51	6	0	113	103	8.85%
STOKES	123	123	121	58	48	44	0	0	171	165	3.51%
SURRY	404	404	371	71	71	62	0	0	475	433	8.84%
SWAIN	50	50	43	0	0	0	0	0	50	43	14.00%
TRANSYLVANIA	32	31	27	30	30	23	98	0	159	50	68.55%
TYRRELL	0	0	0	0	0	0	0	0	0	0	0
UNION	289	274	232	67	40	36	122	0	436	268	38.53%
VANCE	204	198	146	77	73	64	6	0	277	210	24.19%
WAKE	COUNTY HAS NOT PROVIDED INFORMATION			229	210	184	106	311			
WARREN	189	169	124	20	20	20	0	0	189	144	23.81%
WASHINGTON	0	0	0	9	9	8	40	0	49	8	83.67%
WATAUGA	102	100	97	0	0	0	0	0	100	97	3.00%
WAYNE	537	536	481	32	32	29	187	42	797	510	36.01%
WILKES	161	158	138	19	19	17	0	0	177	155	12.43%
WILSON	445	428	389	69	69	33	50	0	547	422	22.85%
YADKIN	169	169	156	20	20	19	0	0	189	175	7.41%
YANCEY	29	29	29	0	0	0	0	0	29	29	0.00%
TOTALS	**26,643**	**26,122**	**22,159**	**6,245**	**5,692**	**4,842**	**3,954**	**3,292**	**38,433**	**26,817**	**30.22%**

10/21/97

Report to the General Assembly

Smart START

1996-97 Annual Report

July 1, 1996 - June 30, 1997

Submitted by

North Carolina Partnership for Children

Report to the General Assembly

1996-97 Annual Report

July 1, 1996 - June 30, 1997

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Smart START

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Smart Start Expansion: On Track to All 100 Counties

North Carolina's young children and families are now one step closer to receiving the critical child care and health services provided by Smart Start. This year, with expansion funding provided by the N.C. General Assembly, Smart Start is able to provide planning funds to the 45 counties that had not been a part of Smart Start in the past.

The Smart Start planning team, made up of businesses, churches, child care providers, local government agencies, parents and community leaders from each county, will work together to develop a strategic plan to meet the needs of local children and families.

The ultimate goal of Smart Start is to have the program fully-funded in all 100 counties by the year 2000. This is a lofty goal, but one that must be met to ensure that all of North Carolina's children enter school healthy and ready to succeed.

Smart Start provides a comprehensive approach to coordinating services and resources for children and families. It assesses existing systems and develops an infrastructure of services that best meet the needs of local children and families and produces the desirable outcomes that achieve school readiness.

Since North Carolina has one of the nation's highest percentages of working mothers, access to high quality child care essential. Recent welfare reform changes also make child care critical so parents can work. Research indicates that high quality child care makes a tremendous difference in a child's early development.

Smart Start is working to address the needs of working families by directing 30 percent of all local funds to child care subsidies so parents can work. Smart Start programs and services are locally-driven to provide higher-quality child care, more child care spaces, better-trained child care teachers, preventive health care and family support services.

Smart Start-sponsored programs like the *Child Care W.A.G.E.$. Project* in Orange County is just one example of innovative programs Smart Start has developed. *W.A.G.E.$.* has achieved what once seemed impossible—a reduction in the turnover rate of child care providers, an increase in quality child care and an affordable price for families. Under the project, teachers, center directors and family child care providers in regulated child care programs are eligible for salary supplements. Increased levels of education and/or increased tenure in the child care profession lead to additional salary supplements. In Orange County this year, 130 child care teachers, directors and providers have participated in the program. The teachers receiving higher education and wages also provide an higher quality care to more than 1,800 children in the county.

Smart Start is one of the nation's first public-private efforts to provide comprehensive services to children and families. Smart Start is seen as a nationwide model for quality child care, health care and family services. Several states, including Florida, South Carolina and Oklahoma, have visited Smart Start partnerships to learn how they work.

Smart Start Successes in 1996-97

Core Services

Smart Start is assuring successful long-term outcomes through the following core services:

- Improving the quality of child care services
- Making child care available for every child who needs it
- Making child care services accessible for every child who needs them
- Delivering effective family support services
- Comprehensive health care and education

Getting Results

Smart Start is getting results. In the 43 counties where Smart Start began, since April 1994:

- More than 37,000 children have received child care subsidies so their parents can work;
- More than 32,000 spaces in child care and education programs have been created;
- More than 87,000 children have received early intervention and preventive health screenings;
- More than 26,000 early childhood teachers and directors have received additional training through Smart Start educational programs.

Accountability

New measures have been put in place this year to make sure controls are tight. In addition, Smart Start partnerships are subject to annual independent audits; project monitoring and uniform fiscal policies and practices; bonding of staff who receive or handle Smart Start funds; and employing independent payroll services. The N.C. Partnership for Children is committed to ensuring the strict accountability of Smart Start programs and services.

National Recognition

This year, *Working Mother* magazine, a Columbia University study, *The Pittsburgh Post Gazette*, *The New York Times*, *TIME* magazine, and *the Atlanta Journal-Constitution*, the National Governor's Association, the US Secretary of Education, and President Bill Clinton, all hailed North Carolina as a model for its bold step to bring communities together through public-private partnerships and collaboration as keys to success.

Private Support

As a public-private partnership, Smart Start is required to raise 10 percent in cash and in-kind contributions. This year, major North Carolina corporations like Carolina Power and Light, Duke Power, Food Lion, First Union, Wachovia and NationsBank provided substantial support to Smart Start. More than $3.5 million was raised in cash contributions and more than $5.3 million in in-kind donations.

Private sector grants were then provided to local Smart Start partnerships to support innovative community projects. Grants were chosen by business representatives of the major corporations providing contributions.

SMART START PARTNERSHIP SUMMARY

Year 1 and Year 2 Partnerships

Twelve Year 1 partnerships, made up of 18 counties, were selected in September 1993 and funded in January 1994. Twelve Year 2 partnerships, made up of 14 counties, were selected in September 1994 and funded in January1995. These partnerships provide the impetus and focal point for a wide range of programs and services for young children and their families. They include child care initiatives to improve the quality of child care and make it more affordable for families, subsidy programs to provide child care funding for low income and working poor families, teacher education and support, new and expanded initiatives to best serve children with special needs, and health initiatives to detect and treat vision, hearing, dental and other problems.

Year 3 Partnerships

Eleven Year 3 partnerships, made up of 11 counties, were selected in January 1995 and given planning funds during the General Assembly's 1996 summer session. During the planning year, these partnerships were involved in collaboration and strategic planning and developed plans for delivery of services. These counties received a half year of funding for 1996-97 and are now implementing a portion of their comprehensive services to meet the needs of young children and their families.

Year 4 Partnerships

Twelve Year 4 partnerships, made up of 12 counties, were selected in April 1996 and were given planning funds during the General Assembly's 1996 Special Extra Session. During the current planning year, Year 4 counties are involved in strategic planning , collaboration, training and organizational development. The focus of their efforts has been the development of long-term strategic plan which will be approved by the state partnership with services to begin in the next fiscal year, based on expansion funds.

Year 5 Partnerships

Thanks to $1.5 million in expansion funding provided by the N.C. General Assembly to Smart Start this year, the remaining 45 counties will now begin the planning phase of Smart Start. Local planning teams, made up of parents and business, church, government and community leaders, will work together to develop a strategic plan to meet the needs of local children and families. Activities may include board and task force development, collaboration and training.

Private Cash and In-Kind Contributions

Smart Start was conceived as a public-private partnership and indeed, the contribution from the private sector, in terms of both funds and volunteers, is at the very root of the program's success. Smart Start leverages resources for communities in many different forms: cash contributions from the private sector, foundation grants, investment in child care centers, resources donated to contracting agencies for use in Smart Start programs, funding that is blended with other resources in ways that add value, and new access to federal funds through cooperation among government, nonprofit and private sector entities. Cash donations and pledges of support from private sources for 1996-97 totaled **$3,569,057**. Total in-kind contributions for the 1996-97 year are **$5,301,342** and **138,969** total volunteer hours have been recorded.

Child Care Resource and Referral

Child care resource and referral services are a vital link in the development of a child care and education system. Smart Start funds have been earmarked for these services in local partnerships. These services include assisting families in finding high quality child care, ensuring that training is available for child care providers, giving technical assistance and making resources available to child care providers and families, and providing community members with information about child care supply and demand. This report includes an update on the various stages of development of child care resource and referral services in Smart Start counties.

Staff to Child Ratios: Monitoring Staff

Compared to other states, North Carolina lagged behind the rest of the nation in the required staff to child ratios in child care programs. The 1993 legislature improved the ratios for children under three years of age. A staff person can now only be responsible for five children under one year of age. Only six one-year-olds can be cared for by one staff person and only ten-two-year olds may be cared for by one staff. To enforce these new ratios as well as other child care requirements, the Division of Child Development (DCD) hired additional monitoring staff. In 1993, caseloads for monitoring staff reached an average of almost 150 facilities per staff; the recommended average is 75. The infusion of new staff in 1994 lowered caseloads only temporarily. Even with additional Smart Start resources, parents' increased need for child care pushed the current average caseload for licensing consultants to 168.

Systems Automation

A new on-line reimbursement system for the state's subsidized child care program has been adapted to accommodate federal and state statutory changes and reporting requirements. It is expected that the volume of Smart Start children processed through the modified system will increase as more funds are allocated to child care subsidies. It is important to note that the on-line subsidy reimbursement system is now available to independent child care purchasing agencies in addition to county departments of social services. Local partnerships which elect to funnel subsidy funds through purchasing agencies other than county departments of social services may choose to use the on-line system to provide required reports. In addition, the division has initiated a plan of action regarding a systems automation recommendation proposed in the 1996 Coopers and Lybrand Smart Start Performance Audit. The recommendation targeted the development of a statewide child care resource and referral database which would increase the availability of child care information to the general public. The major source of data for the child care resource & referral database will be the existing DCD regulatory system database. The child care resource & referral database will reside on the division's web page located on the Department of Human Resources web site. The new system should be available on the web site by Fall 1997.

T.E.A.C.H. Early Childhood Project

A report on the T.E.A.C.H. Project is under separate cover.

North Carolina Partnership for Children

The North Carolina Partnership for Children was established to provide support to the local partnerships and to set goals for children and family services across the state. The state partnership has 39 board members representing state agencies, private business, education, nonprofits, religious organizations, child care providers, parents and members of the General Assembly. The N.C. Partnership for Children provides technical assistance to local Smart Start partnerships in the areas of program development, administration, organizational development, communications, fiscal management, contracts management and fundraising.

Division of Child Development

The division continues to blend programmatic and administrative resources with the North Carolina Partnership for Children (NCPC). The coordination of the subsidized child care reimbursement system with the management of the department's child development knowledge base enables the Division to effectively partner with NCPC in Smart Start strategic planning, development and implementation. DCD and NCPC continue to provide both services and technical assistance to support Governor Hunt's mandate regarding the effective integration of public and private expertise as the new model for doing business in North Carolina.

Evaluation

The evaluation team for Smart Start is comprised of professionals with extensive experience in the areas of program evaluation, early childhood education, health and family support. During the first year, the evaluation team concentrated on developing a statewide evaluation plan to collect a core set of data and provided technical assistance on evaluation issues to the local partnerships. Second-year evaluation activities focused on data collection. Database variables and definitions were created and refined, county evaluation coordinators visited approximately 120 child care centers and interviewed families participating in Smart Start. During the 1996-97 year, the evaluation team has focused evaluation efforts on collecting data on child care quality, exploring the use of unique identifiers in Smart Start partnerships and developing studies of specific Smart Start programs.

Smart Start Allocations and Expenditures in Local Partnerships

Smart Start expenditures in local partnerships cover a wide range of activities. The charts in this report show the 1996-97 allocations of Smart Start funds to each partnership and the total expenditures for each county. A system is being developed to show expenditures by activity and will be included in future reports.

Monitoring and Reporting by Local Partnerships

Local partnerships are closely monitoring the agencies and organizations that have been selected to deliver direct services to children and families in their communities. Selected in an open-bidding process, the Smart Start projects are monitored and evaluated and future decisions are made about continuing those service projects or choosing new ones, based on the outcomes for children and families. On the following pages are some highlights of the kinds of services which are being supported with Smart Start funds, as well as the numbers of children served in these projects. Because individual identifiers have not been assigned to each child, due to privacy and other issues, some numbers may be duplicated, i.e., multiple services may have been provided to a parent or child.

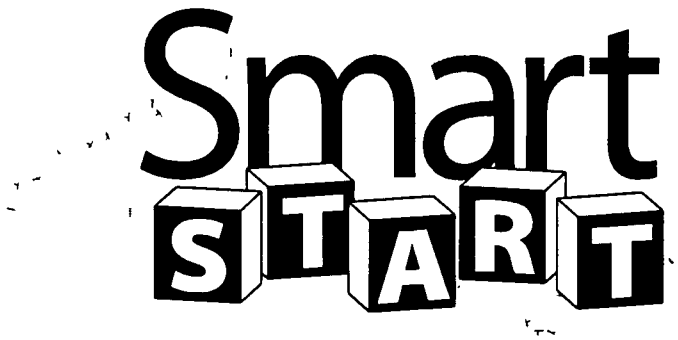
The activities for which there are counts in this report, have been determined to be good indicators of success in reaching the overall goal of Smart Start, that all children will enter school healthy and prepared for success. In addition to the counts reported by local partnerships, there are other significant statistics, attributable to Smart Start, which are tracked and reported through state-level reporting systems. Data is collected through state-level systems for subsidized child care, AA-child care licensing, child care spaces created in child care programs and immunizations. Counts for subsidized child care, and child care spaces created in child care progams, although tracked through statewide systems, are included in the individual county reports that follow.

State Licensing Standards and National Accreditation

One of the goals of Smart Start is to improve the quality of early childhood education, including both center and home-based care. In order to accomplish this goal, Smart Start county partnership initiatives have included quality improvement projects focusing on the upgrade of child care programs to assist them in moving from A to AA-licensing standards. An "A" license represents the minimally-accepted standard of care. "AA"-license represents a higher standard of care, including better teacher-child ratios (i.e., more teachers per child), smaller group sizes, more space per child, and more educational materials.

Another quality improvement project gives assistance to child care centers and family child care homes in becoming accredited. Accreditation is the process whereby an agency or association grants public recognition to a program that meets certain predetermined qualifications or standards.

Year 1 Partnerships



Year 1 partnerships include the 18 pioneer counties that began providing Smart Start programs and services in 1994.

Smart Start Impact

For the past year, the site of the Smart Start funded Dry Ponds Family Resource Center in Burke County has presented some challenges since there is limited space available for programs and problems with flooring. The center's Advisory Committee, comprised of parents and community members, took on the task of finding a more suitable site. In May, the program moved to the Snow Hill United Methodist Church, which is located within the same community. Many of the church members volunteered in helping to prepare the new site and with the move. The larger site has allowed for expansion of programs and the ability to serve more families. The following stories are two examples of children and families served at the Dry Ponds FRC this quarter. Neither of these young boys would have been able to attend a kindergarten readiness program had it not been for Smart Start and the church's willingness to have the family resource program relocate to their facilities.

A mother came to the site in May, begging for her son to be accepted into one of the newly established Kindergarten Readiness Camps. Her son had been expelled from two child care centers and had not performed well on the DIAL-R screening recently completed at kindergarten registration. This child started the kindergarten readiness program in June and has blossomed. His mother is excited about his accomplishments made in such a short time, and is confident that he will be ready for the transition to school.

Another child living at a local children's home was referred for the Kindergarten Readiness Camp. He had recently moved to the children's home after a long unstable family life. This child has also surprised everyone with his enthusiastic participation and adjustment to a structured program.

Improving the lives of children and families.

Kindergarten registration for the Burke County Public Schools was held at the 14 elementary schools in April and May. Over and over, Partnership staff heard from school personnel about how impressed they were with the performance of incoming students who had participated in prekindergarten programs and quality early childhood programs funded by Smart Start.

The following letter to the editor was written by a parent and published in the June 27th edition of The News Herald. *"To the editor: At a time when all we hear are horror stories about child care, I thought you might appreciate a positive and happy ending concerning my child's care. My son attended Hopewell Baptist Preschool. As any working mother knows, peace of mind is vital when it comes to your children. Not once did I worry about my child's happiness and welfare at Hopewell. The staff there are not just "baby-sitters." They nurture your children with love and guidance, as they prepare them for kindergarten. My son did very well on his DIAL-R Screening for kindergarten this fall. The school said he was more than ready to start. I've watched my son grow physically, mentally, and spiritually with their loving guidance. A simple "Thank You!" is not enough to let the staff at Hopewell know how I feel. The teachers have all done a wonderful job. I'm so glad they'll be there for other children, helping lay the foundation for one of the most important times of their lives."*

Human service agencies and organizations are working together in new and better ways because of Smart Start.

When Araceli left her home town of Quetjaltenango, Guatemala seven years ago, she was driven by a desire to improve her children's lives and make sure they received a better education than she did. She did not know she would be educating herself as well. Araceli is one of the 16 Hispanic women who are participating in "Project Flower," an outgrowth of the parent literacy program funded by Smart Start at the Burke County Literacy Council. Initially, the Literacy Council shied away from involvement in teaching English as a Second Language because of classes the local community college already offered.

But more and more parents (primarily mothers) were unable to participate in the community college classes because of the child care they needed and their limited literacy skills. The Literacy Council applied for and received a $2,500 grant from Dollar General Stores to train volunteers and to cover the costs of instruction materials for the Hispanic women. The tutoring takes place at the Salvation Army Church once a week, with each session meeting for about two and a half hours. Child care is provided by local Girl Scouts and transportation is funded by Smart Start. Class instruction is focused on functional aspects of the women's daily lives such as learning the English words for foods they prepare everyday and teaching their children basic concepts such as colors and numbers. Word about Project Flower has spread within the Hispanic community, and more mothers show up for class each week. As they become more comfortable with life in their new community, they are also open to new experiences for their young children. Gaining parent confidence is a critical step in reaching those children most in need of early childhood education that helps to prepare them for school success. Project Flower, funded by Smart Start, is truly a unique service that is a collaborative effort on the part of many volunteers and is meeting a need that no one group alone can address.

Child Care and Education

Subsidies

232 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
336 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

Quality Improvement

99 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
129 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

293 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
884 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

743 children were enrolled in programs/classes that received quality enhancements this quarter, and
876 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs

23 children with special needs received one or more special therapies or interventions this quarter, and
35 children with special needs received one or more special therapies or interventions this year to date.

4 children with special needs received care or support because of an emergency or crisis situation this quarter, and

10 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
551 children received one or more educational programs this quarter, and
1231 children received one or more educational programs this year to date.

Health Care / Health Care Education

99 children received immunizations this quarter, and
409 children received immunizations this year to date.

103 children received health and/or developmental screenings this quarter, and
327 children received health and/or developmental screenings this year to date.

833 families received health care education this quarter, and
2,189 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

168 families received direct child care resource and referral services this quarter, and
613 families received direct child care resource and referral services this year to date.

Parent Education and Support
155 families received parent education and/or support services in family resource centers this quarter, and
196 families received parent education and/or support services in family resource centers this year to date.

326 families received parent education and/or support services in places other than family resource centers this quarter, and
597 families received parent education and/or support services in places other than family resource centers this year to date.

Transportation

266 children and family members were provided transportation to child care, health or other services this quarter, and
266 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

Smart Start has had a major impact in this community during the 1996-97 fiscal year. With the additional $698,000 in Smart Start subsidized child care funding, child care providers have the obvious benefit of this additional income to improve programming. Along those same lines, as additional funds are made available to low-income parents, regulated child care providers experience healthy growth and economic stability. The Smart Start funding represents 41% of the total subsidy dollars available for low-income families and families with young children in the county. Smart Start has also played an important role in this community to insure that we have adequate child care openings for children and their families. And, a recent lead-abatement "nightmare" at our county's largest child care facility caused great concern on behalf of the families needing child care in that area. Smart Start played a leading role in leveraging private foundation funding to address the problem.

Improving the lives of children and families.

Smart Start has provided funding to the Caldwell County Public Schools for the Jump Start program, an activity that provides a readiness skills summer program for children who are eligible to enter kindergarten in the fall and are believed to be at-risk. Teachers in the Jump Start program report:

"A grandmother of one of my students told me she was glad 'Bobby' had the chance to attend Jump Start. There are six other small children in the home. The parents are separated and there is not much time given to 'Bobby.' The grandmother felt Jump Start had been excellent for 'Bobby' and stated, '[Jump Start] should be for every child.'"

"There was a 4 1/2 year old girl who wouldn't separate from her mother the first two days of the Jump Start program. She was argumentative with her mother and teacher about remaining in class. The third day she was less hesitant about remaining in class; and the fourth day she didn't want to leave class. She came in with little concept of appropriate behavior, but improved tremendously in following classroom rules by the sixth day. I was extremely proud of her. She also needed additional help in how to hold and use a pencil. At the end of Jump Start, she was proficient in the use of pencils and crayons. Her recognition of letters, colors, and numbers increased from zero the first day to knowing all primary colors the last day of class. She now also knows her numbers from 1 to 10 and her letters from A to H. Having 15 students in class allowed the teacher and assistant to give more one-on-one help to each child."

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The Smart Start funded Behavior Management Specialist reports that the most exciting collaboration she is currently involved with is her work on the Caldwell County Needs Assessment Task Force. The Caldwell Partnership office has received a grant to do an overall needs assessment of the county to see what services are needed and to help in long term planning for the future. One of the things that the specialist finds impressive about this undertaking is that needs of the community are being looked at as a whole -- the assessment is not limited to early childhood concerns. The Task Force is asking for, and has received, involvement from community and business leaders, schools, households and families, teachers, early childhood educators, and the children of Caldwell County. This is an extremely exciting project and we are very fortunate to have the type of leadership in our partnership to begin tackling these issues. Without Smart Start and its leadership, this type of comprehensive and long term planning might not be taking place. The results and plans that come out of this survey will have a positive impact on all citizens of Caldwell County.

Child Care and Education

Subsidies
53 children with special needs received Smart Start subsidized care this quarter, and
87 children with special needs received Smart Start subsidized care this year to date.

649 other children received Smart Start subsidized child care this quarter, and
688 other children received Smart Start subsidized child care this year to date.

Quality Improvement
115 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

360 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
1,383 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

1,581 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,581 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
82 children with special needs received one or more special therapies or interventions this quarter, and
215 children with special needs received one or more special therapies or interventions this year to date.

26 children with special needs received care or support because of an emergency or crisis situation this quarter, and
73 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
213 children received one or more educational programs this quarter, and
1,779 children received one or more educational programs this year to date.

Health Care / Health Care Education

437 children received immunizations this quarter, and
437 children received immunizations this year to date.

1,307 children received health and/or developmental screenings this quarter, and
1,825 children received health and/or developmental screenings this year to date.

289 children received any other health services, other than transportation, this quarter, and

289 children received any other health services, other than transportation, this year to date.

27 families received health care education this quarter, and
543 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

112 families received direct child care resource and referral services this quarter, and
291 families received direct child care resource and referral services this year to date.

112 families received indirect child care and related information, for example, written materials, this quarter, and
289 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

2,089 families received parent education and/or support services in family resource centers this quarter, and
6,093 families received parent education and/or support services in family resource centers this year to date.

1,365 families received parent education and/or support services in places other than family resource centers this quarter, and
3,416 families received parent education and/or support services in places other than family resource centers this year to date.

2,467 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
6,509 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

268 children and family members were provided transportation to child care, health or other services this quarter, and
399 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

An intense research project has been implemented this quarter by the Cleveland Partnership. This research project will address the "Status of Children, Families, and Communities in Cleveland County." Many board members and other community volunteers have worked to distribute survey instruments and serve on the task force for this project.

Improving the lives of children and families.

Due to the help from the Emergency Assistance Project and the Abuse Prevention Projects funded by Smart Start, a child and the mother were able to escape a violent relationship and stay at the shelter. The mother is now enrolled in school and has full time employment.

"Ben" was screened and evaluated by the special needs screening and evaluation team from Kings Mountain District Schools at age three and qualified as Preschool Developmentally Delayed (PPD). The evaluation also indicated needs in the area of speech. Ben was accepted by the local Head Start Program in a school near his home. The Exceptional Children's Program planned to serve Ben through direct services for speech and developmental delays. Soon after school started, Head Start opened the Smart Start Kenan Program, and Ben and his mom enrolled. Ben attended this program for two years. In the fall of 1996, he enrolled in a kindergarten class at the school in his attendance area. He continued to receive speech and resource services. Ben's progress has been remarkable. According to the Director of Special Populations in Kings Mountain District Schools, *"Each spring the teachers, K-12, are asked to develop a list of students to be evaluated for the Academically Gifted Program. Much to my surprise and delight, Ben's name is on the list to be tested. His teacher's description of Ben is 'He reads like the wind, he is a smart little boy.' I believe that the early experiences provided to Ben has helped to unlock his potential. The Smart Start Program and the opportunities that it provides to integrate with area programs offer services for the leaders of tomorrow."*

Child Care and Education

Subsidies

18 children with special needs received Smart Start subsidized care this quarter, and
78 children with special needs received Smart Start subsidized care this year to date.

34 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

265 other children received Smart Start subsidized child care this quarter, and
410 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs

Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

113 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date (e.g., *Head Start, Chapter I, half-day preschools).

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement

177 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
1,261 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

202 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
910 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

845 children were enrolled in programs/classes that received quality enhancements this quarter, and
846 children were enrolled in programs/classes that received quality enhancements this year to date.

58 substitute child caregivers provided to child care centers to replace absent caregivers this year to date.

Children with Special Needs

130 children with special needs received one or more special therapies or interventions this quarter, and
346 children with special needs received one or more special therapies or interventions this year to date.

8 children with special needs received care or support because of an emergency or crisis situation this quarter, and
31 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs

962 children received one or more educational programs this quarter, and
4,004 children received one or more educational programs this year to date.

Health Care / Health Care Education

116 children received immunizations this quarter, and
1,612 children received immunizations this year to date.

30 children received health and/or developmental screenings this quarter, and
863 children received health and/or developmental screenings this year to date.

5 children received any other health services, other than transportation, this quarter, and
22 children received any other health services, other than transportation, this year to date.

1,712 families received health care education this quarter, and
5,347 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

115 families received direct child care resource and referral services this quarter, and
404 families received direct child care resource and referral services this year to date.

1,100 families received indirect child care and related information, for example, written materials, this quarter, and
1,320 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

662 families received parent education and/or support services in family resource centers this quarter, and
2,163 families received parent education and/or support services in family resource centers this year to date.

658 families received parent education and/or support services in places <u>other</u> than family resource centers this quarter, and
1,449 families received parent education and/or support services in places <u>other</u> than family resource centers this year to date.

647 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
1,397 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

145 children and family members were provided transportation to child care, health or other services this quarter, and
220 children and family members were provided transportation to child care, health or other services this year to date.

<u>Note</u>: The partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

Smart Start Impact

There are several new programs in Cumberland County as a result of Smart Start funding during 1996-97. These are programs that provide valuable services to young children and families across the community.

Teen Moms and Teen Dads: These activities provide support for teen parents in their transition from being teenagers to parents. Services are varied, and are provided through mentoring, regularly scheduled education classes, counseling, resource materials, small group problem-solving sessions, employment, and education opportunities.

Powered Mobility: This activity makes available a powered mobility system on a loan basis to physically handicapped, non-ambulatory children, ages 2 to 5 years, their parents, and the treating therapist. These young children have a scheduled period of time to have the specially designed wheelchair for practice, allowing for the development of "driving" skills. This allows the child and parents access to experiences which would often be denied for these children.

Kindergarten Parent Academy: This activity was provided by the BRIDGES family resource project. Parents of children who will enter kindergarten this fall participated in a ten-session "academy" with emphasis on preparing the parents for the transition of their preschooler into public schools. The sessions were designed to enhance parents' abilities to support their child throughout the education process. Each parent received a Resource Kit of materials to use with his/her child during the remaining weeks of summer.

A new collaboration effort is underway through the Home Visitation Community Task Force. Public and private service providers are working together to plan and implement a home visitation program. More information related to this endeavor will be forwarded in future months.

Improving the lives of children and families.

From the Speech & Hearing/Early-In Programs: *"Crystal is a 4-year, 2-month old female who was admitted to this Smart Start Program at Cumberland County Mental Health due to some extreme behaviors that she was exhibiting. She had some aggressive behaviors and also aggressive verbalizations. Her mother reported that she has engaged in severe self-abusive behaviors on an average of once a month. Crystal would also use aggressive verbal statements, such as telling her dolls to die or telling others that she will 'kill them' or talk about morbid scenes, such as her arm being chopped off. The child also reportedly was having a great deal of trouble with pro-social behaviors and had loose interpersonal boundaries. Community networking was performed between the Speech and Hearing Clinic and services through the Early-In Program to diagnose a suspected hearing problem and to determine the child's need for speech therapy. It was found that Crystal had a significant problem with hearing out of one ear, with a 75% hearing loss. The ear was drained, and throughout therapy, the therapist noticed that her pro-social and interpersonal boundary skills improved greatly. The therapist also helped Crystal learn some anger management skills to help redirect the aggressive behaviors and other maladaptive means she had been using to get her needs met. Crystal is now able to hear normally due to intervention through an ear, throat, and nose specialist to whom she was referred. She is also functioning better in the area of anger management and with more adaptive and appropriate behaviors in her socialization interactions with others, through this collaborative effort among agencies."*

From the Exceptional Children's Preschool: *"Our parent trainer has worked with a child with special needs and his family since Smart Start began funding our program 2-1/2 years ago. This young child has special needs as a result of neonatal exposure to drugs. He lives with his grandmother who is his legal guardian. This child has difficulty paying attention and following rules, is overactive, and has a history of significant behavior problems in his special class and at home. Our parent trainer, during this two-year period, has provided parent training, counseling, home visit follow-up, transportation, and crisis intervention, and has networked with Cumberland County Mental Health, Cumberland Hospital, Department of Social Services, child care, and other local agencies to help this young child and his disabled grandmother. Thanks to Smart Start funds, this child has access to many services which enabled the family to maintain stability and hopefully gain a good start in life for this child."*

From the BRIDGES Family Resource Program: *"L" is a grandmother raising a large family of children of various ages. She has praised Smart Start, the BRIDGES Program, and Head Start for providing her with assistance and encouragement. She has participated in the BRIDGES Kindergarten Parent Academy and various other workshops sponsored by BRIDGES. Her family attended the end of the year field trip, and she has received referrals for her daughter to attend the Tarheel Challenge program as an alternative to completely dropping out of the educational process. This grandmother has become an advocate for our programs, volunteering when she can and referring other parents. She inspires us to all keep on doing what we're doing with her appreciation and support."*

From the Dorothy Spainhour Program: *"In the Fall of 1996, a mother and child entered the Spainhour Smart Start Program. The child had experienced repeated physical abuse, and was exhibiting behaviors indicating depression, anxiety, and low self-esteem. The mother was encountering difficulties herself, in responding to developmental issues with her child who had Downs Syndrome and in trying to create a balance in her life. She expressed an interest in going back to college and obtaining a job. After eight months of participation in this Smart Start program, the family has undergone changes that have benefited the child. First, the mother has established herself economically through community resources, and is working toward an Associate's Degree. She has become more knowledgeable of her child's disability, ways to work with her child, and information about community resources and support. She has strengthened her parenting skills and chosen to become a productive member of the community. The mother has also followed through with obtaining a child care subsidy from the Department of Social Services. The child's placement in a child care program has resulted in advancement in all his developmental areas. He will continue in the program until time for transition into the public school system."*

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Smart Start funded agencies and organizations in Cumberland County are working collaboratively to more effectively make their services available to children and families. They are communicating, planning, and providing activities and services jointly. Those participating in joint activities are Art Trunks, BRIDGES, Preschool Handicapped Program, Teen Moms, and Music Boxes. Although the Cumberland Partnership supports and encourages this collaboration, we must credit the agencies and organization for their initiative and work in making this collaboration happen.

The Cumberland Partnership proudly boasts about an event that occurred on April 16, 1997 -- Smart Start Day. It was a full day of activities, learning experiences for children and adults, and enjoyment by everyone. Exhibits provided by our contractors informed the public about available services and information. Oral health and vision screenings were provided. Information about choosing quality child care was available for parents. Children were entertained by bi-lingual story telling, music experiences, and arts activities. In addition, the contractors learned about each other and collaborative efforts were encouraged by their joint participation on this day. A total of 2,200 children, parents, child care providers, and others from the general public participated in this event. It was a great day!

Child Care and Education

Subsidies
10 children with special needs received Smart Start subsidized care this quarter, and
13 children with special needs received Smart Start subsidized care this year to date.

424 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
989 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

540 other children received Smart Start subsidized child care this year to date.

Quality Improvement
349 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
1,782 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

712 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
1,657 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

6,348 children were enrolled in programs/classes that received quality enhancements this quarter, and
18,170 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
532 children with special needs received one or more special therapies or interventions this quarter, and
2,421 children with special needs received one or more special therapies or interventions this year to date.

3 children with special needs received care or support because of an emergency or crisis situation this quarter, and
10 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
4,329 children received one or more educational programs this quarter, and
11,406 children received one or more educational programs this year to date.

Health Care / Health Care Education

504 children received health and/or developmental screenings this quarter, and
5,822 children received health and/or developmental screenings this year to date.

32 families received health care education this quarter, and
160 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

682 families received direct child care resource and referral services this quarter, and
2,072 families received direct child care resource and referral services this year to date.

312 families received indirect child care and related information, for example, written materials, this quarter, and
4,759 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

354 families received parent education and/or support services in family resource centers this quarter, and
1,259 families received parent education and/or support services in family resource centers this year to date.

394 families received parent education and/or support services in places other than family resource centers this quarter, and
1,548 families received parent education and/or support services in places other than family resource centers this year to date.

Transportation

93 children and family members were provided transportation to child care, health or other services this quarter, and
205 children and family members were provided transportation to child care, health or other services this year to date.

DAVIDSON COUNTY SMART START

Smart Start Impact

From the AmeriCorps program: During the 4th quarter, 32 children in three Davidson County centers received higher quality child care by having a Smart Start funded AmeriCorps volunteer in their classroom. The 32 children included 9 infants, 8 two-year-olds, and 15 four-year-olds. The director of each center reported positive impacts from having an "extra pair of trained hands" in the classroom. Because each of the volunteers was trained and had from six to 15 months of experience, directors consistently reported that the quality of the care they provided was good. Having a volunteer resulted in the equivalent of reduced child-staff ratios, although the AmeriCorps volunteer was not utilized to meet required ratios. Among the feedback were the following comments:

"H was knowledgeable about developmentally appropriate practices and really understands the needs of young children. She is an outspoken advocate for providing quality care and education for preschoolers and she was definitely 'ready' to come into my classroom."

"K was really effective in interacting with infants. She understands what infants need and was committed to holding and communicating with our youngest babies. She was a model for our other infant teachers."

"F was simply wonderful! Having her available in the two year old room was especially helpful to one child when his teacher left during the year. This child really has difficulty adapting to change, and when his teacher left, he was really lost. Because he knew F and was comfortable with her, the transition to a new teacher was much easier for him."

From the Child Care Education & Training program and Quality Enhancement project: The Education & Training program provided 18 training classes for child care providers with 203 participants (unduplicated) and 275 registrations for an average of 15 attendees per class. These participants work with an estimated 1,296 children and represent 33 centers and 14 family child care homes in Davidson County. The program provided on-site technical assistance to 32 staff at 6 child care centers. This technical assistance project to improve quality affected approximately 255 preschool children in Davidson County child care centers. The program also provided on-site technical assistance to 11 family child care home providers and improved child care for approximately 84 children.

During the 4th quarter, a new Quality Enhancement initiative, Incentives for Quality (IQ), was implemented. This program provided Davidson County child care providers with grant funds to purchase materials and equipment for their facilities. All items purchased were selected to assist in implementing the facility's quality improvement plan. Each plan was developed collaboratively by the provider and the Smart Start trainer from the On-site Technical Assistance program. A total of 13 facilities, six centers and seven family child care homes, participated in the project during the 4th quarter, impacting 19 classrooms, 27 classroom teachers, and 291 children.
Changes in center classrooms and family homes were measured by comparing pre and post assessment scores of environmental quality. The rating scale scores increased consistently across participating facilities, a clear indication of improvement in the child care environment. Overall, average scores for family child care homes increased from 5.14 on the pre-assessment to 6.11 on the post-assessment, and, for centers, the increase was from an overall average pre-assessment score of 4.04 to 4.81 on the post-assessment.

From the Davidson County School Readiness Specialist: In the Southwood community during the 1996-97 fiscal year, Smart Start has had a tremendous impact in helping to bridge the gap between home and school. The School Readiness Specialist for Davidson County has worked closely with the principal,

teachers, social workers, and school nurses in providing assistance and information to many families. Families with preschoolers have received services because a need was recognized and the agencies that could provide specific help were alerted. Parents of school age children who also have preschoolers have volunteered in the school for the first time. Many reported that they had never felt comfortable at school as a student or as a parent. Smart Start made it possible for a neutral person to represent the school community in a non-threatening and welcoming way.

Here is an example of one family who was helped by this Smart Start program. After visiting Anna and her mother in their home for seven months, Anna, who is 3, asked when she could come to school. I explained that I had a little room at Southwood School where I met with some of my families and I invited Anna and her mother to come to the school for their next visit. Anna was delighted, but it was obvious that her mother was a bit apprehensive. I assured the mother that it would be a good experience and she agreed to come. On the day of our visit, Anna and her mother arrived thirty minutes early. We went to my room and, after spending the better part of an hour doing our scheduled activity, Anna's mother began telling me that she had dropped out of school and had recently thought about going back to get her GED. She said that she was afraid to go to the community college and that it was a far distance from their home. Her car was not very dependable and she also has two young school-aged boys. I talked with Anna's mother and told her that I had returned to school after being a homemaker for 15 years. I told her that it was something that I had never regretted and I felt sure that she would be successful if she chose to return to school. I told her that the community college had begun offering GED classes in schools and other places that were more convenient for people. I gave her some information and some numbers to call and I feel sure that Anna's mother will eventually feel secure enough to finish her degree. She told me that she did not want any of her children to quit school, and she knew that she needed to finish so that she could encourage them without fear of them saying, "Well you quit - why can't I?."

The Teen Parent Program would not be in existence if it were not for Smart Start. Our community has a high rate of teen pregnancy and this program affects students who get pregnant and are presently attending school. The greatest impact occurs among the students who are 15 years old or younger and decide to keep their babies. Girls in this age group have often not developed higher level thinking skills and may not have the knowledge of parenting skills since they are still children themselves. Through parenting skills classes, on-site training in the child care, and foods and nutrition classes, our program has provided these young mothers with knowledge and skills that have advanced their level of parenting skills. The best measure of success of this program among these students is observation. When these students enter the program, most have not been around young children. Their only knowledge of parenting has been learned through imitating their own parents. In some cases, their own parent's level of parenting skills is low. Through Smart Start funds, we have a certified child care center in the schools with certified child care professionals. These young mothers and students are assigned to the child care center where they learn to model the behavior of these workers. These students also take parenting classes that are paid for through Smart Start funds. Here they gain knowledge and are able to apply it in both the child care center and with their own children. We also invite outside speakers to come and speak to the students to bring additional knowledge to these students. Many times these outside speakers are workers in other Smart Start programs.

Improving the lives of children and families.

From the AmeriCorps program: L was a four year old in the classroom of an AmeriCorps volunteer, H. L never wanted to sleep during nap time, and, frequently, her behavior was disruptive to other children. H noticed that L loved to make "faces" throughout the day. After discussing her idea with the teacher, H talked with L and placed a mirror near L's cot so that L could make faces to herself during nap time. This provided L with an outlet that enabled her to entertain herself during nap time without disturbing her peers. After several days, L asked H, "What does my face look like when I'm asleep?" H reminded L that she had never seen L napping, so she did not know what her face looked like when she was asleep. L asked H if she would tell her what L's face looked like if she went to sleep. After

assurances that H would share, L decided to take a nap. After her nap, L and H had a long talk about what L's face looked like while she was sleep. This anecdote demonstrates the type of interaction between caregiver and child that helps children develop thinking skills, solve problems, and develop self awareness while supporting the child's need to make decisions, explore possibilities, and feel safe. The AmeriCorps volunteer enhanced the child's opportunity for one-on-one interaction with a caring adult; which is the essence of quality care and education.

Comments from providers who participated in the On-site Technical Assistance program in the Child Care Education & Training project included the following:

"I was made more aware of what was needed to have a well-rounded, better organized, and smoothly run child care program."

"The On-site Consultation has helped us to offer more hands-on learning, exploration, and better interaction between child and adult."

"I have been made more aware of what younger children are capable of doing."

"Our staff has learned about developmentally appropriate practices, emergent curriculum, and how to structure our environment in a more child friendly way."

From the Mobile Family Resource Unit: Sarah is 4 years old who has cerebral palsy. She lives with both parents and has a 5 month old sibling. In preschool, Sarah has had difficulty adjusting to her peers and coping with her disability. Smart Start has helped Sarah, through the Mobile Family Resource Center, to make changes in her social and emotional adjustment. Sarah now looks forward to attending school, and Mom feels much better leaving Sarah and is happy with Sarah's new outlook.

From the Davidson County School Readiness Specialist: After weeks of making phone calls and actively recruiting families for the Parents as Teachers program, word of mouth kicked in and parents began to call to inquire about participating in this program. One of these phone calls came from the aunt of a 3 year old boy. Billy lived with his father in a trailer in a very rural section of the county and was cared for during the day by his 75 year old grandmother. During our first visit, it was obvious that Billy had a speech problem. His father recognized the problem and indicated that he felt like Billy was just trying to talk too fast. Billy was eager to talk and jabbered constantly, but I could not understand him. After a couple of visits with Billy, I inquired about the possibility of having his speech and hearing screened by a professional. Billy's father told me that Billy had tubes in his ears, which could possibly be contributing to his speech problem. Since Billy's father worked every day from 8 to 5 and the grandmother did not drive, I told him that I would check into the options and he was very grateful and very receptive. The Smart Start Mobile Family Resource Center was conducting speech and hearing screenings during May in cooperation with the three school systems. Speech pathologists had volunteered to travel around the county on the bus and screen preschoolers so that they could receive early intervention if necessary. There were special hours in the evenings and one of the stops happened to be at the local Walmart. I called Billy's father and asked if he would be interested in making an appointment to have Billy screened. He was quick to agree, so I provided him with the phone number and all of the information he needed. Billy was screened and he indeed can benefit from speech classes before he enters school. Since his grandmother cannot drive, we will arrange for Billy to participate in formal speech classes at the local elementary school and Smart Start will help to provide the transportation. With the help of these Smart Start funded programs, Billy will enter school more articulate and more ready to be successful in kindergarten.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

In 1996-97, Parent Education Services had dialogue with every local Smart Start agency and made contacts with approximately 21 other community agencies. One model collaborative effort has been implemented with the Health Department and the county's two hospitals. PES will provide all Davidson County mothers of newborns with parenting manuals while they are in the hospital. Health Department post-partum nurses, visiting within two weeks of delivery, will refer to the parenting manual and will

introduce the new parents to PES' "Nurturing Touch," a parenting program designed to enhance infant development and maternal-child bonding. PES instructors will provide further in-home Nurturing Touch training visits and encourage new parents to participate in a variety of parent education classes as their child grows and develops.

Child Care and Education

Subsidies

14 children with special needs received Smart Start subsidized care this quarter, and
40 children with special needs received Smart Start subsidized care this year to date.

91 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

625 other children received Smart Start subsidized child care this quarter, and
625 other children received Smart Start subsidized child care this year to date.
**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement

33 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
80 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

253 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
856 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

1,414 children were enrolled in programs/classes that received quality enhancements this quarter, and
2,003 children were enrolled in programs/classes that received quality enhancements this year to date.

32 AmeriCorps members worked with preschoolers in child care centers so they could receive one-on-one care and education this quarter, and
61 AmeriCorps members worked with preschoolers in centers so they could receive one-on-one care and education this quarter.

Children with Special Needs

107 children with special needs received one or more special therapies or interventions this quarter, and
178 children with special needs received one or more special therapies or interventions this year to date.

3 children with special needs received care or support because of an emergency or crisis situation this quarter, and

15 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
1,161 children received one or more educational programs this quarter, and
4,429 children received one or more educational programs this year to date.

Health Care / Health Care Education

2 children received immunizations this year to date.
195 children received health and/or developmental screenings this quarter, and
226 children received health and/or developmental screenings this year to date.

174 children received any other health services, other than transportation, this quarter, and
632 children received any other health services, other than transportation, this year to date.

180 families received health care education this quarter, and
651 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
330 families received direct child care resource and referral services this quarter, and
980 families received direct child care resource and referral services this year to date.

360 families received indirect child care and related information, for example, written materials, this quarter, and
1,022 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
429 families received parent education and/or support services in family resource centers this quarter, and
1,225 families received parent education and/or support services in family resource centers this year to date.

536 families received parent education and/or support services in places other than family resource centers this quarter, and
1,393 families received parent education and/or support services in places other than family resource centers this year to date.

1,240 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
8,349 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

251 children and family members were provided transportation to child care, health or other services this quarter, and

906 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

Smart Start has helped bring the NC Food Bank to the southwestern part of Halifax County. The White Oak Parent Child Center is now a food pantry site. This addition to the services available at the Center came about as a result of the activities of the Parent Advisory Council. Each year, the Parent Advisory Council of the White Oak Parent Child Center has sponsored needy families in the area at Christmas and Thanksgiving by collecting food and other items. In addition, special food and clothing drives have been held for families whose homes were destroyed by fire. Seeing this ongoing need in the area prompted members of the Parent Advisory Council to suggest having a food pantry on site at the White Oak Parent Child Center. With the assistance of Center staff, the application and training requirements of the NC Food Bank have been completed, and a registered food pantry site has been established at the Center. This will aid families that can not get to the Department of Social Services (more than 25 miles away) in times of crisis. In addition, families accessing the food pantry will have an opportunity to learn about other services available at the Center and throughout Halifax County. The White Oak Parent Child Center is a collaborative effort of the Halifax County Smart Start Partnership for Children and the Halifax County Schools, in conjunction with the Choanoke Area Development Association.

In June 1997, the Halifax County Child Care Resource and Referral Service sponsored a conference for early childhood professionals and parents. The conference was held at Halifax Community College. The day-long training event included presenters from all over North Carolina, covering topics such as children with special needs, computers in the classroom, parent involvement, and management. More than 120 participants attended, coming from Halifax, Nash, Edgecombe, Hertford, Warren, Northampton, and Wilson counties. The key note address was given by Dr. Thomas Moore, and, as always, he was an entertaining and inspiring speaker. Representatives from a variety of local agencies also participated as presenters and attendees, including the three school systems, the Mental Health Center, the Health Department, the Department of Social Services, and the community college. Evaluations completed by participants indicated that they found the conference to be helpful and educational. Along with the continuing education credits they received, the participants were also pleased with the variety and quality of the presentations. They also appreciated the opportunity to get together with their colleagues. We hope to make the CCR&R Early Childhood Professional Conference an annual event in Halifax County. The Child Care Resource and Referral Service of Halifax County is funded by the Halifax County Smart Start Partnership for Children with Smart Start and other grant funds.

Child Care and Education

Subsidies

34 children with special needs received Smart Start subsidized care this quarter, and
101 children with special needs received Smart Start subsidized care this year to date.

20 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
109 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

176 other children received Smart Start subsidized child care this quarter, and
383 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs

Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

178 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date (e.g., *Head Start, Chapter I, half-day preschools).

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement

168 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
173 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

26 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
92 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

88 children were enrolled in programs/classes that received quality enhancements this quarter, and
88 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs

34 children with special needs received one or more special therapies or interventions this quarter, and
227 children with special needs received one or more special therapies or interventions this year to date.

1 child with special needs received care or support because of an emergency or crisis situation this quarter, and
9 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs

124 children received one or more educational programs this year to date.

Health Care / Health Care Education

16 children received immunizations this year to date.

828 children received health and/or developmental screenings this year to date.

1,184 children received any other health services, other than transportation, this quarter, and

4,547 children received any other health services, other than transportation, this year to date.

20 families received health care education this quarter, and
805 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

154 families received direct child care resource and referral services this quarter, and
406 families received direct child care resource and referral services this year to date.

1,512 families received indirect child care and related information, for example, written materials, this quarter, and
3,996 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

183 families received parent education and/or support services in family resource centers this quarter, and
350 families received parent education and/or support services in family resource centers this year to date.

340 families received parent education and/or support services in places other than family resource centers this quarter, and
1,528 families received parent education and/or support services in places other than family resource centers this year to date.

159 agencies were added to the IRIS database to increase collaboration and information sharing among agencies this year to date.

Transportation

31 children and family members were provided transportation to child care, health or other services this quarter, and
207 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

Smart Start is sponsoring a breastfeeding education and support program through the NC Cooperative Extension Service, funded by Glaxo-Wellcome. The breastfeeding specialist reported this story: *"A mother wanted to breastfeed, but she could not get the baby to begin to feed. Several nurses were also in the room trying to help her because the baby was hungry and was crying. The stress level was high and the mom was about to cry also when I walked in the room. With my specialized training, I was able to help the mom get the baby to start feeding. The mom and baby were happy, the nurses asked me how I did it, and everyone laughed and relaxed. I had a phone consultation with the mom about two weeks ago and she told me that if it weren't for me being there for her every time she paged me, she would have given up breastfeeding."* Now, because of Smart Start private funds, this infant will have a better start in life!

Improving the lives of children and families.

The Maternal/Child Case Manager, a Smart Start funded position, believes that the Triad Project made a difference in the case of a teen mom who had moved out-of-state soon after her daughter was born. A Child Services Coordination referral had been made for her daughter at birth, but then the family moved to Virginia. The teen mom returned to the hospital in NC about a month ago, pregnant again and showing signs of pre-term labor. The family had been living in very poor conditions in Virginia. The Maternal/Child Case Manager, along with the physician, worked with this mom at the hospital to make sure she had a stable environment to live in and that she received the support she needed. Another referral for CSC was made for the daughter. The mom is following up with her physician and everything is going well at this time.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Hertford Partnership received a grant from Wachovia Bank to fund the Jump Start program. Children who will be entering kindergarten in the fall who have had no previous child care experience were recruited to participate in the summer program. This program is designed to expose children to appropriate classroom experiences and geared toward developing basic cognitive and social skills needed for a smooth transition from home to kindergarten. An advisory committee of members from several different agencies came to the table to plan and execute the project, with the resulting collaboration making this project a success. Hertford County Schools was contracted by the Partnership to provide the program, teachers, and facilities, as well as providing breakfast and lunch. Parents as First Teachers added the parent education component. The Department of Social Services Social Worker helped recruit children and provided continuing support by ensuring child attendance. Choanoke Public Transportation Authority was contracted to provide transportation for the children and arranged its bus routes so that the children's riding time to school was minimized. The Partnership purchased materials for the classrooms. A total of 49 children benefited from this program, and parent feedback has been very positive and appreciative. The same agencies have now held a follow-up meeting to assess the benefits of the project and develop a list of suggestions for improving the project.

Child Care and Education

Subsidies

18 children with special needs received Smart Start subsidized care this quarter, and

22 children with special needs received Smart Start subsidized care this year to date.

20 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

160 other children received Smart Start subsidized child care this quarter, and
191 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs
Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

40 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date (e.g., *Head Start, Chapter I, half-day preschools).

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement
47 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
159 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

41 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
67 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

77 children were enrolled in programs/classes that received quality enhancements this quarter, and
189 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
2 children with special needs received one or more special therapies or interventions this quarter, and
7 children with special needs received one or more special therapies or interventions this year to date.

20 children with special needs received care or support because of an emergency or crisis situation this quarter, and
115 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
49 children received one or more educational programs this quarter, and

49 children received one or more educational programs this year to date.

Health Care / Health Care Education

7 children received immunizations this quarter, and
143 children received immunizations this year to date.

241 children received health and/or developmental screenings this quarter, and
438 children received health and/or developmental screenings this year to date.

272 children received any other health services, other than transportation, this quarter, and
957 children received any other health services, other than transportation, this year to date.

80 families received health care education this quarter, and
368 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

10 families received direct child care resource and referral services this quarter, and
43 families received direct child care resource and referral services this year to date.

53 families received indirect child care and related information, for example, written materials, this quarter, and
174 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

113 families received parent education and/or support services in places other than family resource centers this quarter, and
171 families received parent education and/or support services in places other than family resource centers this year to date.

44 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
388 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

324 children and family members were provided transportation to child care, health or other services this quarter, and
774 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

The funding for the Nurse Educator which began in November 1996 has resulted in a major enhancement of the Jones County Smart Start Program. In less than one year, 39 new born children have received home visits, 39 mothers of newborns have received parenting skills training, 109 children under six have received home visits, 100 parents have participated in the pre-test on parenting skills, and 10 parents have taken the post test. The Nurse Educator works collaboratively with the Health Department, Department of Social Services, Board of Public Education, Health Check Coordination, Child and Family Specialists, Head Start, all registered child care centers in Jones County, cooperative playgroups, and Agricultural Extension. She makes referrals for children and families to other needed services and arranges transportation with the Smart Start CARTS van.

Improving the lives of children and families.

The Nurse Educator made a home visit to a family who had a 4 year old child, based on a referral from the Health Check coordinator. During the visit, the Nurse Educator discovered that the child had had an evaluation at the Developmental Evaluation Center 2 to 3 years ago, but no follow-up or intervention had ever taken place. The Nurse Educator enlisted the help of the Family and Child Specialist who resides in the Smart Start office. Together they worked with the mother and got needed assistance for the child. The mother was also helped, through the work of the therapist, to come to terms with the previous death of infant. During a subsequent visit, the mother had a severe nose bleed, and, in treating her, the Nurse Educator found her blood pressure was extremely high. She was able to coordinate the use of the Smart Start van to take the woman for immediate medical care. This mother and a child are better off, through the coordination of services and the collaborative partnerships that exist in Jones County.

Child Care and Education

Subsidies

15 children with special needs received Smart Start subsidized care this quarter, and
15 children with special needs received Smart Start subsidized care this year to date.

6 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

70 other children received Smart Start subsidized child care this quarter, and
85 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs

Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

30 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date (e.g., *Head Start, Chapter I, half-day preschools).

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement

2 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
36 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

12 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
24 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

91 children were enrolled in programs/classes that received quality enhancements this quarter, and
92 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs

18 children with special needs received one or more special therapies or interventions this quarter, and
27 children with special needs received one or more special therapies or interventions this year to date.

1 child with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs

101 children received one or more educational programs this quarter, and
169 children received one or more educational programs this year to date.

Health Care / Health Care Education

59 children received immunizations this quarter, and
202 children received immunizations this year to date.

205 children received health and/or developmental screenings this quarter, and
387 children received health and/or developmental screenings this year to date.

276 children received any other health services, other than transportation, this quarter, and
276 children received any other health services, other than transportation, this year to date.

312 families received health care education this quarter, and
512 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
43 families received direct child care resource and referral services this quarter, and
56 families received direct child care resource and referral services this year to date.

36 families received indirect child care and related information, for example, written materials, this quarter, and
64 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
117 families received parent education and/or support services in places other than family resource centers this quarter, and
319 families received parent education and/or support services in places other than family resource centers this year to date.

75 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
179 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

42 children and family members were provided transportation to child care, health or other services this quarter, and
261 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

In June, Smart Start of Mecklenburg County awarded the fifth round of Salary Supplements to child care teachers, directors, assistant teachers, assistant directors, and teacher's aides, with improvements to the program. In the previous four rounds, child care facilities received applications along with a cover letter and instructions on how to complete the application. Less than 50% responded to this approach. Additionally, a high percentage of applicants who did return applications were denied supplements because their applications were incomplete. In an attempt to heighten interest and clarify the process, child care directors were invited to attend a workshop at which the Salary Supplement Program was discussed. Of the 170 invitations to the workshop, 122 or 72% of the facilities responded. Child care professionals in 92 facilities submitted a total of 579 applications. Of these 579 applications, 551 were approved and a total of $103,238 was awarded in salary supplements. The number of approved applications in the fifth round surpassed the total number of applications received in any one of the previous four rounds and significantly fewer child care professionals were denied supplements due to incomplete applications. One applicant wrote to say thanks for the supplement and to share her future educational goals, "Smart Start is a very important program. Plans are in the works for my education to continue."

June 1997 was the third anniversary for the Mobile Solution Bus. The bus provides immunizations, WIC nutritional certification for children and pregnant women, and developmental screenings to determine if children ages birth to 5 years are developing motor, language, cognitive, and social skills at about the same rate. The Mobile Solution Bus is able to provide these services to many individuals who do not have transportation or who may need one of the services quickly, without waiting for an appointment. Since becoming operational in 1994, approximately 10,000 clients have received services. Because Smart Start is committed to providing quality training opportunities for early childhood professionals, 85 participants were able to attend High Scope's Active Learning and Music and Movement workshops. High Scope Educational Research Foundation is internationally known for its research center and curriculum development. Active Learning encourages children to actively initiate their own learning experiences, and Movement and Music focuses on expressing creativity through purposeful movement. One participant wrote on her evaluation, "My children will benefit from these techniques. I feel I have grown as a teacher."

Improving the lives of children and families.

The Smart Start Inclusion Training Project provides the training and support necessary for child care professionals to successfully integrate children with special needs into the same care settings as typically developing children. This year, over 80 child care professionals were trained, 68 children were identified as having special needs, and all are now better served. One of the child care administrators at Head Start remembers what is was like before they participated in Inclusion training: "John seemed to be hyperactive, distractible, and impulsive, with a short attention span. Before receiving training, the staff would often become frustrated with him. After completing the Smart Start training, our staff was able to deal more effectively with John. The training heightened our awareness of the disability, gave us information about his specific needs, and we learned about working with other human service agencies. Since then, we have adapted our environment for John, shortened John's waiting time, and made our open areas more interesting so he becomes involved and stays occupied for longer periods of time. Now we can provide experiences that John can do without instruction and he is encouraged and praised for his attempts. The Smart Start Inclusion Training truly made a difference, and now we can provide a setting that will allow John to become successful in life."

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Parents and teachers of preschool age children will soon have a new place to turn for help in finding answers to their child rearing questions. On August 12, 1997, the Parent/Teacher Resource Center will open, giving the public access to information on a wide range of parenting issues, including child development, discipline, special needs, finance, and dealing with loss and grief. Funded by Smart Start of Mecklenburg County, the Center is located in the office of Child Care Resources Inc. The Resource Center is just one piece of an on-going project intended to inform parents of the many resources available to improve their understanding and ability to "parent" more effectively. A Parent Training Clearinghouse was made available in response to a 1995 parent training survey which revealed many parents were unaware of the myriad of educational opportunities offered through various community organizations. The Clearinghouse is a database listing of all parent training and support groups available in Mecklenburg County, including information on the types of training offered, locations, times, and fees. Eventually, the Family Involvement Coordinator will offer parent training programs and will set up "mini" parent information centers in area AA Plus child care centers.

Last year in June, over 300,000 people rallied in Washington, DC, at the Lincoln Memorial to advocate for children. This year, local communities were asked to plan their own events. Child Care Resources Inc. solicited the support of community organizations, including Smart Start of Mecklenburg County, to organize Stand for Children-Charlotte. The event, held June 1, 1997, at Discovery Place, drew over 600 people. Approximately 100 children received free admissions. This fun-filled afternoon featured the Mobile Solution Bus, entertainment, informational booths, refreshments, and special guest speakers including former Charlotte Mayor Harvey Gantt. Over 220 participants signed petitions supporting this year's theme, "Healthy Children," encouraging health coverage for all children.

Child Care and Education

Subsidies

221 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

878 other children received Smart Start subsidized child care this quarter, and
900 other children received Smart Start subsidized child care this year to date.

Quality Improvement

417 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
1,467 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

816 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
1,516 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

551 child care professionals have received salary supplements this quarter, and
551 child care professionals have received salary supplements this year to date.

Children with Special Needs

19 children with special needs received one or more special therapies or interventions this quarter, and

86 children with special needs received one or more special therapies or interventions this year to date.

Health Care / Health Care Education

395 children received immunizations this quarter, and
1,263 children received immunizations this year to date.

153 children received health and/or developmental screenings this quarter, and
1,068 children received health and/or developmental screenings this year to date.

898 families received health care education this quarter, and
2,517 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

120 families received direct child care resource and referral services this quarter, and
446 families received direct child care resource and referral services this year to date.

466 families received parent education and/or support services in places other than family resource centers this quarter, and

1,162 families received parent education and/or support services in places other than family resource centers this year to date.

11,266 families were contacted through community outreach efforts, such as Family Ties, this quarter, and

42,807 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Smart Start Impact

Smart Start funds were made available for playground safety grants to family child care providers. A total of 12 family providers took advantage of this funding opportunity and provided a 20% match to make outdoor areas safer for the children they serve. Improvements included new sand and mulch for safer surfaces, removal of unsafe equipment or tripping hazards like roots, and repairs and replacements of gates and fences. One family child care provider wrote, *"The Smart Start grant provided my facility with installation of a safe sturdy chain link fence surrounding the playground area. The old fence had broken and rusted wires could have injured the children. I greatly appreciate the protection this playground can now provide, and it has helped me to meet some of the new playground requirements."*

Improving the lives of children and families.

Through the Immunization Collaboration funded by Smart Start, new community-based clinics are being offered to families as an alternative to the public health department. At the special clinic held at the local mall, one of the parents who brought her child to be immunized remarked that she had been waiting on this clinic because she felt that her child would be less intimidated than in a medical setting. The child was 17 months old and had had none of his immunizations since birth.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

In Orange County, Day Care Services and the local Department of Social Services work together collaboratively to provide expanded child care referrals and assist low income families with applications for child care subsidies. Day Care Services counselors outstation at DSS many office hours per week in Hillsborough (DCSA is located in the southern part of the county and Hillsborough is about 30 minutes away to the north). These counselors provide information on available child care resources while the family is involved with DSS. This helps busy families by not requiring them to make extra trips to other agencies, and supports them in their search for employment because they encounter no delay between finding a job and locating appropriate child care.

Child Care and Education

Subsidies

11 children with special needs received Smart Start subsidized care this year to date.

78 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
188 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

244 other children received Smart Start subsidized child care this quarter, and
667 other children received Smart Start subsidized child care this year to date.

Quality Improvement

156 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and

616 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

188 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
425 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

999 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,084 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
16 children with special needs received one or more special therapies or interventions this quarter, and
65 children with special needs received one or more special therapies or interventions this year to date.

1 child with special needs received care or support because of an emergency or crisis situation this quarter, and
16 children with special needs received care or support because of an emergency or crisis situation this year to date.

Health Care / Health Care Education

202 children received immunizations this quarter, and
826 children received immunizations this year to date.

2,163 children received health and/or developmental screenings this quarter, and
2,850 children received health and/or developmental screenings this year to date.

Family and Community Services

Child Care Resource & Referral Services
93 families received direct child care resource and referral services this quarter, and
321 families received direct child care resource and referral services this year to date.

6 families received indirect child care and related information, for example, written materials, this quarter, and
27 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
176 families received parent education and/or support services in family resource centers this year to date.

1,067 families received parent education and/or support services in places other than family resource centers this quarter, and
2,631 families received parent education and/or support services in places other than family resource centers this year to date.

5,500 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
15,075 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

36 children and family members were provided transportation to child care, health or other services this quarter, and
58 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

Region A Smart Start sponsors "A Child's Garden" project which provides professional mental health services to children, care providers, and families. The following story is told by Region A mental health professional, who was able to go beyond the ordinary call of duty:

"I work with a little boy, Nick, who was born with a defective heart valve. He has had open heart surgery before and will continue to have valve replacements until he is grown. He has had additional ongoing problems with his heart, and most recently has had a problem maintaining a regular heartbeat. The decision was made to put a heart pacer in him, and he was scheduled for surgery at Duke's pediatric cardiac unit in Durham, several hours away from home. Originally, his mom had several offers by friends and relatives to accompany her on the long trip to Duke, but when the time came, there was no one who was able to go. Nick's mom was extremely concerned about going to Durham by herself -- uncertain of finding her way and afraid of something happening to Nick along the way. With speedy help from people at the Smoky Mountain Center, I was able to arrange to make the trip with them. I was also given gifts of money for this family by many colleagues and friends because this mom had virtually no money and Social Services could only reimburse them for mileage after the trip. The Eblen Foundation said that they would help, too, if needed. I even enlisted the help of my former husband and his wife, who are at Duke, to be a support system after I came back to the mountains.

During the trip down, we sang lots of songs, I told stories and played with Nick, and we generally had a good time. I had not been to Duke Hospital before, and even though the size was intimidating, the people were wonderful. I was really impressed. I worked closely with the social worker there, explaining the situation and leaving telephone and pager numbers if assistance was needed. I also was very aware that I wouldn't have wanted to have done this by myself and couldn't even see how the logistics with car and parking, for example, would have worked without an additional person. I was delighted to see how much the preparation that I had done with Nick paid off in the hospital. He hopped in the wheel chair to go to radiology and said, "Just like the bear in the book!" There were some pretty funny scenes when I was running down the hall with his IV pole and he was riding a tricycle.

One of the ongoing problems with Nick is treating his hyperactivity without medication, due to the multitude of other medications he is on because of his heart. This problem has increased since he got his pacer because he is consistently getting more oxygen to his brain and has even more energy than usual. This is requiring ongoing help for him to learn to control himself as well as educating his mom and caregivers in the best ways to deal with him. There is still work to do on this. But, Nick is doing well -- the other day I heard Nick tell another child that he had had a "peacemaker" put in him."

From the Graham-Swain District Health Department, Graham County Smart Start Nurse:

Smart Start funding has allowed for extensive additions to immunization up-dates on a much more timely basis. Prior to Smart Start , educational classes were not offered in the child care centers or the Head Start settings by the health department. Now multiple programs about the importance of scheduled immunizations are presented to children as well as staff. The Smart Start nurse's position in our health department has also been very instrumental in getting the dental program up and going for our Medicaid children. Without Smart Start sponsorship, Medicaid children would still have to travel up to 150 miles (one way) to obtain dental care. In addition, the Smart Start nurse visits child care centers on a regular basis. She is able to identify health issues and assist in education and referral services for a much broader scope of our community.

Improving the lives of children and families.

Stecoah Valley Satellite Family Resource Center is a community based family support project that was made possible by Smart Start funds used for renovation as well as materials and supplies. Blended with Family Preservation/Family Support funds, a wonderful community resource was created in a remote

area where previously no services or resources were available. There are a number of teenagers in our community which has had a serious problem with teen suicide. One young woman spent a good deal of time here in the Family Resource Center when she was having a tough time at home. She verbalized some suicidal feelings and the FRC Coordinator contacted the counselor at the local mental health clinic who was familiar with the family and guided the coordinator through the process of assessing the level of risk with the girl. It has been an ongoing process that has so far been very productive. The feeling is that the FRC being available and staffed with trained personnel helped avert a possible tragedy. In my estimation, that one incident makes all the funds well spent.

Four Square Community Action provided quality extended child care to 64 children and their families at 2 Head Start centers (Bryson City and Murphy). The children were provided with quality care and instruction. They were provided with an afternoon snack that met USDA requirements. With child care no longer an obstacle, many parents were able to return to school for either GED instruction or to further their college education. Other parents were able to expand their job opportunities because of this program. The program has been very successful and continues to be successful. The Summer Program has provided quality care for 144 children and their families. Parents have not had to find alternative care for their children during the summer months. The children have been able to stay in a familiar setting. We work closely with the health departments to assure that physicals and shot records are up-to-date. The Department of Social Services and the Developmental Evaluation Center make referrals to us for children they are working with. We have an open line of communication with these agencies.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The Far West Children's Dental Clinic is a direct result of professional relationships and collaboration among Cherokee County, Clay County and the Qualla Boundary. The project was developed through Region A Smart Start. Dental care for children in our region has been a tremendous unmet need. Through collaboration, each group brought to the table resources of equipment, facilities, technical expertise, dental staff, and children in need. Smart Start funds have been used to bring other missing resources to the project such as funds for dental staff and equipment needs to get the clinic operating. The dental clinic was opened for services May 23, 1997. The clinic facilities were partially completed three years ago but were never operational. The facility is beautiful and now has all the necessary equipment including fiberoptic equipment. There have been 4 clinics held this fiscal year and 14 children have received dental services. Currently the clinic is using contracted and volunteer staff. One of the goals is to recruit a permanent staff within a year. The clinic will focus on indigent, uninsured, and Medicaid children, who have not had access to dental care.

From the Graham-Swain District Health Department, Swain County Smart Start Nurse: April is always a busy month for child health. During this month, there is much national focus on health and safety, immunizations, and issues relating to children. The Smart Start health department project provided education programs including car seat safety and handwashing to the child care centers. Other Smart Start activities included participating in Swain County's first annual Children's Fair. It should be noted that, prior to the Children's Fair, our county had no focus or emphasis on an event directly targeting children in child care and those of preschool age. This event brought together many agencies that created an event that exceeded our expectations. Agencies involved included the Family Support/Family Preservation, Swain Family Council, Sheriff's Department, County Administration, Social Services, many of our child care centers, SAFE, local radio station WBHN, health department, Career Club, and many others. We even enjoyed visits by Barney and Mickey Mouse. We look forward to even more success with the fair next year. We also had another first in Swain County with the Prevent Child Abuse van coming to our area. We had a good turn out for this with more than 50 people visiting the van and obtaining information on the prevention of child abuse.

Child Care and Education

Subsidies
98 children with special needs received Smart Start subsidized care this quarter, and
122 children with special needs received Smart Start subsidized care this year to date.

75 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

145 other children received Smart Start subsidized child care this quarter, and
361 other children received Smart Start subsidized child care this year to date.

Quality Improvement
268 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
353 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

429 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
430 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

1,831 children were enrolled in programs/classes that received quality enhancements this quarter, and
2,654 children were enrolled in programs/classes that received quality enhancements this year to date.

640 surveys to study the child care workforce were sent to child care providers in Region A this quarter, and
640 surveys to study the child care workforce were sent to child care providers in Region A this year to date.

Children with Special Needs
130 children with special needs received one or more special therapies or interventions this quarter, and
250 children with special needs received one or more special therapies or interventions this year to date.

Educational Programs
1,759 children received one or more educational programs this quarter, and
2,367 children received one or more educational programs this year to date.

Health Care / Health Care Education

1,364 children received immunizations this quarter, and
1,691 children received immunizations this year to date.

1,630 children received health and/or developmental screenings this quarter, and
2,112 children received health and/or developmental screenings this year to date.

115 children received any other health services, other than transportation, this quarter, and
564 children received any other health services, other than transportation, this year to date.

1,474 families received health care education this quarter, and
2,108 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

554 families received direct child care resource and referral services this quarter, and
884 families received direct child care resource and referral services this year to date.

688 families received indirect child care and related information, for example, written materials, this quarter, and
688 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

3,112 families received parent education and/or support services in family resource centers this quarter, and
3,112 families received parent education and/or support services in family resource centers this year to date.

584 families received parent education and/or support services in places other than family resource centers this quarter, and
628 families received parent education and/or support services in places other than family resource centers this year to date.

1,837 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
5,768 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

2 children and family members were provided transportation to child care, health or other services this quarter, and
26 children and family members were provided transportation to child care, health or other services this year to date.

STANLY COUNTY PARTNERSHIP FOR CHILDREN

Smart Start Impact

The Stanly County Arts Council received a community grant from the Stanly Partnership in order to have a series of arts activities for young children entitled "creative pARTners." This series included two public performances of music, theater, and storytelling, as well as music and art experiences provided to small groups of children within child care centers. Caregivers and children were provided with small bags of materials related to the arts activities to take home and use. Performances were well attended, and both artists and caregivers responded positively on evaluation surveys. There are few opportunities for children in Stanly County to participate in arts activities, and the creative pARTners series helped fill a gap for young children's experiences with music and creative arts.

The Stanly Partnership works collaboratively with Stanly Community College (SCC) to support the education and training of early childhood education students. The Partnership promotes SCC college credit courses by listing them in the training calendar distributed biannually by Child Care Resource and Referral. The Partnership also provides space for some of these classes. Some participants have indicated that they are more comfortable attending the classes in the Partnership's facility than they would be if they had to attend class on a college campus. This has been a good opportunity to help further the education of providers who wouldn't otherwise have considered college-level training.

This quarter, 5,556 items were checked out for use by families from the Smart Start funded Early Childhood Resource Center, bringing the total number of items checked out during the year to 17,617!

Improving the lives of children and families.

Recently, a soon-to-be second time mother and father came into the Stanly Partnership, interested in receiving information on the Support For Families program, which is funded by Smart Start. After discussing the program with the mother, the outreach coordinator found the mother had been required to leave her job earlier than expected due to complications with her pregnancy. Financial burdens were piling up due to her leaving her job early and the medical bills were a huge concern for them. After looking at the husband's income, the outreach coordinator realized that the mother may be eligible for Medicaid and WIC. The mother was referred to the Department of Social Services. In addition, the outreach coordinator helped the mother complete and mail an application to the Caring Program to help fund health insurance for her older son. The family was very grateful for the information they received about other services they were eligible for in Stanly County. They also decided to participate in the Partnership's Support for Families program. The combined services they have received have benefited them tremendously.

Stanly County Schools operated a preschool program for LEP Hispanic children during 1996-97. Children were tested at the beginning and again at the end of the program to determine their level of language skill. During the six months the program operated, the average student gained one year of age equivalence in language skills. One student entered the program with an age equivalent of less than two years, and exited with an age equivalent of 3.9 years. Another student actually finished the program with an age equivalent score of 5.8 years, which was more than a year above his chronological age, and placed him in a position to enter kindergarten this fall with language skills which will better enable him to succeed in school.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The Smart Start funded Family Resource Center (FRC) has developed a strong relationship with many other agencies, including the Department of Social Services. DSS staff members now refer parents who are court-ordered to take parenting classes to the Active Parenting series at the FRC.

The Health Department and Arc Services, Inc. have collaborated this year to provide health and developmental services as a team. This Health Team provides services, including screenings and educational classes, in child care centers, during special events, and in classes held at the Partnership and elsewhere in Stanly County.

Child Care and Education

Subsidies

4 children with special needs received Smart Start subsidized care this quarter, and
4 children with special needs received Smart Start subsidized care this year to date.

180 other children received Smart Start subsidized child care this quarter, and
707 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs

Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

40 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date (e.g., *Head Start, Chapter I, half-day preschools).

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement

181 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
738 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

210 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
427 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

476 children were enrolled in programs/classes that received quality enhancements this quarter, and
835 children were enrolled in programs/classes that received quality enhancements this year to date.

42 professionals applied for memberships to the Early Childhood Resource Center this quarter, and
320 professionals applied for memberships to the Early Childhood Resource Center this year to date.

Children with Special Needs
303 children with special needs received care or support because of an emergency or crisis situation this quarter, and
303 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
939 children received one or more educational programs this quarter, and
1,839 children received one or more educational programs this year to date.

Health Care / Health Care Education

14 children received immunizations this quarter, and
26 children received immunizations this year to date.

347 children received health and/or developmental screenings this quarter, and
1,378 children received health and/or developmental screenings this year to date.

15 children received any other health services, other than transportation, this quarter, and
41 children received any other health services, other than transportation, this year to date.

34 families received health care education this quarter, and
52 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
42 families received direct child care resource and referral services this quarter, and
172 families received direct child care resource and referral services this year to date.

328 families received indirect child care and related information, for example, written materials, this quarter, and
625 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
273 families received parent education and/or support services in family resource centers this quarter, and
799 families received parent education and/or support services in family resource centers this year to date.

422 families received parent education and/or support services in places other than family resource centers this quarter, and
1,248 families received parent education and/or support services in places other than family resource centers this year to date.

13,000 families were contacted through community outreach efforts, such as Family Ties, this quarter, and

13,000 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

17 children and family members were provided transportation to child care, health or other services this quarter, and
24 children and family members were provided transportation to child care, health or other services this year to date.

Year 2 Partnerships

Fourteen Year 2 partnerships began providing Smart Start programs and services to the children and families in their counties in 1995.

ASHE COUNTY PARTNERSHIP FOR CHILDREN

Smart Start Impact

The Smart Start Dental Program began last quarter. Without Smart Start Funds, this dental program would not have been initiated. Dental services are now provided to both Medicaid children and children of the working poor that are birth through 5 years old. Ashe County has also received assistance from the Duke Endowment to help school age children with their dental health. These funds would have not have been leveraged if Smart Start had not helped get the dental program started.

Improving the lives of children and families.

A set of twins received their Health Check at the Smart Start funded Family Resource Center Mobile Unit in May, 1997. They will be three years old this fall. Both failed the Denver II developmental screening. They were not speaking in sentences, some words were not understandable, and they were unable to recognize simple animal pictures. They were referred to the Developmental Evaluation Center for evaluation and follow-up.

The Smart Start funded program Jump Start 1997 began on Monday, June 1, 1997, and will run through the summer to assist children in preparing for kindergarten entry. A teacher in the program reported on one of the children: "I first met Justin during the DIAL-R developmental screening. He would not separate from his mother for any of the skill tests and I do not recall his uttering one word during his screening experience. Finally, his screening was marked non-scoreable because of his shyness and his lack of response. I suggested the Jump Start program to Justin's mother during the screening, but she was unable to leave Justin and attend the meeting with our principal where the Jump Start applications were being passed out. When I later realized I did not have an application for Jump Start from Justin, I contacted his mother by mail and invited him to be a Jump Start student. Justin's mother agreed for him to be in our program. The first day Justin clung to his mom just like he had during the screening. She finally sneaked out of the classroom, but when he realized she was gone, he started crying. He cried for over an hour and could not be comforted. He would not eat breakfast. He just cried silently without speaking. He finally stopped crying on the playground, but only sat and watched the other children playing. One of our teaching assistants coaxed him to go down a slide. The next day was much the same for Justin, except this time the crying was accompanied by loud screaming. We viewed this as a positive sign -- he was making noise! He still did not eat breakfast, but the crying did not last as long and he did eat lunch and a snack. He played on the playground but did not participate in circle time. This pattern continued throughout the first week.

Over the course of the program, Justin has quit crying completely. He eats breakfast and communicates with us when he needs or wants something, usually with his body, nodding, or beckoning with his finger. Sometimes he does talk with us, some days more than others. We have learned that Justin enjoys drawing, painting, and making collages. His fine motor skills have developed very well for a beginning kindergartner. He is still very shy and, during circle time, he chooses to just sit and listen. He is able to choose the correct color when I ask him and provides other non-verbal responses when asked, so there is no doubt in my mind that Justin is soaking in just as much as the other, more vocal children. Justin still has a ways to go as far as becoming a vocal and interacting kindergartner, but the strides that he has made thus far have been tremendous. He has successfully separated from his mother. He is more comfortable with the school environment. He has friends who respect his silence, and he has three adults that he will recognize when he comes to "big school" who love him and will look out for him. He is well on his way, thanks to Jump Start and a mother who realized he needed this experience."

Other teachers in the Jump Start program report:

"Jump Start has been one of the most rewarding experiences that I have had in 13 years of teaching. The low numbers allow me to interact with and observe each child on a much more personal basis. Our curriculum this summer centers around acclimating the children and the parents to the school environment. We have planned activities that concentrate on large and fine motor skills. On the first day our circle time lasted 5 minutes. We now have circle time for 30 action packed minutes. During this time we have introduced our students to the letters of the alphabet, colors, numbers, the days of the week, months of the year, and many other concepts. I have tried to incorporate these skills with fun activities. The children seem to enjoy them, and their progress academically and socially has been greater that I could have ever dreamed possible."

"As a kindergarten teacher, I applaud the forces behind Jump Start. It is a much needed program. I hope that funding can be found to do this program again next year. Thank you for allowing me to be part of the first step that these wonderful children take in their formal learning experience."

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The Ashe Services for Aging has members attending Ashe Partnership meetings. They are interested in developing an intergenerational child care system. The staff of Parent Education, professional child care providers, and Child Care Resource & Referral have regularly scheduled meetings in an effort to coordinate and collaborate.

Child Care and Education

Subsidies

2 children with special needs received Smart Start subsidized care this quarter, and
6 children with special needs received Smart Start subsidized care this year to date.

37 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
85 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

324 other children received Smart Start subsidized child care this quarter, and
324 other children received Smart Start subsidized child care this year to date.

Quality Improvement

38 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
46 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

34 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
70 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

363 children were enrolled in programs/classes that received quality enhancements this quarter, and

363 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
10 children with special needs received one or more special therapies or interventions this quarter, and
14 children with special needs received one or more special therapies or interventions this year to date.

1 child with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
326 children received one or more educational programs this quarter, and
362 children received one or more educational programs this year to date.

Health Care / Health Care Education

108 children received immunizations this quarter, and
467 children received immunizations this year to date.

198 children received health and/or developmental screenings this quarter, and
478 children received health and/or developmental screenings this year to date.

69 children received any other health services, other than transportation, this quarter, and
69 children received any other health services, other than transportation, this year to date.

158 families received health care education this quarter, and
558 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
110 families received direct child care resource and referral services this quarter, and
330 families received direct child care resource and referral services this year to date.

20 families received indirect child care and related information, for example, written materials, this quarter, and
65 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
40 families received parent education and/or support services in family resource centers this quarter, and
530 families received parent education and/or support services in family resource centers this year to date.

223 families received parent education and/or support services in places other than family resource centers this quarter, and
621 families received parent education and/or support services in places other than family resource centers this year to date.

1,736 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

20 children and family members were provided transportation to child care, health or other services this quarter, and
61 children and family members were provided transportation to child care, health or other services this year to date.

AVERY COUNTY PARTNERSHIP FOR CHILDREN

Avery Partnership for Children did not report this quarter.

Smart Start Impact

The Children's Resource Center, in collaboration with the Department of Social Services Child Care Unit, Smart Start, and a variety of other organizations, worked together to develop "Family Bags" for children who will be entering child care. The bags contain educational resources, materials on starting child care, toys, books, and information on various programs in the community. This collaboration will continue during the disbursement of the bags to families, allowing agencies to work in concert to provide families with needed resources to ensure that children start school ready to learn.

Improving the lives of children and families.

A young mother and her 3 year old child came in to the Department of Social Services to apply for Smart Start child care subsidy assistance. The mother was returning to work after a two month medical leave to stay home and care for her 25 year old husband. The young husband and father had a history of heart problems and was unable to work. He had been taking care of his child while the mother worked. During the past two months, the father's condition worsened, and the mother took a medical leave from her job to meet the needs of her family. Unfortunately, the father's illness proved fatal. Smart Start child care subsidy assistance will support the mother's efforts to return to work. The child will also benefit from a supportive, stimulating, and structured environment.

The Early Child Support Team consisting of a psychologist, social worker, nurse, and two educational specialists, works with three children at one child care center. All three children have significant behavior problems and family issues. The child care center, because of support and suggestions provided by the team, has continued to work with these children. Previously the children would have been expelled from the center. Through work with these individual children and their families, the child care provider has reported improvements in their behavior.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The most visible example of agencies working together in new and better ways is through the Quality Team. The Quality Team consists of representatives from the Department of Social Services Child Care unit, the Children's Resource Center, the Early Childhood Support Team, and the Smart Start program. These representatives work together to provide assistance to child care centers in a variety of methods. They meet monthly to discuss concerns and to determine how to best offer assistance to providers and children. The team is bound by confidentiality and is able to work cooperatively to provide needed assistance.

Child Care and Education

Subsidies

19 children with special needs received Smart Start subsidized care this quarter, and
59 children with special needs received Smart Start subsidized care this year to date.

30 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
775 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

35 other children received Smart Start subsidized child care this quarter, and
1250 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs
Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

16 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this quarter (e.g., *Head Start, Chapter I, half-day preschools), and
16 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date.

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement
106 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
736 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

70 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
898 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

150 children were enrolled in programs/classes that received quality enhancements this quarter, and
3,347 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
16 children with special needs received one or more special therapies or interventions this quarter, and
16 children with special needs received one or more special therapies or interventions this year to date.

Educational Programs
535 children received one or more educational programs this quarter, and
4,976 children received one or more educational programs this year to date.

Health Care / Health Care Education

14 children received immunizations this year to date.

13 children received health and/or developmental screenings this quarter, and

425 children received health and/or developmental screenings this year to date.

19 children received any other health services, other than transportation, this quarter, and
101 children received any other health services, other than transportation, this year to date.

74 families received health care education this quarter, and
120 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
204 families received direct child care resource and referral services this quarter, and
682 families received direct child care resource and referral services this year to date.

200 families received indirect child care and related information, for example, written materials, this quarter, and
1,396 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
98 families received parent education and/or support services in family resource centers this quarter, and
255 families received parent education and/or support services in family resource centers this year to date.

51 families received parent education and/or support services in places other than family resource centers this quarter, and
215 families received parent education and/or support services in places other than family resource centers this year to date.

400 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
645 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

8 children and family members were provided transportation to child care, health or other services this quarter, and
19 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

Improving the lives of children and families.

The Chatham County office of the NC Cooperative Extension Service sponsors a Smart Start funded program that directly affects children and families. The Kindergarten Preparedness program aims to engage parents and children in activities that help them to be better prepared for kindergarten. Two kindergarten teachers were hired to facilitate the program for 22 Latino children and their parents. Bilingual assistants were also provided for each teacher. The program provides children with school readiness skills and familiarizes them and their parents with the school environment. The eight-week program was held on Friday nights at Siler City Elementary School. While the children rotated through four learning centers, the parents received information about the structure and functioning of the Chatham County School system. Parents also learned teaching techniques useful for working at home with their children on numbers, colors, shapes, and the alphabet. Each week parents were encouraged to borrow books in both English and Spanish to read with their children. Teacher-administered pre- and post-tests showed that the 22 children increased their school readiness and motor skills by an average of 30%. The readiness average at enrollment was 46%, and after eight weeks the average was 76%. The most interesting result was reported on parent satisfaction surveys. Whereas 15% of the parents had never read a book to their child prior to enrolling in the Kindergarten Preparedness program, all of the parents reported that they read to their child regularly during the program. Because of Smart Start, 22 children with limited English skill will be much better prepared for kindergarten.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The Chatham Partnership has developed and supported a number of family support initiatives. These ongoing efforts appear to have made a significant impact on the lives of our children and on their families' abilities to help them be ready to succeed in school. There is a strong commitment to continue to include these family support efforts, such as parent education classes, case management, and basic child development information, in Chatham County projects. Truly collaborative family services require that providers and consumers participate in the planning and design as well as the implementation of services. Therefore, the Chatham Partnership is requiring that all 1997-99 funded projects providing family support or related services participate in a formal collaboration called the Focus on Families Community Service Collaborative. Thirteen projects are members of this collaborative. They have already met once and are planning to meet monthly. The goals and vision of this collaborative are being developed by the participants. Quarterly reports will be made directly to the Partnership Board. A first step for the group will be training on community collaboration and assistance to set goals for development of the collaborative. Similar collaboratives have also been established in other areas in Chatham County, such as the Focus on Child Care and Focus on Health Collaboratives. Each collaborative was formed by suggestion only and participation in these two collaboratives is voluntary. The willingness of all Smart Start funded projects to be a part of one of the three collaboratives points toward promising outcomes for children and their families.

Child Care and Education

Subsidies

5 children with special needs received Smart Start subsidized care this quarter, and
65 children with special needs received Smart Start subsidized care this year to date.

141 other children received Smart Start subsidized child care this quarter, and
474 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs
Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

56 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date (e.g., *Head Start, Chapter I, half-day preschools).

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement
28 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
28 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

59 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
59 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

573 children were enrolled in programs/classes that received quality enhancements this quarter, and
573 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
8 children with special needs received one or more special therapies or interventions this quarter, and
165 children with special needs received one or more special therapies or interventions this year to date.

32 children with special needs received care or support because of an emergency or crisis situation this quarter, and
107 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
51 children received one or more educational programs this quarter, and
119 children received one or more educational programs this year to date.

Health Care / Health Care Education

48 children received immunizations this quarter, and

209 children received immunizations this year to date.

63 children received health and/or developmental screenings this quarter, and
426 children received health and/or developmental screenings this year to date.

8 children received any other health services, other than transportation, this quarter, and
37 children received any other health services, other than transportation, this year to date.

157 families received health care education this quarter, and
576 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
118 families received direct child care resource and referral services this quarter, and
791 families received direct child care resource and referral services this year to date.

217 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
1,197 families received parent education and/or support services in family resource centers this year to date.

226 families received parent education and/or support services in places other than family resource centers this quarter, and
595 families received parent education and/or support services in places other than family resource centers this year to date.

725 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
6,725 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

604 one-way trips were provided for children and families to child care, health or other services this quarter, and
807 one-way trips were provided for children and families to child care, health or other services this year to date.

Child Care and Education

Subsidies
300 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
300 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

453 other children received Smart Start subsidized child care this quarter, and
453 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs
Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

102 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date (e.g., *Head Start, Chapter I, half-day preschools).

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement
731 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
731 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

454 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
454 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

780 children were enrolled in programs/classes that received quality enhancements this quarter, and
780 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
22 children with special needs received one or more special therapies or interventions this quarter, and
40 children with special needs received one or more special therapies or interventions this year to date.

56 children with special needs received care or support because of an emergency or crisis situation this quarter, and
194 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
1,218 children received one or more educational programs this quarter, and
1,218 children received one or more educational programs this year to date.

Health Care / Health Care Education

80 children received immunizations this quarter, and
223 children received immunizations this year to date.

51 children received health and/or developmental screenings this quarter, and
1,354 children received health and/or developmental screenings this year to date.

126 children received any other health services, other than transportation, this quarter, and
736 children received any other health services, other than transportation, this year to date.

365 families received health care education this quarter, and
628 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
76 families received direct child care resource and referral services this quarter, and
266 families received direct child care resource and referral services this year to date.

486 families received indirect child care and related information, for example, written materials, this quarter, and
629 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
187 families received parent education and/or support services in family resource centers this quarter, and
187 families received parent education and/or support services in family resource centers this year to date.

684 families received parent education and/or support services in places other than family resource centers this quarter, and
751 families received parent education and/or support services in places other than family resource centers this year to date.

1,603 families were contacted through community outreach efforts, such as Family Ties, this quarter, and

3,094 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

312 children and family members were provided transportation to child care, health or other services this quarter, and
312 children and family members were provided transportation to child care, health or other services this year to date.

Note: The partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

DUPLIN COUNTY PARTNERSHIP FOR CHILDREN

Smart Start Impact

Smart Start has increased community awareness about the many county agencies and the programs that they offer. The Duplin Partnership Family Resource Center provides a one-stop shopping center for family services which may be provided through information, referral, on-site, or home-based strategies for families and children birth through 5 years of age. The FRC has pamphlets and brochures on various agencies in the county. The FRC-Coordinator recently published a resource manual that lists all agencies in the county that provide services for children and families. Families can utilize the manual to locate an agency to assist them with their needs. The manual is distributed to families who have children birth through 5 years of age. The FRC hopes to strengthen families through positive family experiences and family education and to link families to community services pertaining to health, social, safety, and educational issues.

Improving the lives of children and families.

Duplin County Partnership for Children and the Duplin County Cooperative Extension Service co-sponsor the Breast-feeding Nutrition Program Assistant. During the past year, numerous clients have written letters expressing their sincere thanks for the existence of this program. This is one mother's story: "Once I found out that I was pregnant, the decision to nurse my baby was not a difficult one. I contacted the NC Cooperative Extension Office and they assigned a wonderful woman, Ginny, to help me with all my questions and concerns about nursing. She was knowledgeable, kind, and comforting. She came to my home while I was pregnant. Later she came to visit me in the hospital to make sure that the baby and I were fine and that I was following her instructions. She has since been to my home many times for follow-up and moral support. During these visits Ginny told me everything that I'd ever want to know about breast milk and why it was one of the best things that I could ever do for my baby. She told me how the milk changes to fit the baby's nutritional needs, how the baby gets exactly what he needs, how it will help him fight infections, how it always is the right temperature and never spoils, and how the benefits would last a lifetime. The few reservations I had -- neither of my sisters nursed, I had heard that it would be painful, I heard stories of babies having trouble learning or not catching on at all -- were dispelled by Ginny's information. Finally, the bond that I feel with my baby because of nursing is something that I have difficulty putting into words. Now I'd like to tell other would-be-moms, *"Every mom should try nursing once."* It is just what Ginny told me, *"It is something that no one else can do for your baby."*

Human service agencies and organizations are working together in new and better ways because of Smart Start.

More and more children and families are receiving needed services because of the increase in collaboration among agencies. The Department of Social Services is referring clients to Smart Start. The Medicaid department is assisting in the promotion of the Caring Program for Children. The Duplin-Onslow-Pender Consolidated Human Services Self Sufficiency Program has increased the number of clients they serve through referrals from Smart Start. New forms of communication have been developed through referrals and word of mouth. Clients return to the referring source with great enthusiasm.

Child Care and Education

Subsidies
112 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
175 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

Creating additional spaces for children in preschool programs
Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

116 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this quarter (e.g., *Head Start, Chapter I, half-day preschools), and
128 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date.
**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement
119 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

50 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
75 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

618 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,441 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
9 children with special needs received one or more special therapies or interventions this year to date.

Educational Programs
210 children received one or more educational programs this quarter, and
767 children received one or more educational programs this year to date.

Health Care / Health Care Education

236 children received immunizations this quarter, and
321 children received immunizations this year to date.

117 children received health and/or developmental screenings this quarter, and
141 children received health and/or developmental screenings this year to date.

402 children received any other health services, other than transportation, this quarter, and
402 children received any other health services, other than transportation, this year to date.

69 families received health care education this quarter, and
224 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

17 families received direct child care resource and referral services this year to date.

20 families received indirect child care and related information, for example, written materials, this quarter, and
380 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

42 families received parent education and/or support services in family resource centers this quarter, and
267 families received parent education and/or support services in family resource centers this year to date.

45 families received parent education and/or support services in places other than family resource centers this quarter, and
415 families received parent education and/or support services in places other than family resource centers this year to date.

40 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
265 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

257 children and family members were provided transportation to child care, health or other services this quarter, and
1,238 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

Duke University Medical Center, Prevent Blindness, and Hope for Kids have joined forces to provide comprehensive broad based screening services for young children. This collaborative screening service includes developmental, speech and language, vision, and immunization services in one session.

Improving the lives of children and families.

Healthy Families Durham, funded by Smart Start, has been working with a 15 year old mother and her 10 month old baby. When Healthy Families administered the Denver developmental screening, there was a slight delay in motor skills. Healthy Families recommended simple activities the family could do to enhance the baby's motor skills. When the Denver was given several weeks later, the baby showed motor skills within the normal range.

A Spanish speaking single mother was concerned about her 2 1/2 year old daughter's development. Through home visits with a child service coordinator and a Smart Start funded Spanish interpreter, the child received evaluation services at the Developmental Evaluation Center and a recommended plan of action to address her special health needs of asthma and respiratory problems. The mother is now connected with local resources and is feeling less isolated.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Under the direction of the Durham Partnership, a newly formed health collaborative involving 30 agencies is looking at gaps and duplications in the health care service delivery for young children in Durham. The collaborative identified a lack of consistent reliable data about children's health and a need to map the current health care service delivery system. A Duke University intern has gathered data this quarter and has already begun the mapping process.

Child Care and Education

Subsidies

150 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
350 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

120 other children received Smart Start subsidized child care this quarter, and
149 other children received Smart Start subsidized child care this year to date.

Quality Improvement

713 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
713 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

135 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
138 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

3,619 children were enrolled in programs/classes that received quality enhancements this quarter, and
3,717 children were enrolled in programs/classes that received quality enhancements this year to date.

2,031 requests from child care substitute providers were filled this quarter, and
2,998 requests from child care substitute providers were filled this year to date.

Children with Special Needs
191 children with special needs received one or more special therapies or interventions this quarter, and
388 children with special needs received one or more special therapies or interventions this year to date.

7 children with special needs received care or support because of an emergency or crisis situation this quarter, and
18 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
90 children received one or more educational programs this quarter, and
303 children received one or more educational programs this year to date.

Health Care / Health Care Education

33 children received immunizations this quarter, and
68 children received immunizations this year to date.

794 children received health and/or developmental screenings this quarter, and
5,356 children received health and/or developmental screenings this year to date.

77 families received health care education this year to date.

43 immunization records were updated this quarter, and
125 immunization records were updated this year to date.

97 families were contacted about missed immunizations this quarter, and
488 families were contacted about missed immunizations this year to date.

Family and Community Services

Child Care Resource & Referral Services
136 families received direct child care resource and referral services this quarter, and
377 families received direct child care resource and referral services this year to date.

248 families received indirect child care and related information, for example, written materials, this quarter, and
1,104 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
277 families received parent education and/or support services in family resource centers this quarter, and
580 families received parent education and/or support services in family resource centers this year to date.

135 families received parent education and/or support services in places other than family resource centers this quarter, and
163 families received parent education and/or support services in places other than family resource centers this year to date.

13,456 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
23,087 families were contacted through community outreach efforts, such as Family Ties, this year to date.

130 volunteers were placed in agencies serving young children this quarter, and
310 volunteers were placed in agencies serving young children this year to date.

421 calls were received by the human service information resource and referral line this quarter, and
2357 calls were received by the human service information resource and referral line this year to date.

Transportation

154 children and family members were provided transportation to child care, health or other services this quarter, and
202 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

At the Living Waters-Family Resource / Child Development Center, funded by Smart Start, all children enrolled have demonstrated great improvement in spoken language using complex sentences, asking questions, and talking with expression. Two Hispanic children who spoke no English when enrolled are now speaking English. Six different parent education groups have been provided and parents are beginning to demonstrate improved levels of competence in parenting. One teacher as well is completing her Child Care Credential.

The Hand to Hand-Mentoring Teen Parents program is another one of Forsyth County's successful Smart Start programs. 150 teen parents have been provided with counseling, home visits, interventions and assistance, as well as transportation services to help improve their child's quality of life and their own. Children of participating teens are 100% current on immunizations and enrolled in health care, there have been no reports of neglect or abuse, fewer than 5% of these teens have had a repeat pregnancy, and 90% of these teen parents are in school or working!

The Forsyth Partnership targeted inclusion of children with special needs in regular child care settings as one of its goals. Children with special needs who have been placed in child care centers have had greater than expected gains in self-help, fine motor, and cognitive skills. On average, they have gained more than one year in developmental attainment in a one year period. Growth has been seen across developmental domains as well as in increased independence. Parents cite the development of empathy and acceptance among the other children.

Child Care and Education

Subsidies

24 children with special needs received Smart Start subsidized care this quarter, and
65 children with special needs received Smart Start subsidized care this year to date.

459 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

54 other children received Smart Start subsidized child care this quarter, and
54 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs

Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

966 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this quarter (e.g., *Head Start, Chapter I, half-day preschools), and
966 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date.

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement

110 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
314 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

2,322 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
4,119 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

1,760 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,760 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs

589 children with special needs received one or more special therapies or interventions this year to date.

31 children with special needs received care or support because of an emergency or crisis situation this quarter, and
128 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs

14,650 children received one or more educational programs this quarter, and
28,985 children received one or more educational programs this year to date.

Health Care / Health Care Education

30 children received immunizations this quarter, and
81 children received immunizations this year to date.

76 children received health and/or developmental screenings this quarter, and
5,198 children received health and/or developmental screenings this year to date.

233 children received any other health services, other than transportation, this quarter, and
2,219 children received any other health services, other than transportation, this year to date.

838 families received health care education this quarter, and
4,985 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

409 families received direct child care resource and referral services this quarter, and

1,656 families received direct child care resource and referral services this year to date.

600 families received indirect child care and related information, for example, written materials, this quarter, and
2,797 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
243 families received parent education and/or support services in family resource centers this quarter, and
332 families received parent education and/or support services in family resource centers this year to date.

3,249 families received parent education and/or support services in places other than family resource centers this quarter, and
10,316 families received parent education and/or support services in places other than family resource centers this year to date.

30 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
374 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

310 one-way trips were provided for children to child care, health or other services this quarter, and
2,724 one-way trips were provided for children to child care, health or other services this year to date.

Note: The partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

Smart Start Impact

The positive recognition and support that child care providers are receiving as a result of Smart Start is the biggest impact seen in our two counties. Providers are receiving community acknowledgment that quality in child care is of paramount importance. Providers who can provide higher quality care are in greater demand. Working parents are becoming better informed. What happens in a child's brain in those first months of life is being discussed by the early childhood community. Many parents and providers are beginning to understand that through nurturing and some early intervention, children showing up at the steps of kindergartens will be ready to learn.

New forms of collaboration became reality this spring through the opening of a new Regional Training Center. The local community college, Head Start, and Smart Start were able to pool their resources to fund this much needed facility. Plans are underway to pursue accreditation. A full training schedule for child care teachers is underway. Early childhood students can now observe model classrooms in our community. It is no longer necessary to travel to other parts of the state. More importantly, providers can take new innovative ideas back to their facilities and implement them.

Improving the lives of children and families.

A story that came out of one of the family literacy programs that receives Smart Start funds concerned a young mother and her two sons. This is her story: *"The Family Literacy program has helped me overcome a large obstacle in being a good parent for my sons. That obstacle was my shyness. When someone spoke to me, I could not look them in the eye. I looked at the floor and answered them. I didn't have any confidence in myself. I had very little self-esteem. Now all that has changed. The Family Literacy program has helped me work toward my GED. Receiving my high school certificate was very important to me and improved the way I see myself. This also moves me one step closer to my goal of becoming a social worker, which I have confidence I can reach. Another benefit from the Family Literacy program was the opportunity to improve my parenting skills. I now read to my children and help them with their homework, something I never had as a child. We have home visits from staff members once a month that help, too. I do volunteer work and help others in any way that I can. Recently I got to go to a parent workshop in another city. There, along with other young mothers and fathers, we talked about welfare reform and Work First. I learned the importance of everyone having self-confidence, looking people in the eye, speaking up, and setting goals for yourself."*

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Three organizations working together were able to train providers in playground safety. Through the guidance of our Child Care Resource & Referral office, provider training was led by two county Cooperative Extension Services, a Department of Social Services Child Care Coordinator, and Head Start teachers. The Partnership was able to obtain the donated services of a professional trainer from North Carolina State University. Upon completion of the playground safety training, all centers and homes were given a playground audit kit. These kits are being used by the providers, under the helping hand of the Smart Start office. Recently, providers have been able to apply for quality improvement grants to help them financially in providing a safe playground. Those agencies involved in this endeavor continue to work together in the next round of funding and have invited others to join in as they plan other projects. This effort led by Smart Start has been a positive example to other agencies.

Child Care and Education

Subsidies
6 children with special needs received Smart Start subsidized care this quarter, and
6 children with special needs received Smart Start subsidized care this year to date.

4 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
71 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

286 other children received Smart Start subsidized child care this quarter, and
334 other children received Smart Start subsidized child care this year to date.

Quality Improvement
200 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
645 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

71 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
569 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

4,313 children were enrolled in programs/classes that received quality enhancements this quarter, and
6,203 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
58 children with special needs received one or more special therapies or interventions this quarter, and
90 children with special needs received one or more special therapies or interventions this year to date.

Educational Programs
1,030 children received one or more educational programs this quarter, and
1,030 children received one or more educational programs this year to date.

Health Care / Health Care Education

99 children received immunizations this quarter, and
334 children received immunizations this year to date.

482 children received health and/or developmental screenings this quarter, and
2,104 children received health and/or developmental screenings this year to date.

322 children received any other health services, other than transportation, this quarter, and
733 children received any other health services, other than transportation, this year to date.

1,472 families received health care education this quarter, and
1,472 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
43 families received direct child care resource and referral services this quarter, and
88 families received direct child care resource and referral services this year to date.

34 families received indirect child care and related information, for example, written materials, this quarter, and
246 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
652 families received parent education and/or support services in places other than family resource centers this quarter, and
652 families received parent education and/or support services in places other than family resource centers this year to date.

Transportation

54 children and family members were provided transportation to child care, health or other services this quarter, and
147 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

Improving the lives of children and families.
Physical examinations, supported by Smart Start funding, were done on two different children in a local child care center. A heart murmur was found in one child. It was followed up by the patient's physician and found to be benign. The other child exhibited physical problems and is now scheduled to be seen in an orthopedic clinic.

Child Care and Education

Subsidies
9 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

475 other children received Smart Start subsidized child care this year to date.

Quality Improvement
88 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
283 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

51 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

529 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,115 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
36 children with special needs received one or more special therapies or interventions this quarter, and
77 children with special needs received one or more special therapies or interventions this year to date.

36 children with special needs received care or support because of an emergency or crisis situation this quarter, and
77 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
787 children received one or more educational programs this quarter, and
1,260 children received one or more educational programs this year to date.

Health Care / Health Care Education

5 children received immunizations this year to date.

206 children received health and/or developmental screenings this quarter, and
748 children received health and/or developmental screenings this year to date.

120 children received any other health services, other than transportation, this year to date.

84 families received health care education this quarter, and
766 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
31 families received direct child care resource and referral services this quarter, and
244 families received direct child care resource and referral services this year to date.

24 families received indirect child care and related information, for example, written materials, this quarter, and
217 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
14 families received parent education and/or support services in family resource centers this quarter, and
1,402 families received parent education and/or support services in family resource centers this year to date.

88 families received parent education and/or support services in places other than family resource centers this quarter, and
608 families received parent education and/or support services in places other than family resource centers this year to date.

79 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
7,293 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

30 children and family members were provided transportation to child care, health or other services this quarter, and

203 children and family members were provided transportation to child care, health or other services this year to date.

Note: The partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

Smart Start Impact

The Smart Start funds in Person County have made services available to many children, families, and preschool educators. The funds in Person County have made homes safer, parents more aware of their child's needs, opened doors for child care providers to expand their services and knowledge, and made the community more aware of the needs within it. Prior to Smart Start in Person County, many families had called on the same local agencies to meet their needs, such as Department of Social Services and the Person County Health Department. Now, with Smart Start, these families and their children have choices that provide new ideas and alternatives for their situations. Services can be delivered in a more timely manner and up close. Many of the Smart Start programs bring the service to the parents and children of the community. One of the greatest impacts of Smart Start in Person County is that the offered services are keeping up with the growing population and changing needs of the community.

Improving the lives of children and families.

Smart Start has improved the lives of many families in this community. Two Smart Start funded programs offer the approach of home based intervention. A community nurse visits with new parents to assess their needs and make them aware of the community services that may assist their family. During one of her community visits, a parent was concerned with the breathing of her premature child. The nurse recommended an immediate doctor visit. The doctor revealed that the child had pneumonia. The family was very thankful for the home visit by the community nurse. A second family is involved in the VIP program, which provides in home parenting skills and developmental assessments for children birth through three years. The parent reported that the reason she enjoys this program so much is because the parent educator makes her feel comfortable and not rushed. The parent reported that she and her child are able to interact with the parent educator in a non-threatening environment, thereby increasing her willingness to participate and follow through. A third story concerns two parents involved in the Smart Start funded Family Literacy Program. These parents now have a higher level of education, which provides a good model for their children and the possibility of a more financially secure future. They both passed the GED test and one plans to attend the local community college while the other plans to locate a job.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

In the 1996-97 fiscal year, Smart Start has funded 25 programs, including the Person Partnership. There has been collaboration among all 25 of the programs. Some agencies and programs work together more often than others because of the individuals they have identified to serve. Other programs collaborate because of the multifaceted needs of each family and child. The newest committee developed to continue to address the needs of this community and increase collaboration among programs has been the Child Care Resource & Referral Task Force. The idea for the task force began in this fiscal year and will continue into the 1997-98 fiscal year. The goals of the task force are to bring together child care providers, CCR&R staff, Department of Social Services subsidy staff, local health department staff, Head Start teachers, and the Person Partnership staff, with a future goal of revitalizing private industry involvement in services for young children. This task force is Person County's effort to continue to create new and better ways to expand Smart Start to all the children of this community.

Child Care and Education

Subsidies
5 children with special needs received Smart Start subsidized care this quarter, and
5 children with special needs received Smart Start subsidized care this year to date.

126 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
147 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

148 other children received Smart Start subsidized child care this quarter, and
150 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs
Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

9 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date (e.g., *Head Start, Chapter I, half-day preschools).

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement
78 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
177 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

136 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
262 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

602 children were enrolled in programs/classes that received quality enhancements this quarter, and
997 children were enrolled in programs/classes that received quality enhancements this year to date.

966 hours of staffing were provided by CCR&R substitutes in child care facilities funded by Smart Start this quarter, and
4137.5 hours of staffing were provided by CCR&R substitutes in child care facilities funded by Smart Start this year to date.

Children with Special Needs

71 children with special needs received one or more special therapies or interventions this quarter, and
105 children with special needs received one or more special therapies or interventions this year to date.

2 children with special needs received care or support because of an emergency or crisis situation this quarter, and
13 children with special needs received care or support because of an emergency or crisis situation this year to date.

Health Care / Health Care Education

179 children received health and/or developmental screenings this quarter, and
563 children received health and/or developmental screenings this year to date.

31 children received any other health services, other than transportation, this quarter, and
369 children received any other health services, other than transportation, this year to date.

412 families received health care education this quarter, and
665 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

53 families received direct child care resource and referral services this quarter, and
190 families received direct child care resource and referral services this year to date.

114 families received indirect child care and related information, for example, written materials, this quarter, and
249 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

305 families received parent education and/or support services in places other than family resource centers this quarter, and
572 families received parent education and/or support services in places other than family resource centers this year to date.

Transportation

45 children and family members were provided transportation to child care, health or other services this quarter, and
68 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

The Smart Start funded Goodwill Family Resource has gone through many changes this past year. Originally, the center was located in the upstairs portion of the Goodwill Retail Store. Families and children were located together in close quarters. At times it made concentrating difficult for parents, with the sound of children playing in the background. Goodwill wanted to start many new programs, but simply did not have the space to do so. Looking for a new location became a major priority. Several different options were presented, all of which were very expensive and some not conducive to the needs of the parents and children. Miraculously, the Executive Director of the Health Foundation approached the Executive Director of the Wilkes Partnership and offered the use of a school building that had just been donated to the Health Foundation. The set-up was perfect! The Goodwill Family Resource Center now has a new home. The children have a new playground and larger play area, and the parents have an atmosphere that allows them to concentrate and learn. The Goodwill Family Resource Center is currently working with Wilkes Regional Medical Center to set up an LNA Course at the new site. This collaboration would have never taken place if Smart Start had not been a part of the Goodwill Family Resource Center. We have learned that if you present a well deserving need to our community, some how, some way, members of the community will fill that need.

Improving the lives of children and families.

Last October, B.T., a mother of 5 children, enrolled in the Smart Start funded Clingman Family Resource Center to help with her niece's child who was exposed to drugs prenatally. The child's biological mother was in prison and B.T. was applying for custody of Brooke. B.T. had dropped out of high school ten years earlier to have her first child. She enrolled in the Adult High School Diploma program at the Clingman Family Resource Center and put Brooke in the developmental day care center located there. While at the FRC, B.T. participated in all of the Family Literacy activities on site such as MotheRead, the parent support group, and Out For Lunch. Parent and Child Time helped her bond with Brooke. Brooke began to thrive in the structured environment and B.T. was allowed to adopt her since she had learned how to care for Brooke's special needs. B.T. has now graduated with her Adult High School Diploma, she is successfully employed, and Brooke is in a Smart Start funded child care center full time. B.T. attributes her success to having a community family center in a rural location that helped her learn to care for Brooke and help her feel successful in her own life.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

An example of collaboration in Wilkes County is illustrated in the efforts to form a multi-county collaboration with Alexander and Yadkin County. All contract management and fiscal management of private donor grants has been assumed by Wilkes County. Grants are written with all three counties participating and benefiting from services. Program income moneys are currently being used to provide stipends for agencies in all three counties to promote on-site child development activities while parents participate in Smart Start sponsored activities. Since child care was identified as the main barrier to services, the three counties are making an effort for all agencies that provide services to families of preschool children to have the ability to access child care services. Smart Start will provide program assistance with training for staff at each site to learn about developmentally stimulating activities for children whose parents are participating in adult activities. Two developmental trainings will occur with all three counties participating. These training includes Story Share (a MotheRead activity) and the Start with the Arts program which is designed to develop early literacy skills by teaching children how to express and discuss their thoughts and feeling through their artwork. Both programs also provide follow up activities that can be done at home.

Child Care and Education

Subsidies
20 children with special needs received Smart Start subsidized care this quarter, and
34 children with special needs received Smart Start subsidized care this year to date.

9 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

454 other children received Smart Start subsidized child care this quarter, and
485 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs
Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

10 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this quarter (e.g., *Head Start, Chapter I, half-day preschools), and
95 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date.

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement
566 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
934 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

58 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
58 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

1,033 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,033 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
50 children with special needs received one or more special therapies or interventions this quarter, and
116 children with special needs received one or more special therapies or interventions this year to date.

Educational Programs
297 children received one or more educational programs this quarter, and
589 children received one or more educational programs this year to date.

Health Care / Health Care Education

64 children received immunizations this quarter, and
113 children received immunizations this year to date.

502 children received health and/or developmental screenings this quarter, and
562 children received health and/or developmental screenings this year to date.

3 children received any other health services, other than transportation, this quarter, and
146 children received any other health services, other than transportation, this year to date.

681 families received health care education this quarter, and
815 families received health care education this year to date.

661 immunization records were reviewed in child care facilities this quarter, and
1035 immunization records were reviewed in child care facilities this year to date.

Family and Community Services

Child Care Resource & Referral Services
180 families received direct child care resource and referral services this quarter, and
433 families received direct child care resource and referral services this year to date.

75 families received indirect child care and related information, for example, written materials, this quarter, and
393 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
11 families received parent education and/or support services in family resource centers this quarter, and
378 families received parent education and/or support services in family resource centers this year to date.

98 families received parent education and/or support services in places other than family resource centers this quarter, and
186 families received parent education and/or support services in places other than family resource centers this year to date.

47 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
268 families were contacted through community outreach efforts, such as Family Ties, this year to date.

104 people used the lending library this quarter, and
591 people used the lending library this year to date.

Transportation

139 children and family members were provided transportation to child care, health or other services this quarter, and
263 children and family members were provided transportation to child care, health or other services this year to date.

Year 3 Partnerships

Eleven Year 3 partnerships spent 1996 planning for Smart Start and began providing programs and services in 1997.

Smart Start Impact

Smart Start sponsored a series of meetings at Alleghany County's three elementary schools for rising kindergartners and their parents that offered the youngsters a chance to experience what public school would be like and provided parents with educational materials and instruction on how to better prepare their child for school. Glade Creek School was so impressed with the parents' responses to the program, that they opened their library two nights a week for those and other parents to check out books and receive assistance from the librarian. They were interested in expanding this outreach to other parents in their community, so the Partnership suggested they discuss the matter with the non-Smart Start Family Resource Center. As a result, a grant application has been made for money to support a Family Resource Center satellite at the school.

Improving the lives of children and families.

The Alleghany Public Library has the Smart Start contract for Read-2-Me, a series of programs for parents and children that includes demonstrations on how to read to youngsters and encouragement for parents to follow through at home. One mother of three preschool children expressed concern that her oldest son, a 5 year old rising kindergartner, had a diagnosed attention deficit disorder and would find it difficult to sit still for the sessions. He was something of a handful, but stayed with the program. The parents followed through with reading at home. After two months, he began to quiet down. His mother reported that he was more attentive during their reading at home as well. She also reported that formerly he had shown little interest in books, but now he was pulling them off the shelf at home for parents to read. Both parents and all three children were active in the program. At the end of the quarter, they were recognized as the family that had read the most books together: 281!

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Smart Start has promoted on-site visits by the Department of Social Services Child Care Coordinator to child care facilities to sign parents up for child care subsidy assistance. Smart Start also began assisting parents with payments of their subsidy fees in January, 1997. In December, 1996, a new full-time DSS Child Care Coordinator replaced a 40% position shared with a neighboring county and has been active in making on-site visits to child care centers to meet providers and sign up eligible parents for subsidy assistance. In the first six months of this year, average per-month subsidy payments are 187% of the average per-month payment during the last six months of the previous year. This dramatic rise is a combination of factors, among them the close working relationship between Smart Start and the Child Care Coordinator, as well as that coordinator's willingness to reach out to parents needing services in the community.

Child Care and Education

Subsidies

34 children received Smart Start subsidized child care this quarter, and
72 children received Smart Start subsidized child care this year to date.

Quality Improvement
29 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
32 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

5 children were enrolled in programs/classes that received quality enhancements this quarter, and
5 children were enrolled in programs/classes that received quality enhancements this year to date.

Educational Programs
171 children received one or more educational programs this quarter, and
370 children received one or more educational programs this year to date.

Health Care / Health Care Education

5 families received health care education this quarter, and
11 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
20 families received direct child care resource and referral services this quarter, and
97 families received direct child care resource and referral services this year to date.

224 families received indirect child care and related information, for example, written materials, this quarter, and
816 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
48 families received parent education and/or support services in places other than family resource centers this quarter, and
222 families received parent education and/or support services in places other than family resource centers this year to date.

Smart Start Impact

Supplemental funds made available through Smart Start have assisted Buncombe County child care centers in improving quality by 1) purchasing additional supplies and materials, 2) providing one-to-one care, 3) reducing child/staff ratios, and 4) offering staff training.

Three centers have received $1,799 for supplies and materials to meet the special identified needs of four children. These items have been purchased to bridge what the child uses at home, are now available to reinforce center activities, expand on the material available for therapeutic needs of the child, and provide additional opportunities for socialization.

This quarter, one center received a grant to hire support staff to work with children with special needs for several hours each day during the summer months when previously assigned school personnel went on summer break. This provided the opportunity for continuity of services in the classroom for the children with special needs. A one-to-one caregiver was also assigned to work at different times during the day with children, and was used within the classroom to address child safety issues in the case of a child with global physical delays, to assist during indoor to outdoor transition times when close supervision was necessary, and to enhance interactions between children with special needs and typically developing children.

Improving the lives of children and families.

These comments are taken from parent evaluations of Smart Start funded programs:

"I thank you very much for the help when the bottom fell out. It took a lot of pressure off."

"This program enabled me to leave an abusive situation, pursue a job, and work."

"Thank you. After searching, I am now able to work, and my children are receiving excellent care."

"Words cannot express to you how very grateful I am for your help. Simply, thank you."

Sara, a parent of 4 young children, came to see a nurse practitioner at the Emma Family Resource Center because she was feeling very poorly. After spending time with Sara, the nurse became convinced that Sara was clinically depressed. Eventually, Sara confided in the nurse that she came in because she intends to kill herself. The nurse had heard that emergency counseling services were available through the Smart Start funded Totline for parents with a preschool child. The nurse contacted a Totline counselor to see if she could meet with Sara. Within an hour, the nurse, Sara, and the counselor, were sitting down and talking in a counseling session. Without the Totline service, Sara would have needed to get herself to the public mental health center and sit in a waiting room until a worker was available – often not even within 24 hours. After the initial session, Sara would have needed to wait several weeks for her next appointment. Through the Smart Start funded service, Sara met immediately with a counselor, made a "safety plan," and agreed to receive a call the next day from the Totline. Once through the immediate crisis, Sara took advantage of 3 more free counseling sessions in which she identified a past sexual assault as the primary cause of her depression. The Totline counselor has arranged services for Sara at the Rape Crisis Center that are comprehensive and appropriate for her. Family systems are fragile. Project Tots works from the assumption that an appropriate intervention with a parent will positively effect the development and well-being of the young children in the home. Sara's story clearly illustrates this point.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Although Buncombe County Child Development sponsored the training days for child care substitutes, others in the community came together to make the training successful. Training was held at a child care center. The center allowed visits inside their center and provided lunch. Trainers were volunteers from

directors of child care centers, the state Division of Child Development, the supervisor of State Licensing Consultants, family counselors in private practice, and Buncombe County Child Development staff.

Since March, 1996, a "new" group called the Buncombe County Family Resource Coalition has met three times to explore how Smart Start family support services can enhance existing neighborhood based services. Before this project began, individuals operating neighborhood based family support centers were not meeting on a regular basis. The group has decided to work together to develop a list of "Guiding Principles" for family centers in our county. In August, 1997, the group will meet for the fourth time. A facilitator will guide the group through closely examining the "Family Support Principles" as written by similar national and state level groups. By the end of the fourth meeting, the local coalition will have a set of agreed upon principles that will guide how services are delivered in our county.

Child Care and Education

Subsidies

203 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
203 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

365 other children received Smart Start subsidized child care this quarter, and
447 other children received Smart Start subsidized child care this year to date.

Quality Improvement

20 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
73 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

78 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

Children with Special Needs

6 children with special needs received one or more special therapies or interventions this quarter, and
6 children with special needs received one or more special therapies or interventions this year to date.

27 children with special needs received care or support because of an emergency or crisis situation this quarter, and
76 children with special needs received care or support because of an emergency or crisis situation this year to date.

Family and Community Services

Parent Education and Support

13 families received parent education and/or support services in family resource centers this quarter, and
13 families received parent education and/or support services in family resource centers this year to date.

862 families received parent education and/or support services in places other than family resource centers this quarter, and
862 families received parent education and/or support services in places other than family resource centers this year to date.

15,000 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
18,000 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Smart Start Impact

An Intervention Specialist funded by Smart Start has had a tremendous impact on child care providers and their ability to work with children with special needs in the classroom. Children exhibiting problematic behavior in the classroom were demanding a disproportionate amount of the teacher's time and energy, and disrupting the positive learning environment of the classroom. Child care providers were at a loss for support and assistance and often resorted to asking parents to move the child to another center. Children with behavioral and emotional difficulties often ended up being bounced from one center to another, further aggravating the problem. The Intervention Specialist was able to respond to requests from child care providers to observe a child in the classroom setting who was exhibiting atypical behavior. The Intervention Specialist, through observations and ongoing consultations, worked with the provider, the parents, and the child, offering intervention strategies such as behavior management plans, relevant literature, and referrals to community resources. The Intervention Specialist recommended additional mental health or developmental assessment when appropriate.

With support available, many providers feel much more confident in working with these children, eliminating the compounding difficulty of multiple placements. Early intervention has also been shown to be key in preventing children having future difficulties and in the early identification of children eligible for special education services. From a proactive standpoint, the Intervention Specialist works collaboratively with an Inclusion Specialist from United Cerebral Palsy to offer an 8-part training session for center directors, teachers, and family home providers on working with children with special needs. The objective of the training is to eliminate barriers to inclusion through education and technical support. This training is also funded by Smart Start.

Improving the lives of children and families.

Growing Readers is a Smart Start funded program designed to enhance the early literacy development of children in child care centers through on-site storytime programming in centers, circulation of thematic collections of age-appropriate books, training for child care providers, and education outreach to parents. Some of the most important results of early literacy development – attitudes toward books and reading – are ones that statistics just can't count. For instance, there is the reaction of a group of little boys who giggled and talked during the first stories read to them, but settled into chanting along with the lines of the poem-story, Rain Makes Applesauce. At the end of the book, the programmer knew she had them hooked when the most giggly of them all shouted, "READ IT AGAIN!" She did. At the end of the school year, another programmer was saying good-bye to a kindergarten class, all of whom would be going to different schools in the Fall. One boy, a little sad at the thought of not seeing programmer in class next year, announced an alternate plan: "Instead of first grade, I'm going to the Library!" He was assured that there would be plenty of books in first grade, too ... but he is still considering his options! Or look at the change in attitude of the four-year-old at one center who, during her first visit from a Growing Readers programmer, flung herself on the floor in apparent agony and moaned, *"How many books do we have to hear?" By the third visit she met the "library lady" at the door, pulling books out of the Growing Readers bag and begging, "Will you read them all?" Indeed, we are "growing readers."*

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Smart Start has been the catalyst for a number of meetings among service providers to discuss gaps in existing services for children, alert each other about potential duplication of services, and identify existing funding streams. A recent example occurred in a meeting to discuss case management and therapy services for children ages birth through 5 years. Represented were the area Mental Health agency, the Developmental Evaluation Center, the Health Department, the County Schools and the Smart

Start Partnership. A very productive discussion took place. Agencies discovered that their knowledge of the services provided by other agencies was, in some cases, inaccurate and outdated. One representative was unaware that Child Service Coordination extended past age one. Referrals are now being made. Another did not realize that nutrition therapy could be provided in the home, where necessary, by the DEC nutritionist. That collaboration is now taking place. All who participated underscored the lack of mental health therapy services for children birth through 5 years. Without Smart Start, this meeting would not have taken place. The mandate that Smart Start has not to duplicate services and not to supplant existing funding sources brought about this discussion and allowed community organizations to work together to identify the most pressing needs and to avoid expending funding on programming that was already in place and simply needed to be accessed. Hence, funding decisions for the programs discussed will be more efficient and effective.

Child Care and Education

Subsidies
1 child received Smart Start subsidized child care this quarter, and
1 child received Smart Start subsidized child care this year to date.

Quality Improvement
802 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
1237 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

516 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
1,361 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

381 children were enrolled in programs/classes that received quality enhancements this quarter, and
845 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
23 children with special needs received one or more special therapies or interventions this quarter, and
31 children with special needs received one or more special therapies or interventions this year to date.

Educational Programs
1,920 children received one or more educational programs this quarter, and
3,912 children received one or more educational programs this year to date.

Health Care / Health Care Education

8 children received immunizations this year to date.

784 children received health and/or developmental screenings this quarter, and
1,025 children received health and/or developmental screenings this year to date.

24 children received any other health services, other than transportation, this quarter, and
53 children received any other health services, other than transportation, this year to date.

87 families received health care education this quarter, and
94 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services

247 families received direct child care resource and referral services this quarter, and
515 families received direct child care resource and referral services this year to date.

363 families received indirect child care and related information, for example, written materials, this quarter, and
642 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

688 families received parent education and/or support services in places other than family resource centers this quarter, and
1,612 families received parent education and/or support services in places other than family resource centers this year to date.

20 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
20 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Note: The partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

PAMLICO COUNTY PARTNERSHIP FOR CHILDREN

Smart Start Impact

Using Smart Start funds, the small and remote town of Hobucken, NC, in rural Pamlico County, is currently developing a playground for the young children in its community. When completed, this playground will fill a great need, as the nearest town with a playground is 20 miles away and most of the families with young children in Hobucken and nearby towns are without the necessary transportation to get to that distant location. Residents of the town are working together to make their dream of this first and only community playground a reality. A local elementary school, closed 30 years ago and given to the community by the school board, has been selected as the site for the playground. The site is being transformed by the residents of Hobucken. The building is now being used as a community center and the grounds are being landscaped. The playground will be the focal point of the grounds when completed. Smart Start funds are being used to purchase the materials for the community volunteer-based construction of the playground. Without this funding, the playground would still be only a long desired and unfulfilled dream in Hobucken.

Improving the lives of children and families.

A three-year-old who was not talking at all received speech therapy funded through Smart Start at her child care home this past year. Her speech has improved so dramatically that family and staff members now understand many of the words she's using. Her grandmother calls her "our miracle."

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Two recently funded Smart Start activities are addressing a county need for qualified personnel to meet and serve the needs of county residents. These two positions, a medical social worker and a child and family specialist, will naturally dove-tail with each other as they work with families in the area. The medical social worker has been hired through the Pamlico County Health Department and the child and family specialist through the Neuse Center for Mental Health, Developmental Disabilities, and Substance Abuse. Although the two positions have both been funded only within the last month, the two professionals have already met with local Partnership staff and each other to formulate collaborative strategies.

Child Care and Education

Subsidies

6 children with special needs received Smart Start subsidized care this quarter, and
7 children with special needs received Smart Start subsidized care this year to date.

83 other children received Smart Start subsidized child care this quarter, and
83 other children received Smart Start subsidized child care this year to date.

Quality Improvement

10 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
10 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

Educational Programs

16 children received one or more educational programs this quarter, and
16 children received one or more educational programs this year to date.

Health Care / Health Care Education

20 children received health and/or developmental screenings this year to date.

ROBESON COUNTY PARTNERSHIP FOR CHILDREN

Smart Start Impact

There are approximately 800 births to non-Medicaid individuals each year in Robeson County. Previously, these mothers did not receive the home assessments offered to mothers on Medicaid. The Newborn/Post Partum Home Assessments Program, funded by Smart Start, allowed 405 non-Medicaid mothers to receive assessments within 48 to 72 hours after discharge. The assessments address the physical, emotional, and socioeconomic status of the family and are used to guide interventions and/or referrals. On two occasions this quarter, the newborn assessment nurse noticed that two babies were jaundiced. Through the visiting nurse's early detection, appropriate referrals were made. Home visits from the nurse are helping to prevent an increase in infant mortality in the community.

Approximately 1,100 parents and children attended our first annual Smart Start Day on June 28, 1997. Family members and friends gathered to support over 300 graduates of the Learning Together Program, a Smart Start funded program that stresses parents and children learning together. After graduation, awards were presented to board members, contributors, volunteers, Smart Start programs, and participating child care providers. Smart Start Day allowed agencies to collaborate and share information with the public. Information was available on parenting skills, discipline tips, childhood injury prevention, childhood poison prevention, bicycle safety, and more. Parents were able to receive all the information and referrals necessary at one location. Smart Start Day helped break barriers in Robeson County by allowing a diverse group of people to interact in a relaxed setting.

Improving the lives of children and families.

Josh lives with his parents and a younger brother. His mother is expecting another child. Josh was not eligible for Head Start because of his father's income. Josh was also unable to get into the public prekindergarten program because he scored too high on developmental assessments. Unable to afford other options, his mother was working with him informally at home. Josh demonstrated enough need to be selected for the Smart Start funded Learning Together program and now he and his mother are able to receive formalized school readiness training. Not only will this help Josh, but also his mother will gain skills needed to match her enthusiasm and interest in actively educating her children.

Child care subsidies allowed Linda to accept custody of her 2 grandchildren. She is employed and was able to maintain her job and not become a welfare recipient. Child care subsidies also allowed Marla, a 36 year-old single parent, to gain employment at our local university. Marla reports that child care subsidies allow her to contribute money toward other financial obligations to better care for her child.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Smart Start helped many human service agencies come together in a collaborative effort to assist Robeson County's children reach their fullest level of functioning. Agencies that participated in this process were: Department of Social Services, Robeson County Health Department, Child Care Directions, Robeson County Public Schools, Public Libraries of Robeson County, Children's Clinic, and more. All of these agencies worked together to determine new and better ways to make Smart Start efficient and effective in our county. A newsletter was created to communicate to the public about what Smart Start is doing. Also, a monthly calendar with scheduled events of all child-related events was sent out. The Health Department, in collaboration with the Center for Community Action, shared staff members to make the Learning Together project a success. The Partnership also looks forward to working with BB&T over the next year as we find other methods of improving the quality and quantity of child care in Robeson County. We see our partnership with BB&T as the first of many partnerships with the business community.

Child Care and Education

Subsidies
35 children with special needs received Smart Start subsidized care this quarter, and
35 children with special needs received Smart Start subsidized care this year to date.

342 other children received Smart Start subsidized child care this quarter, and
749 other children received Smart Start subsidized child care this year to date.

Quality Improvement
489 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
489 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

358 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
358 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

1,238 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,238 children were enrolled in programs/classes that received quality enhancements this year to date.

Educational Programs
390 children received one or more educational programs this quarter, and
390 children received one or more educational programs this year to date.

Health Care / Health Care Education

713 children received health and/or developmental screenings this quarter, and
713 children received health and/or developmental screenings this year to date.

739 children received any other health services, other than transportation, this quarter, and
739 children received any other health services, other than transportation, this year to date.

2,228 families received health care education this quarter, and
2,228 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
98 families received direct child care resource and referral services this quarter, and
98 families received direct child care resource and referral services this year to date.

1,102 families received indirect child care and related information, for example, written materials, this quarter, and
1,102 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
2,231 families received parent education and/or support services in places other than family resource centers this quarter, and
2,231 families received parent education and/or support services in places other than family resource centers this year to date.

2,361 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
2,361 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

877 children and family members were provided transportation to child care, health or other services this quarter, and
877 children and family members were provided transportation to child care, health or other services this year to date.

Note: The partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

Smart Start Impact

Smart Start has promoted and publicized the Caring Program for Children, a program which provides free medical coverage for children under age nineteen who meet required guidelines. The program has been promoted through the school system, medical clinics, child care homes, child care centers, and the local hospital. Smart Start staff have met with counselors, doctors, nurses, and child care providers to explain the program and the eligibility requirements and ask that they do follow-up with their clients or patients who may benefit from the Caring Program for Children.

The following story exemplifies the positive impact of Smart Start and how working collaboratively helps people in need: *Tracy had medical coverage on himself but no coverage for his wife and nineteen-month old daughter. Due to income restrictions, Tracy and his family did not qualify for Medicaid, yet could not afford medical coverage. Not knowing where to turn, Tracy called First Call for Help. The Information & Referral Specialist explained to him about the Caring for Children Program. He was provided a telephone number that he called to find out about the coverage qualifications. He was also sent an application and requested an information packet from the Caring for Children Program. Fortunately, Tracy's family qualified for free medical coverage for their daughter. Had it not been for First Call for Help and Smart Start funding, Tracy may not have ever gotten the help he and his family needed.*

Improving the lives of children and families.

The M. family consists of the parents, their adopted daughter, and four foster children. Ages of the children range from 18 months to 6 years. All of the foster children have special needs. Two of the foster children are developmentally delayed and the other two have been neglected and abused. The family was referred to Smart Start due to the fact that the mother was emotionally burnt out, had limited support, and had little knowledge of resources. At the time of referral, she was calling a Department of Social Services worker after hours, asking that some of her children be placed elsewhere. Through assessment of the family's needs, case management services were initiated due to the children's needs exceeding the family's resources. Interventions utilized were: parental education on parenting issues and behavior management, increasing support systems for the family, providing respite care, and teaching stress reduction techniques. As a result, the threat of loss of placement has been eliminated. Support systems were increased by encouraging the father to assume more responsibility with household chores and child care, and utilizing friends, family, and church members for respite. The foster care social worker taught stress reduction techniques such as exercising, networking with friends, attending social activities, taking time out from parenting, organizing time and tasks, seeking assistance when needed, and engaging in hobbies. The mother has increased coping skills and knowledge of how to obtain assistance as needed, and the father has assumed a more direct parental role and remains at home more often. This has increased the mother's capacity to care for the foster children and their specialized needs. The DSS worker no longer receives calls after hours.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

In the past quarter, another agency has collaborated with Child Care Resource and Referral in the planning and implementation of a dental education project for children birth through 5 years in child care centers and homes. This project, when approved, will use the resources of the CCR&R database and the training and education of state dental health providers while child care providers teach appropriate dental hygiene and dental education. The collaboration of the CCR&R and the dental health workers will make getting the education materials and the training of staff much easier and more cost effective because staff can be cross trained and shared to do all aspects of the project. This new program will be an added

service of the CCR&R and will also give dental health workers another avenue with which to educate parents and children.

Child Care and Education

Subsidies
22 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
190 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

4 other children received Smart Start subsidized child care this year to date.

Quality Improvement
118 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
311 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

47 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
47 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

1,062 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,062 children were enrolled in programs/classes that received quality enhancements this year to date.

60 hours of technical assistance were provided to **6** providers being trained for recruitment of non-traditional care (such as, infant care, sick care, 2nd. shift care) this quarter, and
100 hours of technical assistance were provided to 14 providers trained for recruitment of non-traditional care this year to date.

Educational Programs
49 children received one or more educational programs this quarter, and
110 children received one or more educational programs this year to date.

Health Care / Health Care Education

28 children received health and/or developmental screenings this quarter, and
35 children received health and/or developmental screenings this year to date.

100 families received health care education this quarter, and
173 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
66 families received direct child care resource and referral services this quarter, and
297 families received direct child care resource and referral services this year to date.

234 families received indirect child care and related information, for example, written materials, this quarter, and
657 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
68 families received parent education and/or support services in places other than family resource centers this quarter, and
150 families received parent education and/or support services in places other than family resource centers this year to date.

57 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
241 families were contacted through community outreach efforts, such as Family Ties, this year to date.

STOKES COUNTY PARTNERSHIP FOR CHILDREN

Smart Start Impact

The Stokes Partnership has been planning and collaborating for years in anticipation of providing Smart Start services to families in our county. This is the first quarter direct services were able to be provided to families through funding from the Smart Start. Here are two examples of the kinds of impact Smart Start in Stokes County is having at the end of the first quarter of direct services.

As a rural mountainous county, Stokes County has a shortage of affordable child care options for families with young children. However, the Stokes Partnership has enabled many at risk families to find access to child care and related services. The Child Care Resource and Referral program has assisted family child care providers in creating 27 new child care spaces to provide safe and legal educational learning environments for children.

The Prevent Blindness Program, a Smart Start Partner, has provided vision screening to children in all but one of the child care centers in Stokes County. As a result, 361 children and their families have received visual health information, 259 children have been screened, 24 children have been referred for follow-up services, and five of those have received glasses through the program. Because of the lack of physicians in Stokes County, "donor docs" from Winston-Salem were recruited to help with the service. So far, 361 children have received visual health information, 259 children have received a vision screening, 24 children have been referred for follow-up services, and 5 children have received glasses.

Another accomplishment of the Partnership was the provision of cash awards to early childhood providers who participated in continuing education training and agreed to continue employment in the early childhood education field. This WAGE$ project helps enhance teacher skills and continuity. Forty-three providers, almost 50% of the early childhood teachers in the county, participated in this project.

Improving the lives of children and families.

In one family, a grandfather and father were co-parenting a three year old boy. The grandfather worked first shift and the father worked second shift. There was one overlapping hour when neither of them could provide child care. The Partnership was able to locate and arrange with a family child care home to provide a regular one hour time slot of child care so that the adults could both work. The family was able to maintain economic self-sufficiency and the grandfather was very appreciative of the service provided by the Stokes Partnership.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Service providers in Stokes County have decided to hold regular monthly partner meetings for training, technical assistance, and information sharing. Attendance has averaged 15 to 20 people representing fifteen of the eighteen provider agencies since meetings began in April, 1997. At these meetings partners discuss their successes and obstacles, decide how to provide reporting and documentation of services, and set up collaborative efforts for anticipated services. In June, our liaison from the Frank Porter Graham Child Development Research Center at UNC-CH gave a presentation on statewide evaluation efforts. The partners are establishing a monthly newsletter and calendar of events to be disseminated by the Stokes Partnership.

The Stokes Partnership has provided collaborative leadership in exploration of regionalization with the surrounding counties of Alamance, Caswell, and Rockingham, who are not yet funded for Smart Start. We have contracted with a facilitator to explore what strengths each can offer in Smart Start collaboration. The projected outcomes include shared fiscal management and reduced administrative costs as well as collaboration on funding development possibilities and shared program services.

Child Care and Education

Subsidies
8 children with special needs received Smart Start subsidized care this quarter, and
8 children with special needs received Smart Start subsidized care this year to date.

77 other children received Smart Start subsidized child care this quarter, and
77 other children received Smart Start subsidized child care this year to date.

Creating additional spaces for children in preschool programs
Note: Child care spaces created in licensed/registered child care centers and family child care homes will be reported through a state-level reporting system.

8 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this quarter (e.g., *Head Start, Chapter I, half-day preschools), and
8 permanent child care spaces were created in legally operating, but unlicensed preschool programs-this year to date.

**Head Start programs and Public Preschool/Chapter I programs are not required to be licensed by the state. However, some of these voluntarily choose to obtain state licensing.*

Quality Improvement
50 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
166 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

61 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
61 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

Children with Special Needs
10 children with special needs received one or more special therapies or interventions this quarter, and
10 children with special needs received one or more special therapies or interventions this year to date.

Educational Programs
450 children received one or more educational programs this quarter, and
450 children received one or more educational programs this year to date.

Health Care / Health Care Education

259 children received health and/or developmental screenings this quarter, and
259 children received health and/or developmental screenings this year to date.

1 child received any other health services, other than transportation, this quarter, and

16 children received any other health services, other than transportation, this year to date.

361 families received health care education this quarter, and
361 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
29 families received direct child care resource and referral services this quarter.

29 families received indirect child care and related information, for example, written materials, this quarter.

Parent Education and Support
21 families received parent education and/or support services in places other than family resource centers this quarter, and
70 families received parent education and/or support services in places other than family resource centers this year to date.

16 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
16 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Note: The Partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

Smart Start Impact

The Bright Beginnings Preschool has begun a bilingual preschool program funded by Smart Start in Surry County which includes both English and Spanish in its curriculum. Children are learning to communicate across cultural and language differences. Not only are Hispanic children being exposed to English and translation being provided for their families through center staff, but English speaking children are learning Spanish and their families are learning to appreciate the diversity of the community.

Improving the lives of children and families.

The Teen Moms program assists teen mothers with young children in learning skills and acquiring services to assure healthy young children. Four teen aged moms have just begun participation in various Smart Start projects and are paired with Smart Start volunteers. These mothers have been linked to health and child care services, received tutoring and educational assistance to enable them to stay in school, had a baby shower focusing on educational learning toys for their children, participated in parenting classes, and made action plans to address potential child neglect issues and the moms' continued education. One of the participants told her Smart Start volunteer that this was the first time that she really felt like she was her child's mother.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The service providers have decided to hold regular monthly partner meetings for training, technical assistance, and information sharing. Attendance has averaged about 15 people representing ten of the twelve provider agencies since meetings began in May, 1997. At these meetings, partners discuss their successes and obstacles, decide how to provide reporting and documentation of services, and set up collaborative efforts for anticipated services. The partners are establishing a monthly newsletter and calendar of events to be disseminated by the Early Childhood Partnership.

Child Care and Education

Subsidies

21 children with special needs received Smart Start subsidized care this quarter, and
21 children with special needs received Smart Start subsidized care this year to date.

81 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
81 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

991 other children received Smart Start subsidized child care this quarter, and
991 other children received Smart Start subsidized child care this year to date.

Quality Improvement

190 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and

190 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

138 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

811 children were enrolled in programs/classes that received quality enhancements this quarter, and
811 children were enrolled in programs/classes that received quality enhancements this year to date.

Children with Special Needs
91 children with special needs received one or more special therapies or interventions this quarter, and
91 children with special needs received one or more special therapies or interventions this year to date.

4 children with special needs received care or support because of an emergency or crisis situation this quarter, and
4 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
251 children received one or more educational programs this quarter, and
251 children received one or more educational programs this year to date.

Health Care / Health Care Education

59 children received immunizations this quarter, and
59 children received immunizations this year to date.

15 children received health and/or developmental screenings this quarter, and
15 children received health and/or developmental screenings this year to date.

66 children received any other health services, other than transportation, this quarter, and
66 children received any other health services, other than transportation, this year to date.

25 families received health care education this quarter, and
25 families received health care education this year to date.

Family and Community Services

Child Care Resource & Referral Services
165 families received direct child care resource and referral services this quarter, and
165 families received direct child care resource and referral services this year to date.

52 families received indirect child care and related information, for example, written materials, this quarter, and
205 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support
275 families received parent education and/or support services in places other than family resource centers this quarter, and
393 families received parent education and/or support services in places other than family resource centers this year to date.

202 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
260 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Smart Start Impact

Smart Start has had a significant impact in the Wake County community during the 1996-97 fiscal year. One impact that Smart Start has had is that children in identified Ready To Learn child care settings in Southeast Raleigh are now receiving physical, developmental, and behavioral screenings that will earlier detect those conditions that would otherwise impede a child's ability to learn or be successful at school. Providing screening, intervention, and family support services to child care providers in a consistent and effective manner will positively impact the academic abilities of children and also improve the ability of parents to better nurture and support the healthy growth of their children. To date, over 293 children and 115 families have been assisted through this project. A project of this scope has never been developed or provided to children or families in child care. In the past this population has been underserved and largely ignored.

This quarter, 42 Wake County agencies and organizations received school readiness materials and information from the Wake Smart Start Partnership.

Improving the lives of children and families.

Sis is a 4 year old girl who has lived with her great aunt and uncle for the last 9 months since they "rescued" her from a life of inconsistent care. Her mother has experienced a long history of mental instability, substance abuse, unstable housing, and life on the streets. Both the aunt and uncle report that they understood this was quite an undertaking but that they just couldn't live as witnesses to the kind of upbringing Sis was exposed to. They remain hopeful that Sis' mother will straighten out her life and be able to raise Sis even while they realize that this wish is not realistic and that they probably face 14 more years of childrearing. The aunt called Wake County Human Services with a long list of concerns, the major ones being a need for child care since she works full time, a need to reduce Sis' uncontrollable, abusive, and hyperactive behaviors, and a need for support to their family. It appeared to her family that Sis was "smart" and that she demonstrated most of the developmental milestones within an acceptable time frame. Even though she was exposed to drugs in the prenatal period and there is a family history of attention deficits, behavioral problems, and learning disabilities, Sis was talking well, showing good problem solving skills, and playing "normally." It was her self injurious and aggressive behaviors that were most concerning the family as they were feeling somewhat manipulated and abused by this child. Dissent was descending upon family members as they struggled with Sis' influence on their daily lives.

Smart Start child care funding was secured to provide a consistent and stable daytime routine for Sis with some immediate positive results. Both her daytime and evening structures became more predictable for her and thus less confusing and threatening. Even though the child care reported frequent trips to "time out" at first, slowly these decreased and the staff focused on her strengths, becoming very fond of her. Family consultation through Enriching Families/Nurturing Children, a Wake County Smart Start initiative, was provided to the aunt and uncle to address the serious problems in the household that were threatening this family and might cause them to give up on Sis. Extensive evaluations revealed that Sis could neither see nor hear well, but after given corrective glasses and having tubes put in her ears, her world seemed to be coming into focus for her. Further evaluations noted significant weaknesses in her motor abilities and sensory processing rendering Sis virtually incapable of self-calming. She is currently beginning direct occupational therapy aimed at teaching her and her family strategies to help calm her. Further, the family is receiving training from the family psychologist consultant on in-home responses to her behaviors. Sis' biological mother is to be included in this training so that she can respond similarly to Sis' provocation. Lastly, the aunt and uncle, as well as other family members, are receiving supportive counseling as they struggle to adapt to the commitment they have made to Sis. Sis does exhibit significant problems developmentally but they are not seen as interfering with her ability to learn at this point so that she does not meet eligibility for Part B preschool services. But anyone associated

with this family can see that Sis is at great risk for failure in school. There is a good chance that she will ultimately be diagnosed as ADHD as she approaches school age, but if her home situation receives no intervention or assistance, she risks a return to her former life. Enriching Families/Nurturing Children offers Sis and others like her the chance to begin school with a year or two of stability and support that would not be attainable otherwise.

One child in a local Ready To Learn Center was characterized by child care staff as being "slow, unresponsive, and going to be a discipline problem for kindergarten teachers next year." Because of this comment, the child was screened and found to be normal on all developmental and behavioral scales. Given this, the project staff began working with this child 30 minutes a day on more developmentally stimulating activities. The parent was also provided one-on-one consultation on how to reinforce these activities at home and was further provided materials and activities to do at home with her child which would extend the readiness activities the child was being exposed to. The outcome of this is that the child now knows his numbers and colors, has improved speech/language skills, and is now viewed in the center as a bright, able child who will do well in kindergarten. Project staff no longer feel this child is a discipline problem and are amazed at his progress in such a short amount of time. Project staff feel this child was simply "bored" and, like too many children in this center, needed to be involved in activities that were more developmentally stimulating and appropriate. Project staff are now working with the child care providers in this area.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Through participation in the Local Interagency Coordinating Council group meeting about Wake County health issues, Prevent Blindness North Carolina has had the opportunity to share experiences, results, and concerns about health issues, particularly as they related to screening programs. For the first time, Prevent Blindness North Carolina also had the opportunity to collaborate with Wake County Head Start centers to screen this typically higher risk population.

Wake County has actively been recruiting businesses to get involved with issues of quality child care and family support. A total of 160 business people participated in Parent Education Information Sessions this year (80 participated in this quarter alone), and 92 businesses and community organizations have been contacted about availability and types of parent support.

Child Care and Education

Subsidies

24 children with special needs received Smart Start subsidized care this quarter, and
34 children with special needs received Smart Start subsidized care this year to date.

872 other children received Smart Start subsidized child care this quarter, and
1,180 other children received Smart Start subsidized child care this year to date.

Quality Improvement

887 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
2,423 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

190 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and

344 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

3,652 children were enrolled in programs/classes that received quality enhancements this quarter, and
7,091 children were enrolled in programs/classes that received quality enhancements this year to date.

1067 hours were worked by substitutes in child care centers this quarter, and
1519 hours were worked by substitutes in child care centers this year to date.

22 child care centers and homes received Hurricane Fran Capacity Restoration Grants this year to date.

Children with Special Needs
23 children with special needs received one or more special therapies or interventions this quarter, and
58 children with special needs received one or more special therapies or interventions this year to date.

12 children with special needs received care or support because of an emergency or crisis situation this quarter, and
44 children with special needs received care or support because of an emergency or crisis situation this year to date.

Educational Programs
561 children received one or more educational programs this quarter, and
658 children received one or more educational programs this year to date.

Health Care / Health Care Education

68 children received immunizations this quarter, and
93 children received immunizations this year to date.

2,379 children received health and/or developmental screenings this quarter, and
3,288 children received health and/or developmental screenings this year to date.

100 children received any other health services, other than transportation, this quarter, and
194 children received any other health services, other than transportation, this year to date.

3,303 families received health care education this quarter, and
6,495 families received health care education this year to date.

16 dental health staff were trained to work with families to prevent dental disease this year to date.

Family and Community Services

Child Care Resource & Referral Services

1,666 families received direct child care resource and referral services this quarter, and
3,381 families received direct child care resource and referral services this year to date.

16,109 families received indirect child care and related information, for example, written materials, this quarter, and
22,861 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

116 families received parent education and/or support services in family resource centers this quarter, and
218 families received parent education and/or support services in family resource centers this year to date.

403 families received parent education and/or support services in places other than family resource centers this quarter, and
886 families received parent education and/or support services in places other than family resource centers this year to date.

962 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
6,206 families were contacted through community outreach efforts, such as Family Ties, this year to date.

400 surveys were completed that asked employers and employees about family friendly policies for the Early Childhood Forum this quarter, and
400 surveys were completed that asked employers and employees about family friendly policies for the Early Childhood Forum this year to date.

Transportation

39 children and family members were provided transportation to child care, health or other services this quarter, and
90 children and family members were provided transportation to child care, health or other services this year to date.

Note: The partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

Smart Start Impact

Smart Start has been instrumental in the development of a "pilot" family literacy program in Washington County. From the beginning, their focus has been on serving both parents and children in the most efficient ways. Working together in cooperation with Martin Community College, Washington County Department of Social Services, Roanoke Development Center, Tideland Mental Health, Plymouth Housing Authority, and the Washington County Health Department, Smart Start helped to plan each phase of the literacy program. The Partnership was involved with helping to locate a site that would accommodate both parents and children. They provided toys, playpens, infant carriers, changing tables, snacks, and saw to it that the children were cared for by qualified child care providers. This was an essential element to the success of the program. The parent participants felt secure in the knowledge that their children were well cared for. This allowed them to feel free to be a part of the group discussions and activities. It also afforded them the opportunity to get a "break" from their own parenting duties, which can be quite overwhelming for a full-time single parent. Smart Start not only cared for the child care needs of the parents and children but also the transportation and safety of the children as well. Working with other agencies, they helped to secure transportation and car safety seats which added an element of convenience for the parents. The parents knew that they had transportation for themselves and car seats for their children. Without Smart Start's involvement in the planning, organization, and implementation, the family literacy program could not have been successful. Their efforts helped this program to have a profound impact on what the participants gained from attending these classes. According to the parents, they achieved much from being a part of a close, supportive group. They felt uninhibited and contributed a great deal to the discussions and activities. The family literacy program encompassed broad areas, such as adult basic life skills, job skills, concerns about parenting, positive approaches to discipline, and improving self esteem in both parents and children. The participants felt very grateful for the support of all those involved and expressed a desire to continue in another program when possible.

Washington County has been actively moving towards regionalization of Smart Start efforts by beginning to collaborate with and plan projects with currently non-Smart Start funded counties.

Improving the lives of children and families.

An owner/director of a family child care home in Washington County had a hyperactive child who sometimes got out of hand. Due to the Quality Enhancement Grants awarded through Smart Start, she was able to purchase a sand and water table. This piece of equipment helped to soothe and fascinate this child, therefore calming her right down. This is helping to teach her how to keep her attention and stay focused on one activity at a time.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Human Service Agencies such as the Department of Social Services, Roanoke Development Center, Washington County Agricultural Extension and the NC Department of Labor (JTPA) have worked very closely together to provide the needed transportation to parenting and literacy classes offered through Smart Start. Roanoke Development Center provided the needed means of transportation, and because of Smart Start, were able to provide child care and car seats, along with transportation, purchased through the Department of Social Services. Due to child care being provided, mandated Work First recipients were able to attend programs and meet all of their requirements. Working with Smart Start has formed a strong communication between agencies such as the Department of Social Services, Washington County Agricultural Extension, Tideland Mental Health, Washington County Health Department, Plymouth

Housing Authority, Roanoke Development Center, and the community colleges, with a common goal of making a difference in the lives of "our" children in Washington County.

Child Care and Education

Subsidies
4 children with special needs received Smart Start subsidized care this quarter, and
5 children with special needs received Smart Start subsidized care this year to date.

23 other children received Smart Start subsidized child care this quarter, and
30 other children received Smart Start subsidized child care this year to date.

Quality Improvement
43 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this quarter, and
46 teachers received teacher education, technical assistance and/or support services through a child care resource & referral agency this year to date.

31 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
31 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

130 children were enrolled in programs/classes that received quality enhancements this quarter, and
130 children were enrolled in programs/classes that received quality enhancements this year to date.

Health Care / Health Care Education

1 child received immunizations this quarter, and
1 child received immunizations this year to date.

185 children received health and/or developmental screenings this quarter, and
185 children received health and/or developmental screenings this year to date.

Family and Community Services

Child Care Resource & Referral Services
10 families received direct child care resource and referral services this quarter, and
10 families received direct child care resource and referral services this year to date.

259 families received indirect child care and related information, for example, written materials, this quarter, and
259 families received indirect child care and related information, for example, written materials, this year to date.

Parent Education and Support

68 families received parent education and/or support services in places other than family resource centers this quarter, and

90 families received parent education and/or support services in places other than family resource centers this year to date.

Transportation

22 children and family members were provided transportation to child care, health or other services this quarter, and

22 children and family members were provided transportation to child care, health or other services this year to date.

Smart Start Impact

Smart Start has had a tremendous impact in Wilson County. The entire effort has brought citizens together to discuss important issues regarding Wilson County's young children. People are excited and are willing to work together like never before. Many new initiatives have begun such as the expansion of subsidized child care, adolescent parenting skills training, family literacy, and the immunization project. Through Smart Start funding the DSS Satellite Clinic has been expanded to one full day per week where some of the most needy children are getting screening and immunizations. This quarter, the vision screening project with the Wilson Partnership and Prevent Blindness NC has impacted the local community and families of young children through a significant number of vision screening. In this quarter, PBNC offered screenings to 16 child care settings, with 3 refusals. There were 791 families who received educational materials about the importance of good vision and eye health. In Wilson County, 651 children had a quality photorefractive vision screening and 30 children were referred for follow-up care. PBNC has been fortunate to offer this effective photorefractive technology in mass screening and only could do so with the help of Smart Start. Now seen as the experts in use of this technology on this population, PBNC has been awarded a contract to train the state's Developmental Evaluation Centers to use the equipment and screen their special needs population. As a result, more children will be served and more vision problems averted.

Improving the lives of children and families.

The Prevent Blindness NC Follow-Up Coordinator continues to work with families of referred children. Since most of the Wilson County vision screening project occurred late in May, the child care provider's evaluation cards and referral information is just now starting to come back. Once received, we will have a better picture of who the referred children are and how early detection of vision problems has impacted their lives.

Many parents in Wilson County have expressed their appreciation of the Smart Start Baby Basics and Child Health program in providing educational support. Many of these parents would have little or no knowledge of what to do if their child choked or stopped breathing, for example. They have learned how to take care of their newborns and what to do to keep their environment safe. As one parent stated, *"Great service to the community. Appreciate your tenacity in implementing Smart Start for the moms and dads of Wilson County."*

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Agency representatives are working together in an effort not to duplicate services or build new agencies but rather to enhance many of the fine efforts already underway. The school system, non-profit agencies, and public agencies as well, are cooperating around the common goal of improving the lives and potential of our young children. A good example of the effort is our local board committee structure. We have representatives from all agencies and citizen groups working together making decisions on behalf of the Wilson Partnership.

Health Department immunization staff are currently collaborating with the Wilson County School Literacy Project and Health Check to find children needing assessments and/or immunizations and to ascertain the best place to provide the service.

Prevent Blindness NC has brought members of the eye care professional community "to the table" through successful recruitment of this group into our "Donor Doc" pool of professionals. This aspect of our programming does a lot to forward our ability to communicate and interface with eye care professionals, which means a lot to our organization. In addition, successful programming with Smart Start has helped PBNC gain a better statewide presence. As such, our ability to sell other programs that

serve children has increased. During the spring of this past year, PBNC found funding for equipment and training for the Developmental Evaluation Center serving Wilson County. In addition, PBNC will be training all public school screening volunteers in Wilson County to provide vision screening in the schools, K-6.

Child Care and Education

Subsidies

82 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this quarter, and
82 children received Smart Start subsidies through an increase in the eligibility scale or categories expansion this year to date.

83 other children received Smart Start subsidized child care this quarter, and
184 other children received Smart Start subsidized child care this year to date.

Quality Improvement

113 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this quarter, and
113 teachers received teacher education, technical assistance and/or support services (not provided by a child care resource & referral agency) this year to date.

1,350 children were enrolled in programs/classes that received quality enhancements this quarter, and
1,350 children were enrolled in programs/classes that received quality enhancements this year to date.

Educational Programs

19 children received one or more educational programs this quarter, and
19 children received one or more educational programs this year to date.

Health Care / Health Care Education

103 children received immunizations this quarter, and
103 children received immunizations this year to date.

65 children received health and/or developmental screenings this quarter, and
65 children received health and/or developmental screenings this year to date.

1,238 families received health care education this quarter, and
1,238 families received health care education this year to date.

Family and Community Services

Parent Education and Support

76 families received parent education and/or support services in places other than family resource centers this quarter, and
76 families received parent education and/or support services in places other than family resource centers this year to date.

7 families were contacted through community outreach efforts, such as Family Ties, this quarter, and
7 families were contacted through community outreach efforts, such as Family Ties, this year to date.

Transportation

36 children and family members were provided transportation to child care, health or other services this year to date.

Note: The partnership has not verified its year to date counts to the Smart Start Evaluation Team at FPG-UNC or the North Carolina Partnership for Children. Thus, year to date counts may contain duplications or errors, and may over-report true year to date counts.

Year 4 Partnerships

Year 4 partnerships include 12 counties that have spent 1997 planning for Smart Start programs and services and will receive program funding in FY 1997-98.

Smart Start Impact

The partnership is presently providing services to teenage parents through two private sector grants. The advisory committee facilitating these grants has renamed the program TIPS (Teen Information and Parenting Services). With Anson County's rate of pregnancies to single teens 92nd out of 100 counties, the partnership is focusing on this area of concern.

Data collection from teen parents has begun with the help of two public school employees contracted for the summer weeks. Public forums for teen parents as well as private home visitations have been conducted. Approximately thirty teens with children have expressed interest in TIPS. Among the teen mothers is a fifteen year old student. This particular teen is serving on the TIPS Advisory Committee to help plan services for her peers. As an honor student who plans to attend college and eventually become a district attorney, this teen mother is helping TIPS as TIPS helps her. She is planning speaking engagements to spread the word in her community that Smart Start and CPC are helping tee parents in Anson County.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The Anson County Partnership for Children completed an intensive strategic planning process involving four grassroots task forces and approximately one hundred and fifty volunteers. A total of twenty-five meetings spanning approximately seventy-five hours were facilitated by a private consulting firm. All agencies providing services to young children collaborated on the strategic plan.

One thread running through the task forces has been "systems change". As part of the planning process, a three hour workshop was conducted for ACPC board members and volunteers on a framework for thinking about community change. Board members will continue coordinating and building on the work launched by other initiatives, such as Healthy Ansonians. Agencies have expressed cooperation and willingness to continue the open discussion of how to "change the system" in order to improve services to young children.

During the planning process three agencies (Anson County Health Department, Anson County Building Inspectors, and Anson Community College) offered leveraged funding toward implementation of the plan. Leveraged funding for the entire plan totals $109,150.00. In addition, other agencies have pledged support in administration of the smart start activities.

The community volunteers and board members anxiously await approval of the plan and implementation of services through Smart Start.

BERTIE COUNTY PARTNERSHIP FOR CHILDREN

Smart Start Impact

The Bertie Partnership has made a significant impact on the community during the fourth quarter of this fiscal year. Among its many activities, the Partnership was instrumental in providing child care services for a local Community Summit, as well as assisting with the visits of Mr. Robin Britt of NC Department of Human Resources and UNC-CH Chancellor Michael Hooker.

The second annual Bertie County Community Summit was held at Bertie High School. The summit, attended by over 500 people and covered by the local newspaper, was part of the Perdue Incorporated Schools Restructuring effort. The purpose of the summit was to develop positive relationships between the school system and the community. Events and activities included arts and crafts, a puppet show, a magic show, and focus groups for parents, teachers and community residents. The Partnership helped organize the summit and child care services for parents attending this summit. County child care centers assisted the local Partnership Executive Director in providing child care.

The Bertie Partnership received a $15,000 grant from R.J. Reynolds for child care subsidy scholarships. This grant will fund child care scholarships to mothers between the ages of 12 and 22 who are in need of financial assistance for child care services and was covered by the local newspaper. Plans are made to expand this effort to include grants from other businesses interested in subsidizing scholarships. Because of this grant, a new form of collaboration has developed between the Partnership, Health Department, Department of Social Services, and Family Resource centers. Representatives from these organizations have met concerning the implementation of this grant. The scholarships will be disbursed to eligible mothers in the near future.

The Bertie Partnership completed its first Smart Start Strategic Plan and submitted it to the NC Partnership. This plan contained 20 activities that addressed the five core services of the Smart Start concept.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The Bertie Partnership is in the process of planning for service implementation once the strategic plan is approved.

Improving the lives of children and families.

The Bertie Partnership has established a Technological Center in Windsor to assist child care centers and other organizations involved with children birth through 5 years. Most of these centers and organizations cannot afford printing services and the closest printing company is located in Greenville, which is over 40 miles from Windsor. The equipment available for common use in the Technological Center includes a copier and duplicating machine, a scanner, a fax machine, three computers, and two laser printers. Future equipment and services proposed will include automatic paper folders, a laminator, Internet services, videos, technical assistance, child care quality classes, professional development books, handouts on specific topics, consultation services, and curriculum kits complete with materials that providers will be able to check out for working with their children.

The Partnership is working with local child care centers by providing pertinent information and technical assistance concerning quality child care. One child care center has recently received AA licensing. This is the first AA licensed center in Bertie County.

Smart Start Impact

The Touching the Lives of Children Volunteer Tutor program is a new program administered through the Brunswick Partnership which has encouraged and elicited new collaboration in the county. The program is a joint effort of the Brunswick County School District, county child care providers, and individual volunteer tutors. The program materials consist of a library of early childhood educational activities. Program implementation includes recruitment, training, matching volunteers with families, and honoring volunteers, parents and child care providers in an effort to increase the county children's school readiness and success skills. The program has been very well received in the communities of Brunswick County. Both county newspapers printed feature articles and photos of volunteers in training for the program. By mid-October, 1996, over 150 volunteers had been trained to volunteer in the program. In January, 1997, 62 child care providers participated in training to initiate their access to the program. Responses from volunteers on year end surveys demonstrate high satisfaction with the program. A sampling of their comments is provided. Volunteers liked:

"The approach that the partnership has toward helping children, working one-on-one with children."
"It gave the children good skills and comprehension and it [helped] me also."
"Seeing children come out of their shells and participate and perform better than predicted."
"It teaches learning skills while the children are having fun."
"Watching each child's confidence and self-esteem grow as [he or she] learned."

Parent, community volunteers, and child care providers responded with enthusiasm to attending the training and committing to the 45-60 minutes per week to help children develop the necessary skills to promote readiness and success skills for school. Preliminary data analysis in Brunswick County shows that for each month of program participation, children make an average of two months developmental gain.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The implementation of the Touching the Lives of Children program has promoted interaction and collaboration among

Local child care providers in coordinating use of materials;

The Brunswick County Association of Child Care Professionals that serves as the vehicle of communication for gathering and disseminating information about the program among various providers;

The schools and local child care providers who have increased interactions since many materials are housed in elementary schools and providers borrow from them;

Volunteer tutors in one elementary school and the assigned site-coordinator, in promoting better organized community involvement the community volunteer program at the school.

Further, collaboration with the local Communities in Schools agency, whose mission it is to promote school success, includes future joint training efforts and referral to the Touching the Lives of Children program as an option for volunteers. A library of program materials is located in an area Family Resource Center for community access. Civic organizations and churches have also directly supported the program by encouraging volunteer participation.

In this first year, the Touching the Lives of Children program boasts over 3000 volunteer hours donated to the program. The efforts of these volunteers as a group have been acknowledged in a nomination for the Governor's Award for Outstanding Volunteer Service.

Other collaborative efforts are occurring as well. Child Care providers are interested in knowing how other facilities are promoting the program: what works and what doesn't. The approval of our 1997-98

Smart Start Strategic Plan and budget will enable the adoption of 3 AMERICORPS Volunteers under the WINGS program to be recruited by the Partnership. These positions would involve assignment at child care facilities as well as a parent outreach component: training parents to understand and promote school readiness skills through the WINGS program. The program has been well received in the Brunswick County community as a way of improving the lives of children in a meaningful and proactive way. The collaborations built because of this are starting to spill over into collaborative efforts in other areas of the Brunswick Partnership's mission.

Child Care and Education

Subsidies

6 children received Smart Start subsidized child care this quarter.
14 children received Smart Start subsidized child care this year to date.

Quality Improvement

70 child care providers received training through the Brunswick County Association of Child Care Providers this quarter.
85 child care providers received training through the Brunswick County Association of Child Care Providers this year to date.

147 children participated in the preschool music program this quarter.
147 children participated in the preschool music program this year to date.

Educational Programs

415 children participated in Touching the Lives of Children program this quarter.
415 children participated in Touching the Lives of Children program this year to date.

Family and Community Services

Parent Education and Support

25 pregnant and parenting teens received parent education, health screenings and services, and family support services this quarter.
25 pregnant and parenting teens received parent education, health screenings and services, and family support services this year to date.

Smart Start Impact

Our partnership has received much needed publicity in our local papers and many more individuals are calling and asking for information. The Strategic Planning Process brought over 50 persons from different areas to the table. The summary of the plan was published in local papers.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

We collaborated with the Health Department and Chamber of Commerce to help a new dentist re-locate to our community and become eligible to use the experience in lieu of paying back school loans, as well as collaborated with the Family Resource Center to come under new sponsorship which will increase the success level. We have been involved in a regionalization process over the past three months with Brunswick, Pender, and New Hanover Counties. Two representatives from our county are on the local regionalization committee.

Smart Start Impact

The activities of the organization during the past 3 months have focused on the development of our first Smart Start plan for services. The plan was due on May 30 and most of the time during this quarter was spent on the development of activities and budgets for next year's program of action. Individual board members, tasks forces and the Board, as a group, have gone through the proposed activities carefully. Representatives of organizations continued to learn about each other's programs. Care was taken to avoid duplication of existing services. Through the review of the plan, we learned as a group that we were missing certain elements necessary to have an infrastructure related to quality of early childhood care. We learned that we did not have some basic services covered in health related fields, i.e., as a group, we learned where the gaps were. We also learned that our first year of services involved developing an infrastructure for childhood care and intervention, and that most of our planned activities were interdependent. We realize that all future services will build on each other. For example, we need to develop opportunities for child care providers to improve their education and knowledge before we can provide the WAGES program or quality enhancement grants. Because of Smart Start planning, we now have plans to have a maternal outreach worker, a child services coordinator, and a better health check program. We are also planning to develop an early childhood education program at the local community college as a direct result of the planning process.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The development of the child care Task Force has brought representatives of various agencies together. We have identified common activities for improving the child care work force and provision of early child care services. Having these individuals plan activities as a group should create a wide investment in positive actions taking place once the plan has been funded and implemented. Also, individuals and agencies are much better informed about each other's services after going through this wide planning process.

Smart Start Impact

Smart Start continues to have a very positive impact on our community. Through the distribution of 6,000 flyers throughout the community and in each of our public library branches, we have received numerous inquiries about Smart Start. Additionally, the Executive Director and the Board Chair taped a one-half hour television show about Smart Start in our community which will air on WAAP-TV sometime during the month of July.

Nine Board members and the Executive Director attended Governor Hunt's Smart Start Awards Ceremony in Raleigh held on May 10.

The Board held a Press Event to accept a check for $15,000 from Duke Power Company to enhance family support services. The Board agreed that the grant will be used to expand our county-funded home visitation program for at-risk newborns. This program is recommended for expansion in our strategic plan.

The Board was also very pleased to accept a check for $20,000 from Sara Lee Corporation, and $500 from the United Way of Greater Greensboro during this quarter. As soon as the strategic plan is approved, the Board will determine the best use of these funds.

Our strategic plan was completed and sent to the North Carolina Partnership for approval. We are anxiously awaiting beginning our proposed services.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

During this quarter, the working committees of the Board (Child Care, Health, and Family Support) completed their recommendations for activities to be included in the strategic plan that was due on May 31 to the North Carolina Partnership. These committee meetings were extremely well attended by agency and community representatives and there was a great deal of "give and take" as activities were prioritized and finalized.

During the month of June, the Nominating Committee was busy at work to replace board members and recommend officers for the coming fiscal year beginning July 1. The Board unanimously accepted the recommendations of the Nominating Committee.

The Search Committee worked tirelessly in selecting an Executive Director from a field of 98 applicants from North Carolina and 16 additional states. An applicant was offered and accepted the position, and will begin August 1.

Guilford County government continues to provide a great deal of in-kind support to the Smart Start effort. For this fiscal year, the total is $10,259.15. In addition, the Director of the Guilford County Office for Children has served the role of Executive Director during this entire strategic planning process, and has ensured the integrity of the organization, as well as obtaining incorporation and 501c(3) status. Beginning August 1, this person will become a Board member and serve as Treasurer.

HOKE COUNTY PARTNERSHIP FOR CHILDREN

This partnership did not submit a quarterly report for the period April 1 - June 30, 1997.

Smart Start Impact

Smart Start has raised the "dare to dream" level in our community. Owners of child care centers have commented often on their costs to do business, specifically, banking. We are now working with a local bank to see how to eliminate banking costs, or at least create more efficient, effective ways to do business. Some creative thinking is going on.

Smart Start has been highlighted on several occasions. A magazine section of the Statesville Record and Landmark was published during National Teacher Appreciation Week. Smart Start and the Iredell County Partnership for Young Children were featured in the centerfold.

The local community college has committed to offer an Associate Degree program in the fall and to offer Credential I and II in both locations in the county as a result of Smart Start collaboration.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

New groups of agencies are coming together now to discuss a coordinated subsidy effort, communicating with new parents, and how to conduct a community-wide needs and resources assessment. A local doctor and his wife hosted a dinner entitled "Respecting Our Heritage" and "Celebrating Our Future" to honor the Historic Downtown Statesville Development Corporation and the Iredell County Partnership for Young Children. Over 150 persons attended an elegant dinner. Over $1,800 in private contributions came in to the Partnership from guests who attended the dinner.

Smart Start Impact

The Lee Partnership has focused on collaborative work within the county during the fourth quarter. We have attempted to foster new linkages among natural partners and revitalize existing linkages to create a more viable network of collaboration for proposed funding initiatives. For example, these was no formal organization for child care providers to advocate and share mutually beneficial information on changing policies and trends in North Carolina. Second, the family child care home providers and center providers were estranged and viewed themselves in competition rather than a coalition of workers with similar issues and needs. During the past few month, the Lee Partnership has acted as a catalyst to reconvene separate meetings for child care providers and family home providers to meet and organize as newly functioning groups. A consensus among both groups recognized a need to organize and come together as separate entities first, and then meet periodically to share resources. Reorganization of the Lee County Association of Family Home Providers and the Lee County Day Care Association has proven to be a significant enhancement to the Partnership's goals. Both groups are excellent mediums for promoting quality child care and advocating for increased standards of professionalism among early childhood educators and workers. To date, both groups have elected executive committee members to further formalize their associations. Smart Start can be credited with playing a critical role in organizing and mediating as a neutral party in bringing these two groups together as cooperative linkages and partners.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

The Lee Partnership has also tried to increase the diversity and level of involvement of broad-based community groups in our efforts to enhance planning and implementation of future Smart Start projects. Special efforts have been made to recruit and involve parents and members from other special populations in a community mobilization project. Local residents are being trained in community change strategies and outreach strategies by Partnership staff. These residents will be recruited to assist in several health and educational outreach efforts to insure that young parents and their children participate in early screenings and immunization services in Lee County.

The Partnership is also in collaboration with the Greater United Way of Lee County to coordinate a county-wide needs assessment that will provide current demographic, human service, and educational data. The initial project was introduced by the Partnership as a plan to identify local needs and to map assets of families with children between birth and four years of age. In order to reduce costs and to increase collaborative efforts, the United Way, the Partnership and other agencies decided to combine resources. A total collective of six organizations will coordinate the project and Lee Partnership will assume the lead role for organizing and monitoring the data collection and analyses. Immediate benefits are easily calculated in the combined efforts of various groups to share, exchange, coordinate and expand current resources to meet a common end. Long term benefits will include increased quality and efficient use of needed resources to meet the needs of young children and their families.

Smart Start Impact

Both local newspapers highlighted the Smart Start planning process as a news story at no cost to the Partnership. The Independent published an article on June 26, 1997 and The McDowell News published an article on June 29, 1997.

NOTE: The Partnership does not, as of this reporting period, have service money.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Smart Start and the McDowell County Schools Educational Foundation, as a result of a grant through the NCPC from NationsBank, are providing funding for a summer enrichment program at the North Cove Family Center.

MOORE COUNTY PARTNERSHIP FOR CHILDREN

Smart Start Impact

In recent months, the Partners for Children and Families became a working board, more dedicated than ever to meeting the needs of our children. This spread into the other agencies, organizations, business leaders, and residents as talks and work became more focused on a strategic plan that focuses on these needs. Activities, pending state approval, have been designed that will increase and enhance current programs in the county as well as assist in bringing new opportunities in areas desperately needed.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

In the fast paced and hectic phase of strategic planning, the board, along with other agencies, residents, and business people, "came to the table" by creating "task forces" that were charged with the mission of designing a plan that would be the foundation of services for children 0 - 5 in Moore County. Numerous hours were sacrificed from individuals' places of employment as well as their personal lives, as many worked weekends, holidays, and evenings. These task forces have agreed to continue in a working role when needed and in an advisory role as future programs are designed.

Smart Start Impact

Began an Even Start grant - brought various agencies together to plan for grant.

Human service agencies and organizations are working together in new and better ways because of Smart Start.

Co-sponsored State of Child Conference on May 15, 1997 at Livingston College. Approximately 80 people from various service agencies attended.

Participated in Day of Child - April 14, 1997 with a booth (fliers and videotape on choosing quality child care was run all day).

Private Sector Cash and In-Kind Contributions

Each year, Smart Start is mandated by legislation to raise a total of 10 percent In private contributions (five percent in cash contributions and five percent in-kind donation).

FINAL REPORT: July 1, 1996 - June 30, 1997
PRIVATE SECTOR CASH AND IN-KIND CONTRIBUTIONS

Smart Start received unprecedented support from the private sector during FY 1997, confirming once again that this program has solid support across the state. As of June 30, 1997, nearly $3.6 million in cash contributions had been received by local partnerships and the North Carolina Partnership for Children on behalf of Smart Start. In addition, more than $5.3 million in in-kind contributions had been contributed on behalf of Smart Start partnerships and programs. Individuals, companies, and foundations from around the state have made an investment in Smart Start because they understand that Smart Start is an investment in the future.

The increase in private sector support for Smart Start is an important indicator of how much this initiative has grown and strengthened in the past year. As the public learns more about Smart Start and recognizes the impact that Smart Start can have on their own lives and communities, this support will only increase.

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Listed below is a summary of the total private sector cash and in-kind donations made either to the North Carolina Partnership for Children and the 47 local partnerships or in support of Smart Start-funded programs for the 1996-1997 fiscal year. This does not begin to reflect the total private sector support for Smart Start programs.

Cash Gifts: Cash donations to the North Carolina Partnership for Children and local Smart Start partnership organizations

North Carolina Partnership for Children	*$2,693411.00*
Local Partnerships	*$875,646.00*
Total Cash Contributions Received through 6/30/97:	**$3,569,057.00**

In-Kind Contributions: Most in-kind contributions are made directly to Smart Start programs and activities. These contributions include the gift or loan of equipment, supplies, or other goods and are reported at fair market value. Contributions of services are recognized if they create or enhance nonfinancial assets or require specialized skills, are provided by individuals possessing those skills and would need to be purchased if not provided by donations.

Total In-Kind Contributions Received through 6/30/97:	**$5,301,342.00**
Volunteer Services Received through 6/30/97:	**138,969 Total Volunteer Hours**

Child Care Resource and Referral Services

CHILD CARE RESOURCE AND REFERRAL SERVICES

In the design of the Smart Start Initiative, Child Care Resource and Referral (CCR&R) services were determined to be a vital part of the development of a child care and education system. Each county has funded these services or planning for these services at varying levels.

What is CCR&R? CCR&R is a service that has developed in local communities to link all people and groups concerned about child care -- parents, child care providers, local governments, businesses and human service agencies. It does this by:

- *Providing parents with information to help them make informed child care choices.* This information is more extensive and personalized than a mere list. It includes such things as types of child care available, licensing requirements, components of quality care, how to evaluate care, financial assistance available, other needed community services and written follow-up materials. Specific recommendations about which facility to use are not made by CCR&R staff; the aim is to provide parents with the full range of choices for child care in the community beyond the simple listings of programs in the yellow pages;

- *Ensuring that training is available for the people caring for children, providing technical assistance to help potential child care providers get started in the business, helping existing providers improve the quality of their care*, and supporting providers through newsletters, associations, resource libraries, and helping them become more visible and well-utilized;

- *Developing new or additional child care resources* in the community, if parents need them. As the local economy develops, the supply of high quality child care must be in place to support the economic growth; and

- *Providing people in the community such as human service agencies, local government, potential child care providers, Chambers of Commerce, employers, and realtors with valuable information on child care supply and demand that helps them serve customers better, make better business decisions and more effectively allocate limited resources.* The information supplied includes unregulated (but legal) as well as regulated care. Many CCR&Rs have contracts with businesses to provide enhanced referral services for their employees.

CCR&Rs do not serve as regulators and have no vested interest in advocating for one type of care over another. This enables them to play a critical role in creating a more cohesive child care system that supports parent choice and builds on the valuable diversity present in our current system.

How is CCR&R Developing in NC? Nationally and in North Carolina, CCR&Rs have been developing since the early 1970s. These services have usually been created in response to the needs of parents and/or child care professionals. Typically, there are several stages of development of CCR&R services:

- *The planning stage* is where a broad-based community group learns about CCR&R, studies parents' and providers' needs, and then determines what services are most needed there and how CCR&R should function and be structured in that community. Counties in this stage include Anson, Bertie, Brunswick, Dare Duplin, Hoke, Iredell, Lee, Pamlico, Rowan and Wilson;

- *The start-up stage* is where staff are hired, an office is established, educational materials for parents and providers are developed, a database of providers is created, policies and procedures are written (how providers are to list the CCR&R, what to do when a parent complains about a facility, how referrals are made, etc.), services are advertised. The CCR&R is working towards the core services. Counties in this category include Ashe, Caldwell, Jones and Surry;

- *The core service stage* is where, at a minimum, basic CCR&R services to parents, providers and the community are being provided. Counties in this stage range from those that have recently begun offering services to those that have been providing services for almost two years and are ready to move into the next stage so there is a great amount of variation among them. Counties in this stage include Alleghany, Avery, Cleveland, Cumberland, Halifax, Hertford, Lenoir-Greene, McDowell, Orange, Pasquotank, Person, Robeson, Stanly, Stokes, Washington and Wilkes;

- *Beyond the cores services stage*, CCR&R programs typically work on improving their services and add new services as they are needed and as funds are available to provide them. CCR&R programs may seek accreditation from the NC CCR&R Network to help ensure a certain professionally recognized level of quality in services provided. There are varying levels of accreditation so agencies can continually strive to provide better services.

The NC Child Care Resource and Referral Network operates a nationally recognized accreditation process. CCR&R programs accredited by the Network operate in these Smart Start counties: **Buncombe, Burke, Catawba, Chatham, Columbus, Davidson, Durham, Forsyth, Guilford, Mecklenburg, Moore, Nash-Edgecombe, New Hanover, Region A, Rutherford and Wake**.

Of the 47 local Smart Start projects, eighteen had CCR&R services prior to receiving Smart Start funds which means they were supported by funds other than Smart Start. All of the accredited programs listed above receive funding from a variety of sources in addition to Smart Start funds. Sources may include United Way, local and federal government, foundation and corporate grants, corporate contracts for services, membership fees, fund-raisers, etc. Therefore, when CCR&R programs report numbers served for this report, they are reporting only those customers served with Smart Start funds. For example,

- Work/Family Resource Center in Forsyth County received less than one quarter of their funding to provide direct child care information and referrals to parents through Smart Start.

- Child Care Resources, Inc. in Mecklenburg County, received less than ten percent of their funding to provide direct child care information and referrals to parents through Smart Start.

Establishing CCR&R services is hard work but is critical to the success of a Smart Start effort. It is similar to building a bridge, an infrastructure, that can help support the child care system at the local level. Instead of cars, this bridge helps connect and transport the various players in the child care community -- parents, child care provides, businesses and a wide variety of agencies. Typically, those counties that have taken the time to solicit community input for the development of CCR&R services and thoroughly planned for this local infrastructure have created stronger programs that will serve the community for many years to come.

State-Level Administration and Support Services

North Carolina Partnership for Children
N.C. Division of Child Development

STATE-LEVEL ADMINISTRATIVE AND SUPPORT SERVICES

North Carolina Partnership for Children

Created by 1993 legislation, the mission of the North Carolina Partnership for Children, a private nonprofit organization, is to take action on behalf of the people of North Carolina to support children under six and their families through statewide and local community partnerships. The North Carolina Partnership provides administrative support and offers technical assistance to local partnerships in the development of Smart Start strategic plans. The work of the North Carolina Partnership for Children during the fourth quarter included the following:

- Provided on-going technical assistance to 47 funded local partnerships, including program development, organizational development, board development, budget and contracts development, strategic planning, and operating policies and procedures.
- Reviewed the program plans and budgets for 35 local partnerships that currently receive Smart Start funds and the 12 local partnerships that receive planning funds.
- Provided information and support to the 45 counties (Year 5) that were selected by the North Carolina Partnership for Children to become eligible for Smart Start funding in the 1997-98 fiscal year.
- Conducted a one-day orientation conference for 45 Year 5 counties.
- Conducted regional orientation sessions for new executive directors and board chairs of local partnerships.
- Organized and co-sponsored with the Public Transportation Division of the North Carolina Department of Transportation a statewide Transportation Summit in response to a mandate from the General Assembly. The forty participants included representatives from local partnership boards and staff, local transit agencies, state-level agencies, Head Start, and county commissioners. A report of the meeting is available and a best practices guide is being developed.
- Provided on-going training to local partnerships on fiscal and contracts management.
- Conducted the installation and training of MIP fiscal accounting software systems for local partnerships.
- Organized and participated in monthly forums for executive directors of local partnerships focusing on in-depth training and sharing knowledge and information.
- Conducted regional child care resource & referral training sessions.
- Assisted in the organization and development of the Local Partnership Advisory Committee, which was created by legislation.
- Participated in county meetings to discuss multi-county collaboration and regionalization of local partnerships.
- Participated in evaluation meetings with the Frank Porter Graham Child Development Center.
- Coordinated statewide activities related to the "I Am Your Child" Campaign.

- Coordinated a Health Advisory Team to review health portions of local partnership strategic plans and to assist them with health concerns.

- Coordinated with the Division of Child Development a Child Care Subsidy Work Group to develop best practices' guidelines for local partnerships.
- Participated in the Finance Project Learning Cluster conference to develop strategies for financing child care systems. Participated in a subsequent learning cluster to develop strategies applicable to North Carolina.
- Participated in two Starting points conferences sponsored by the Carnegie Corporation. The Carnegie Corporation is currently providing funding for technical assistance to local partnerships.
- Participated in the White House conference on early childhood development and learning.
- Participated with Prevent Child Abuse North Carolina in developing a statewide plan for prevention of child abuse and neglect.
- Organized the first annual Smart Start Awards Banquet, attended by approximately 900 people.
- Gave technical assistance and information to other states that are developing early childhood initiatives. Hosted a delegation from Florida's Governor's office and took them on a site visit to the Chatham Partnership for Children.
- Presented at a national conference sponsored by the White House, "Public-Private Partnerships and Community Collaboration."
- Initiated plans for a National Foundation Summit on Smart Start, to be held in November, with representatives of 30 national foundations that have a strong interest in children's issues.
- Co-sponsored with the Research Triangle Institute a two-day conference on brain development.

DIVISION OF CHILD DEVELOPMENT

The Division of Child Development (DCD) in the Department of Human Resources continues to work closely with the North Carolina Partnership for Children, Inc. (NCPC) in an effort to assist with transition activities and to ensure uninterrupted funding for existing local partnership projects. DCD and NCPC continue to coordinate their efforts to offer the local partnerships maximum expertise as they develop strategic plans and implement services. During the fourth quarter of the 1996-97 state fiscal year, DCD accomplished the following:

- Managed and monitored contracts for Year 1 and 2 local partnerships which included amending contracts, assisting with budget revisions, processing reimbursements and year-end issues.
- Managed and monitored eight contracts for Year 3 local partnerships which included assisting with budget revisions, processing reimbursements and year-end issues.
- Managed and monitored nine of the Year 4 local partnerships planning contracts by assisting with budget revisions, processing reimbursements and with year end-issues.
- Managed contract with NCPC that included funds for the local partnerships. This contract included local partnership funding for four Year 3 local partnerships and three Year 4 local partnerships. This contract allowed NCPC to begin the local contract process as mandated by the 1996 legislation.
- Provided technical assistance to NCPC on DCD's contract approval system.
- Provided administrative support to state-wide Smart Start projects and programs, including T.E.A.C.H., the Smart Start evaluation and NCPC.
- Provided to the Office of the State Auditor information regarding contracts from the 1995-96 state fiscal year to assist in the auditing process. Collaborated with the fiscal director at NCPC to design technical assistance to local partnerships based on individual findings and patterns of findings.
- Provided NCPC and local partnership staff/board with information and technical assistance to strengthen subsidy programs.
- Provided NCPC and local Family Resource Center staff with information to enhance and strengthen program efforts in family involvement, grant writing, building collaboration and staff development.
- Provided information on Smart Start to individuals and groups in North Carolina and throughout the nation.
- Assisted NCPC by amending its contract to add additional funding provided by legislation and approved by the NCPC Board of Directors.
- Provided technical assistance to Frank Porter Graham on the expanded scope of the evaluation efforts.
- Assisted NCPC in the review of all 1997-99 local partnership strategic plans. Offered comments and recommendations on the outcomes of these proposals.

Smart Start Evaluation

Frank Porter Graham Child Development Center,
University of North Carolina, Chapel Hill

Smart Start Evaluation Progress Report

April 1, 1997 -- June 30, 1997

A brief overview of the Frank Porter Graham Child Development Center (FPG)-UNC evaluation activities during this quarter is provided below. A more comprehensive report of a Smart Start evaluation child care quality study, *The Effects of Smart Start on the Quality of Preschool Child Care*, is included as an appendix to this report. A list of all Smart Start evaluation products is also attached.

Child Care Quality Comparison Study. We gathered information on the quality and types of services provided by over 100 licensed child care centers in a sample of third- and fourth-round partnerships. We are currently analyzing these data to determine baseline information regarding the quality of care in counties that have more recently begun participating in Smart Start.

Collaboration Study. Investigators at the UNC Jordan Institute for Families are conducting a study of the collaboration among public and private agencies in the pioneer Smart Start counties. To date, in-depth interviews have been conducted with over 100 agency administrators, and additional interviews are currently being conducted.

Feasibility Study of Unique Identifier Systems. Four pioneer Smart Start partnerships participated in a feasibility study of establishing a unique identifier system in which Smart Start programs gathered similar types of demographic data from participants, using a unique identifier such as social security number. Qualitative and quantitative data have been gathered and are being synthesized into a brief report.

Playground Safety Study. To examine the impact of Smart Start-funded playground improvement grants to child care facilities, we have gathered data on playground safety from 30 licensed child care facilities in a Smart Start and comparison non-Smart Start county. These data are currently being analyzed and will be described in an upcoming report.

REPORTS FROM THE UNC SMART START EVALUATION TEAM

Emerging Themes and Lessons Learned: The First Year of Smart Start (August 1994)

This report describes the first-year planning process of the pioneer partnerships and makes some recommendations for improving the process.

Smart Start Evaluation Plan (September 1994)

This report describes our comprehensive evaluation plan, designed to capture the breadth of programs implemented across the Smart Start partnerships and the extent of possible changes that might result from Smart Start efforts.

Keeping the Vision in Front of You: Results from Smart Start Key Participant Interviews (May 1995)

This report documents the process as pioneer partnerships completed their planning year and moved into implementation.

North Carolina's Smart Start Initiative: 1994-95 Annual Evaluation Report (June 1995)

This report summarizes the evaluation findings to date from both quantitative and qualitative data sources.

Reinventing Government? Perspectives on the Smart Start Implementation Process (November 1995)

This report documents pioneer partnership members' perspectives on 2 major process goals of Smart Start: non-bureaucratic decision making and broad-based participation.

Center-based Child Care in the Pioneer Smart Start Partnerships of North Carolina (May 1996)

This brief report summarizes the key findings from the 1994-95 data on child care quality.

Effects of Smart Start on Young Children with Disabilities and their Families (December 1996)

This report summarizes a study of the impact of Smart Start on children with disabilities.

Bringing the Community into the Process: Issues and Promising Practices for Involving Parents and Business in Local Smart Start Partnerships (April 1997)

This report describes findings from interviews and case studies about the involvement of parents and business leaders in the Smart Start decision-making process.

The Effects of Smart Start on the Quality of Child Care (April 1997)

This report presents the results of a 2-year study of the quality of child care in the 12 pioneer partnerships.

North Carolina's Smart Start Initiative: 1996-97 Annual Evaluation Report (April 1997)

This report summarizes evaluation findings related to each of the four major Smart Start goals.

Kindergartners' Skills in Smart Start Counties in 1995: A Baseline From Which to Measure Change (July 1997)

This report presents baseline findings of kindergartners' skills in the 43 Smart Start counties.

To obtain copies of these reports, please call Marie Butts at (919) 966-4295.

THE EFFECTS OF SMART START ON THE QUALITY OF PRESCHOOL CHILD CARE

Report to the Department of Human Resources

by the Smart Start Evaluation Team
Frank Porter Graham Child Development Center
University of North Carolina at Chapel Hill

April 22, 1997

This report was written by Donna Bryant, Kelly Maxwell, Peg Burchinal, and Betsy Lowman, with sincere thanks to the many child care center directors and teachers who allowed us to visit their classes, the field data coordinators around the state who worked so diligently to collect the data, and our team who entered and analyzed the data.

For further information about this report or other Smart Start evaluation reports, please contact Dr. Donna Bryant at 919/966-4295.

60 copies of this public document were printed at a cost of $59.87 or $.99 per copy.

Abstract

This study examined the effect of a broad-based community initiative (Smart Start) to improve the quality of child care between 1994 and 1996. Data were collected from child care centers in 12 counties implementing the community initiative. Data collectors visited 180 child care centers in 1994 and 187 in 1996. The quality of child care was measured by the Early Childhood Environment Rating Scale (ECERS, Harms & Clifford, 1980).

The quality of child care was significantly higher in 1996 than 1994, both across the entire sample and the subset of 91 centers observed in both years. The quality of child care in 1996 was significantly related to the level of participation in local quality improvement activities by the child care centers, and to the percent of full-funding counties received and the proportion of this funding that the county chose to spend on child care. These latter two variables interacted such that the proportion spent on child care was significantly more related to ECERS quality in the counties that received a higher percentage of their full-funding amount.

These data indicate that child care quality was significantly better in the 12 counties after 2 years of Smart Start implementation and that factors associated with Smart Start participation were significantly related to the change. This broad-based community initiative is accomplishing one of its major goals -- improving the quality of center-based child care.

Introduction

The North Carolina Early Childhood Initiative, known as Smart Start, was established by Governor Jim Hunt in 1993 as a partnership between state government and local leaders, service providers, and families to better serve children under six and their families. The primary goal of Smart Start is to ensure that all children enter school healthy and prepared to succeed. Research in early childhood education has demonstrated the importance of high quality child care in preparing preschoolers for school success. Specifically, young children who receive high quality child care demonstrate

better cognitive and social skills than children who receive lower quality child care (Bryant, Burchinal, Lau, & Sparling, 1994; Cost, Quality, & Outcomes Study, 1995; Howes, Phillips, & Whitebook, 1992; NICHD Early Child Care Research Network, 1997). Unfortunately, many children in North Carolina--and across the country--do not receive high quality care.

Smart Start's innovative approach requires local community partnerships to plan how best to meet their own community's needs, improve and expand previous programs for children and families, and design and implement new programs. Twelve county partnerships were competitively selected in 1993 for a year of planning. (One partnership was actually comprised of a 7-county confederation, but we considered this partnership's data as if it were from one county.) Between 1994 and 1996 these 12 partnerships received over $60 million from the NC legislature to deliver new or improved services. (Each year since, 12 new partnerships have been funded, but this report covers only the first partnerships.)

As an important step in preparing children for school success, all local Smart Start partnerships funded projects in their communities to improve the quality of early childhood education, including center-based care. Examples of local projects include increased, improved, or specialized training for child care providers; quality improvement grants for centers to purchase educational curricula, equipment, and materials; and financial incentives for centers to demonstrate their provision of higher quality care by becoming licensed at the AA level (instead of A) or by achieving accreditation from the National Association for the Education of Young Children (NAEYC). The number of different quality improvement activities in which a child care center participated might be related to the quality of child care that the center provides.

Two additional factors may affect the potential influence of these improvement efforts within counties: (a) the percentage of full-funding received by the county, and (b) the proportion of funding allocated to child care quality enhancement. These county-level variables are described more fully below.

(a) Percentage of Full Funding Received

The full-funding allocation for each partnership was estimated in 1993 to be the amount of funds needed to improve the quality of care for children already in subsidized care and to enroll the rest of the county's poor children (birth to five) in a child care program for a half-day. The amount allocated each year by the legislature has fallen short of the full-funding amount. The percent of full-funding received may affect the level of implementation and success of the initiative in different counties.

(b) Proportion spent on child care

The local partnerships determined their own county's needs for services for young children and made funding decisions accordingly. Some partnerships allocated more of their funds to child care because they perceived a high need for more and better child care in their community; other partnerships chose instead to spend relatively more on improving health care services or establishing family resource or parenting education programs. The proportion spent on child care quality improvement activities might be related to the number or type of opportunities provided for child care centers and thus to quality enhancement.

Smart Start has generated increased attention to early childhood education and child care in North Carolina, a state that has among the least stringent child care licensing standards. The question investigated in this paper is whether this type of broad-based community initiative will affect the quality of preschool child care. Researchers at the Frank Porter Graham Child Development Center collected data in 1994 and 1996 to begin answering this question. The main hypotheses were:

- Overall quality of child care for preschoolers will be better in 1996 than in 1994.

- Preschool child care quality will be higher in counties that received more of their full-funding allocation.

- Preschool child care quality will be higher in counties that spent a higher proportion of their funds to improve child care.

- Child care centers that participated in more Smart Start quality improvement efforts will be rated better in 1996 than those who participated in fewer.

Method

Sample

In 1994, researchers visited 180 child care centers in the first 12 partnerships. In 1996, 187 child care centers from the same counties were visited. Ninety-one (91) centers were visited in both 1994 and 1996. Of the centers invited to participate in the study, 75% agreed to do so in 1994; 64% in 1996.

In each year of data collection, data were obtained from two samples of child care centers: a partnership-nominated sample and a random sample. The nominated sample consisted of child care centers that the 12 partnerships noted were involved in local Smart Start child care quality improvement efforts. These centers were visited in 1994 and again in 1996. The nominated sample was included to study directly the effect of Smart Start on child care in centers that were confirmed to be participating. The second sample of centers was randomly selected from the 1994 and 1996 lists of licensed child care centers in the counties (regardless of a center's participation in Smart Start). The random sample was included to measure the overall quality of care and to provide a comparison with the nominated sample. This process resulted in the selection of some centers both randomly and by nomination, a more frequent occurrence in small counties with fewer child care centers. In analyses, the data from such centers were included in both the nominated and random group. These two samples were not significantly different on any child care variable in 1994 or 1996, so they are combined in all further analyses presented here.

Table 1 describes characteristics of the 1994 and 1996 samples, which were very similar on several structural characteristics of child care.

Table 1. Center Characteristics in the 1994 and 1996 Child Care Samples

	1994 (N=180)	1996 (N=187)
Sample Type		
Randomly Selected Only	83	107
Nominated Only	52	49
Randomly Selected & Nominated	45	28
Type of Center		
Not for Profit	57%	58%
Church-Sponsored	21%	21%
Head Start	11%	15%
Independent	48%	44%
Public Preschool	4%	2%
Franchise	2%	4%
Median % of Subsidized Children per Center	38%	41%
Center Director with a BA Degree or Higher	39%	41%
Lead Teachers with a BA Degree or Higher	17%	21%
Participation in at Least 1 Smart Start Activity	95%	94%
Mean Number of Activities	5.3	5.9

Procedures

At each center visited, data collectors completed the Early Childhood Environment Rating Scale (ECERS, Harms & Clifford, 1980) in one randomly selected preschool classroom. The ECERS is a well-established measure of child care quality that assesses seven general areas: personal care routines, furnishings and display for children, language-reasoning experiences, fine and gross motor activities, creative activities, social development, and adult needs. Scores on each of 37 items can range from 1 to 7 with the overall mean score obtained by averaging all items typically used as a global measure of the developmental appropriateness or quality of the classroom. An overall score from 1 to 3 is considered poor; scores from 3 to 5 are considered mediocre; and scores of 5 or greater are considered good.

Data collectors were trained on the ECERS to an agreement criterion of 85%, counting two ratings that were identical or within one point as agreements. In 1994, field reliability data were obtained during one visit for observers who rated more than 10 classrooms. These reliabilities averaged 86% (ranging from 75% to 92%). In 1996, field reliability data were gathered on each observer after every 5-8 child care visits. These reliabilities averaged 85% (ranging from 72% to 94%).

Data collectors also interviewed center directors to obtain information about center characteristics and services, including a checklist of 14 different Smart Start improvement activities the center or center staff might have participated in during the past year. The data collector was unaware of the number of such activities in which the center had participated because the interview was typically conducted after the observation. In addition, only 2% of centers were visited by the same data collector in 1994 and 1996. About half of the 1996 visits were made by new observers who had not collected any 1994 data and the observers who gathered data both years were shifted to different counties in 1996. These procedures greatly reduced the possibility that any data collector bias influenced the results.

Results

Figures 1 and 2 present the distributions of the county-level predictor variables used in the first analyses. Figure 1 arrays the partnership counties by the percentage of full-funding they received. Nine counties received above 70% of full funding, but three others (among the most populated counties) received 20%, 26%, and 53% of their estimated full funding. Figure 2 arrays the counties by the proportion of their funding spent on child care quality enhancement activities. The proportion of funding devoted to child care quality enhancement ranged from 18% to 73%.

These two variables and time (1994-1996) were included in a Hierarchical Linear Model analyses (HLM) to test the first three hypotheses. Results are presented in Table 2. The quality of child care as measured by the ECERS was significantly higher in 1996 than in 1994, $F(1, 351) = 22.4$, $p < .0001$. The mean ECERS score in 1994 was 4.25 ($SD = .64$); in 1996, 4.51 ($SD = .68$). Figure 3 presents the distribution of the quality of center-based care in 1994 and 1996, illustrating a shift to the higher scores. Overall, only 14% of the preschool classes in 1994 were providing good quality care. In 1996, 25% of the preschool classes were providing good quality care.

Other evidence for increases in quality care came from the 91 centers that were observed in both 1994 and 1996. Among these centers quality of care improved significantly over the two years, $F(1, 176) = 12.05$, $p = .0007$, and the percentage licensed at the higher AA level increased from 38% to 52%, a statistically significant increase (χ^2 adjusted for repeated measures = 12.53, $p < .001$).

Table 2 also shows that the percentage of full funding received by a county and the proportion spent on child care activities were each significantly related to quality, although these main effects should not be interpreted because a significant interaction was found between these variables. This interaction indicates that proportion of funding spent on child care accounted for much more of the variance in ECERS quality scores in counties that received a high percentage of funding compared to those that received a low percentage of the full-funding allocation, $F(1, 353) = 4.81$, $p = .029$. The effect on quality of proportion spent on child care in the low-funded counties

Figure 1. **Distribution of Full Funding Received by Partnerships**

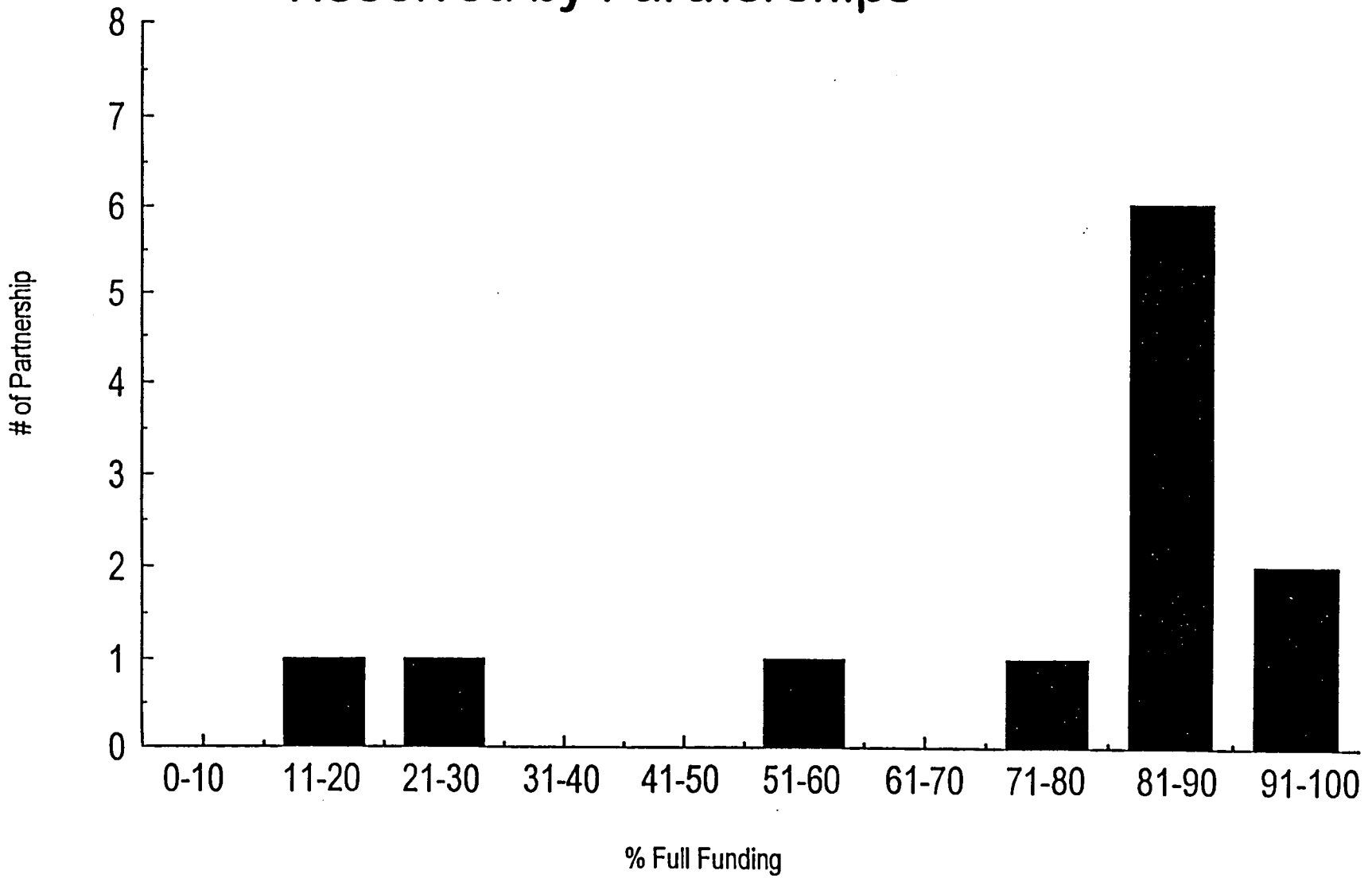


Figure 2. **Distribution of Funds Spent by Partnerships on Child Care**

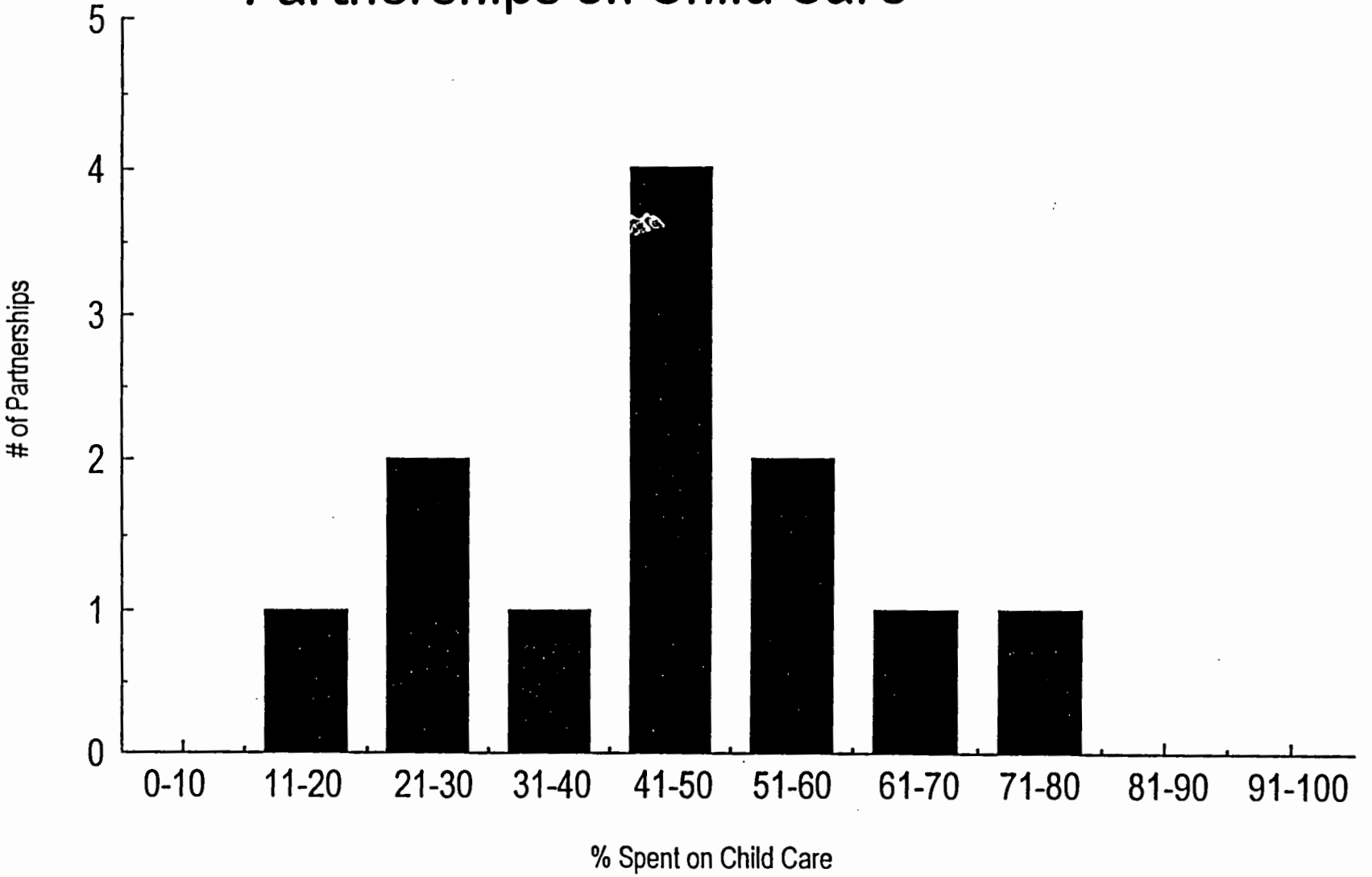


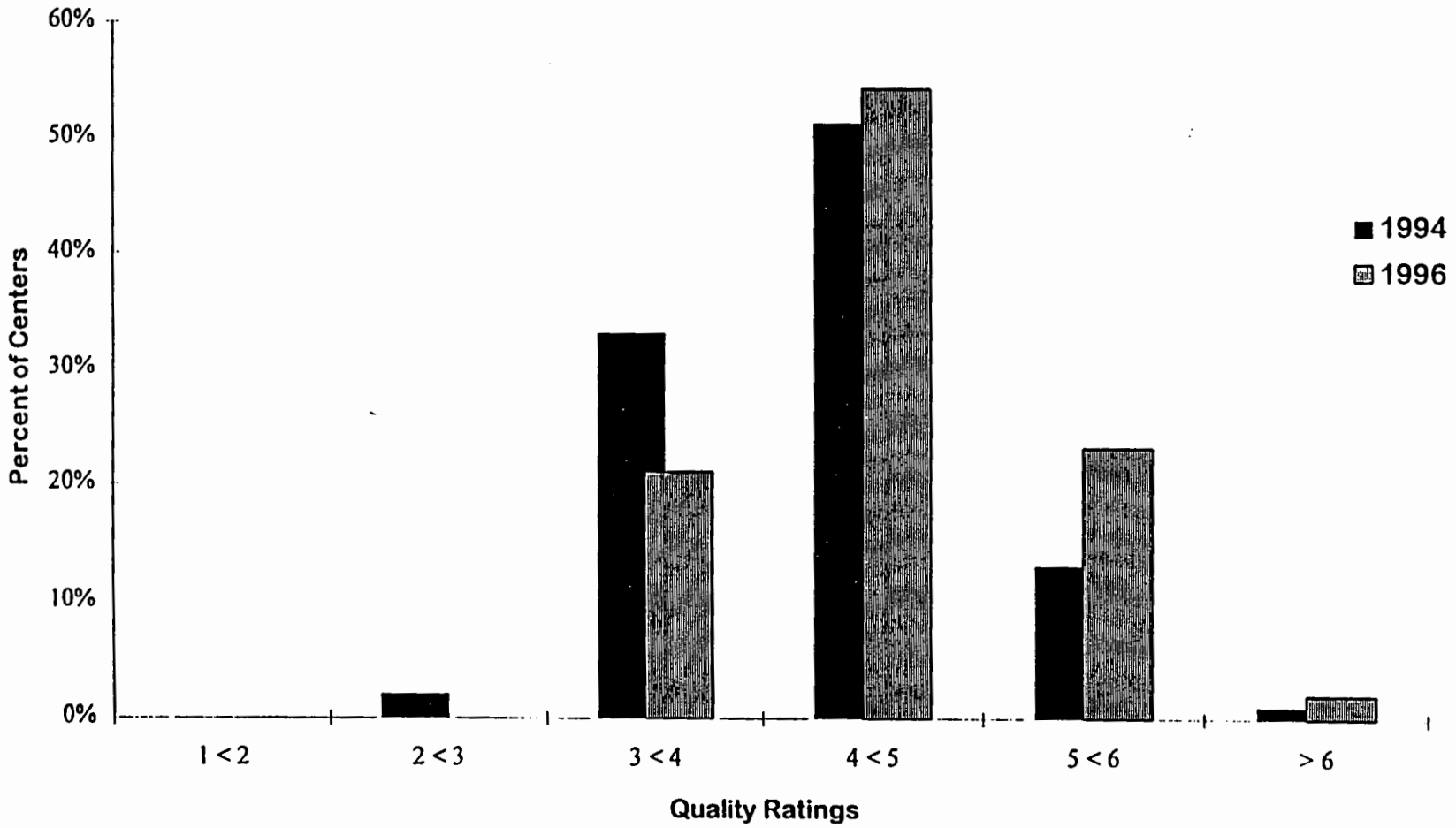
Table 2. HLM Analyses: Child Care Quality (ECERS total score) as a Function of Year, Funding Level, and Proportion of Funds Spent on Child Care[a]

	B	se	F	p
Intercept	4.26	.06		
Method[b]			1.44	.24
Both	.16	.10		
Nominated	.04	.08		
Random	-	-		
Year			21.4	<.0001
1994	-	-		
1996	.23	.05		
Funding Level			3.73	.054
Low Funding	-.16	.08		
High Funding	-	-		
Prop. Spent			8.33	.004
Low Prop.	-	-		
High Prop.	1.61	.52		
Funding Level x Proportion Spent			4.81	.03
Low Funding: Prop. Spent	.23	.37		
High Funding: Prop. Spent	1.61	.52		

[a]Partnership and child care center were entered as random variables to adjust for their effects as repeated measures.

[b]Selection method was used as a control variable.

Figure 3: Quality of Preschool Classrooms in 1994 and 1996



is much lower than in the higher-funded counties (B= .23 vs. 1.61). This interaction is illustrated in Figure 4 which shows that proportion of funds spent on child care quality improvement efforts was more strongly related to ECERS quality for the counties that received greater than 70% of their full-funding allocation.

Figures 5 and 6 present the distribution of centers based on their level of participation in Smart Start child care quality improvement activities in 1994 and 1996. In 1994 the number of activities averaged 5.3 (SD = 3.2) with a range of 0-13; in 1996, the mean was 5.9 (SD = 3.4) with a range of 0-14. Using these variables, an HLM analysis was used to test the fourth hypothesis. Results are presented in Table 3. This analysis looked at the effect of an individual center's participation in Smart Start funded child care efforts on the preschool quality in that center. Again there was a significant effect of year, indicating that 1996 quality was higher than 1994 quality. Participation in Smart Start quality improvement activities was also statistically significantly related to quality, $F(1, 335) = 9.84$, $p = .0019$, with centers participating in more activities likely to score higher on the ECERS.

Simple correlations also add support to the fourth hypothesis. In the 91 child care centers that were observed in both 1994 and 1996, participation in early Smart Start activities was significantly related to quality of care provided in 1996 ($r = .24$, $p = .019$). In the 1996 total sample of 187 centers, reported participation was also significantly positively related to the quality of care ($r = .24$, $p = .001$).

Figure 4: Child Care Quality by Partnership's Proportion of Funds Spent on Child Care and Percent of Full Funding

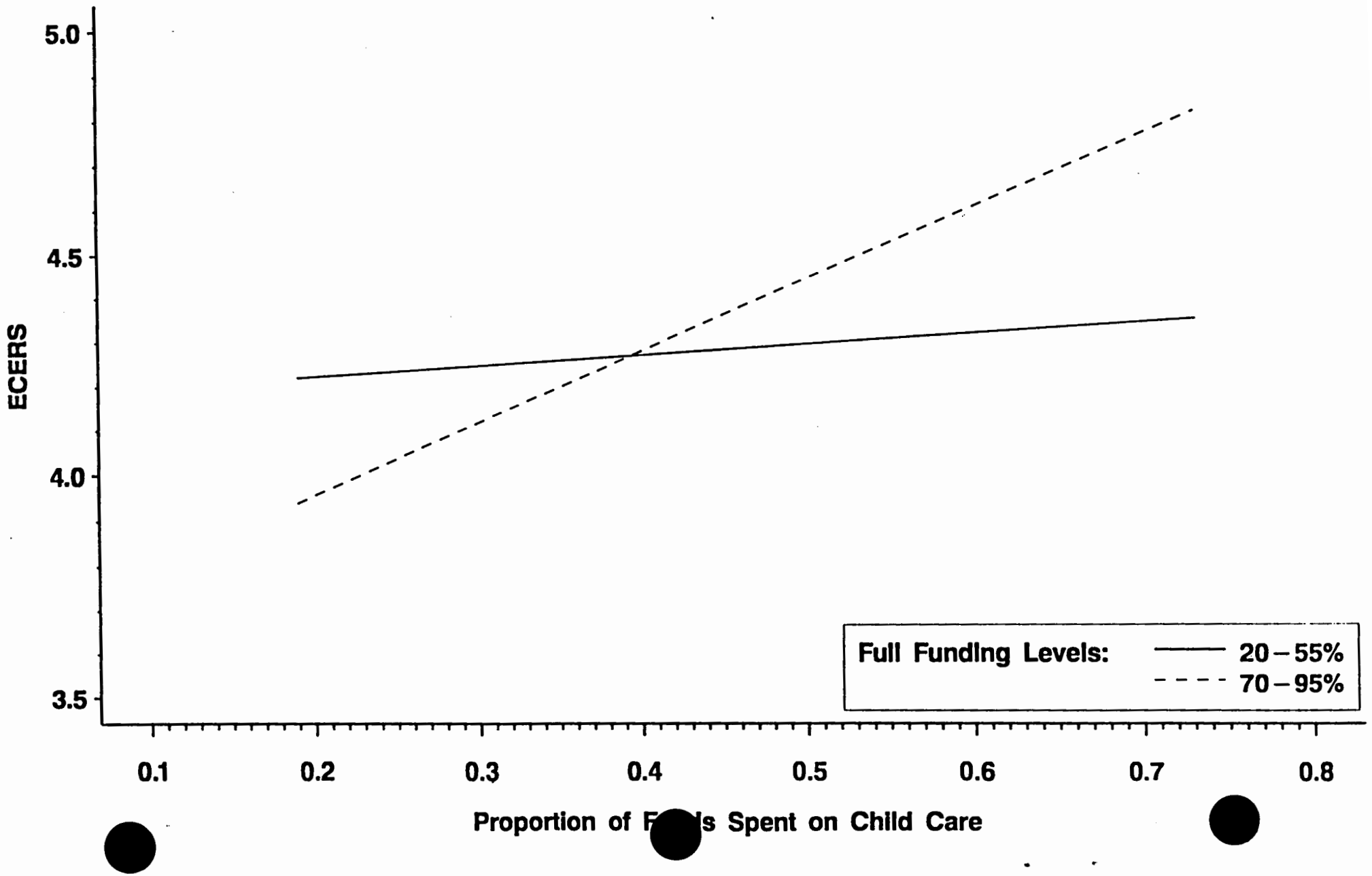


Figure 5: 1994 Smart Start Activity Participation

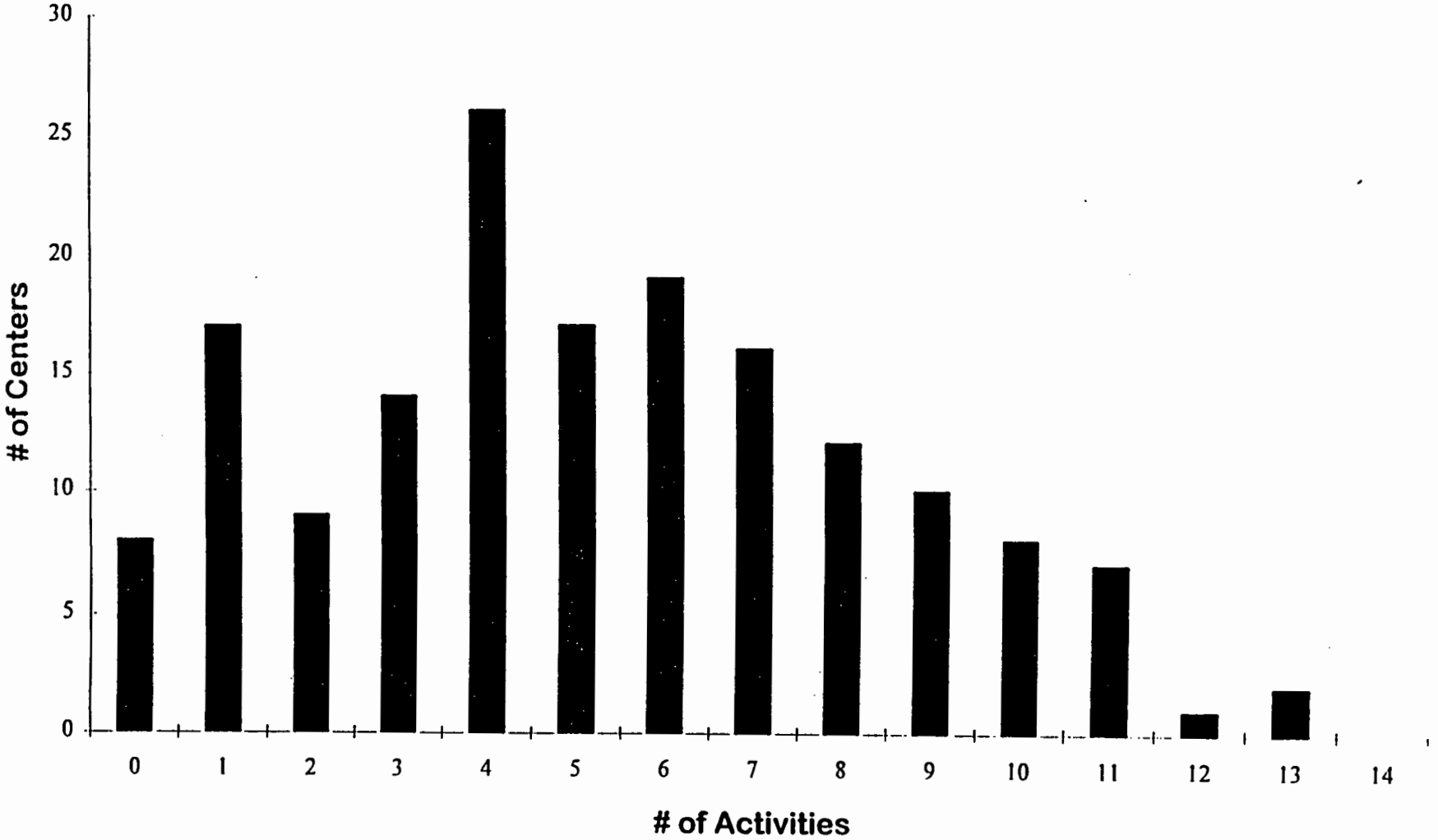


Figure 6: 1996 Smart Start Activity Participation

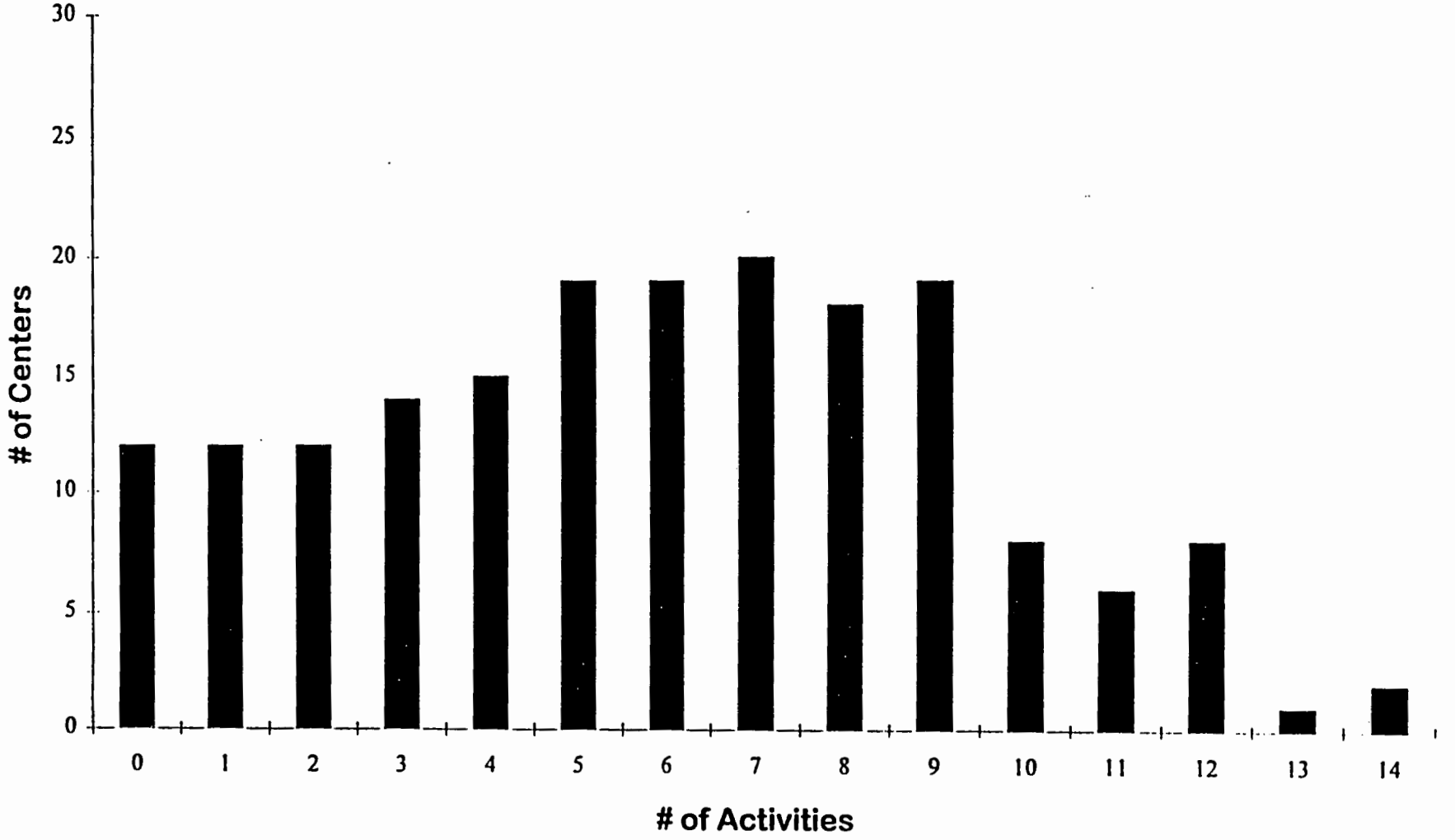


Table 3: HLM Analyses: Child Care Quality (ECERS total score) as a Function of Year and Participation in Smart Start Activities

	B	se	F	p
Intercept	4.04	.07		
Method[a]			.10	.91
Both	-.02	.10		
Nominated	-.04	.08		
Random	-	-		
Year			15.58	:0001
1994	-	-		
1996	.21	.05		
Participation	.03	.01	9.84	.0019

[a]Selection method was used as a control variable.

Discussion

The significant change over time in the observed child care quality ratings is a positive sign that the variety of different child care quality improvement efforts being implemented by Smart Start seem to be improving quality, as intended. The effect size (.58) is considered to be in the moderate range. Finding a difference of this magnitude is particularly notable since, in Smart Start's first years, it has been a diverse set of "treatments" implemented in a wide variety of settings with a varying degree of intensity. Support for the conclusion that the changes seen from 1994 to 1996 were related to Smart Start and not just general improvement in the state is that the 1996 quality ratings were significantly related to three factors that theoretically should affect quality--the number of activities in which a center participated, the percent of full-funding allocation received by the county, and the proportion of funds allocated to child care. Further, the rate of increase in the proportion of centers licensed at the AA level has been higher in Smart Start counties than in other North Carolina counties.

The finding that the proportion of funding spent on child care was significantly related to improvements in quality indicates that focusing fiscal resources in a targeted area (i.e., child care quality improvement) while allowing counties to decide how resources are spent is a viable strategy to improve overall quality of care. It is not surprising that this influence was much stronger in counties that received a high proportion of their full-funding allocation compared to low-funded counties. For example, the county that spent the highest proportion of its allocation on child care was also the county that received the lowest percentage of its full-funding allocation. Under these conditions, the effect of a high proportion of child care spending is less.

A higher percentage of centers refused to participate in the study in 1996, which the directors sometimes attributed to having participated in too much research recently (indeed true in some Smart Start counties) and sometimes to a dissatisfaction with the local Smart Start decision-making. Although it is possible that more centers of lower quality refused participation in 1996 than in 1994, significant improvements in quality occurred in the sample of 91

centers seen in both years. In addition, the significant relationships between predictors (level of funding, proportion spent on child care, participation in improvement activities) and outcome (improved ECERS) existed regardless of selective refusal, adding to our confidence in these findings.

We should note that these findings pertain to the quality of preschool classes for children in North Carolina's first 12 Smart Start counties, not to the quality of infant and toddler care. Other studies have shown that infants generally receive less safe and developmentally appropriate care in group settings than do preschoolers (Cost, Quality, and Outcomes Study, 1995). When we began this study we intended to include a sample of infant care, but found that very few centers provided care for infants and few Smart Start activities were directed specifically to improving the quality of infant care. As more Smart Start activities become directed at infant care, a more focused study of infant care might be desirable.

One of the most interesting findings was the large number of centers that were indeed participating in Smart Start-funded quality improvement efforts. Many centers took advantage of multiple opportunities. We expected this in the nominated sample, but it was also true in the random sample, which is probably why we found no difference in samples recruited in these two different ways. Smart Start is reaching a large number of centers in counties large and small, urban and rural. Its effect can be most noted to date in the increase in child care quality from 1994 to 1996 and in the significant relationship between participation in Smart Start and observed quality of care.

A second finding of note was the relatively large number of children from poor families being served by the centers. About 40% of the children in the hundreds of centers observed were receiving a child care subsidy. (Full subsidies are usually given to the children of unemployed poor families with smaller subsidies provided for children as parents move up the income scale.) It appears that centers benefiting from the Smart Start quality improvement efforts serve families in a range of incomes, thus benefiting a wide range of children, not just those from a single income group.

This study does not answer questions about child care quality improvement activities that many will want to know. Which types of activities are most effective in improving preschool classroom quality? Are in-service workshops more effective than sending teachers to community colleges for further training? Are enhancement funds better spent on literacy materials than on playgrounds? The Smart Start evaluation is not a randomized study that can address these questions. Some counties did not offer all 14 different types of quality enhancement activities, and child care centers within a county chose to participate in as many or as few activities as they desired or were allowed. Because centers vary in their own starting points and needs, it is likely that the best and most effective improvement activities for one center would be somewhat different than those that would benefit another center. Our data do show, however, that more participation is related to increased preschool classroom quality.

In conclusion, the effect of North Carolina's commitment to young children and their families as evidenced by legislative and community support and funding for the Smart Start program is now being seen in improved quality of child care for preschoolers. The evaluation of this initiative will continue to include monitoring of child care quality as well as changes in child health and readiness, family services, and collaboration among agencies serving children and families.

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Smart Start Allocations and Expenditures

Summary of Smart Start SFY 96-97 Expenditures as of June 30,1997

Year 1 Counties	1996/97 Allocation	Payment to Contractors	Subsidy Allocation	Payment for Subsidy	Payment for DSS Admin.	Total Expenditures
Burke	$2,172,646	$1,603,393	$524,253	$524,253	$45,000	$2,172,646
Caldwell	$2,176,371	$1,410,708	$598,000	$598,000	$141,100	$2,149,808
Cleveland	$2,185,053	$1,344,136	$693,349	$595,537	$106,399	$2,046,072
Cumberland	$4,054,664	$2,124,354	$1,148,477	$1,148,109	$111,713	$3,384,176
Davidson	$2,391,735	$1,557,475	$623,464	$585,826	$44,000	$2,187,301
Halifax	$1,915,340	$1,154,978	$663,904	$663,734	$85,932	$1,904,644
Hertford	$716,243	$570,855	$105,000	$105,000	$40,388	$716,243
Jones	$408,207	$364,379	$32,000	$24,305	$11,827	$400,511
Mecklenburg	$5,303,828	$1,112,269	$3,440,033	$3,438,442	$0	$4,550,711
Orange	$2,217,146	$2,109,896	$66,000	$66,000	$41,250	$2,217,146
Region A	$2,237,036	$1,174,002	$1,063,034	$1,063,034	$0	$2,237,036
Stanly	$1,783,994	$1,082,158	$561,840	$561,840	$73,343	$1,717,341
Total	$27,562,263	$15,608,603	$9,519,354	$9,374,080	$700,952	$25,683,635

Year 2 Counties	1996/97 Allocation	Payment to Contractors	Subsidy Allocation	Payment for Subsidy	Payment for DSS Admin.	Total Expenditures
Ashe	$621,884	$421,024	$157,032	$156,603	$0	$577,627
Avery	$503,611	$423,211	$55,000	$32,498	$25,400	$481,109
Catawba	$3,190,094	$930,943	$2,089,875	$2,086,099	$168,324	$3,185,366
Chatham	$1,240,351	$737,351	$503,000	$503,000	$0	$1,240,351
Duplin	$1,244,776	$814,943	$383,033	$355,499	$30,927	$1,201,369
Durham	$5,186,227	$4,212,728	$952,769	$936,581	$20,730	$5,170,039
Forsyth	$4,737,494	$4,207,306	$500,000	$485,233	$28,000	$4,720,539
Lenior-Greene	$2,156,792	$1,593,958	$484,450	$448,112	$42,272	$2,084,342
Nash-Edgecombe	$3,521,785	$3,282,532	$125,000	$118,959	$114,253	$3,515,744
Pasquotank	$1,169,349	$888,147	$164,794	$163,582	$0	$1,051,729
Person	$1,000,688	$817,967	$92,650	$92,650	$41,817	$952,434
Wilkes	$1,495,550	$895,478	$539,145	$516,548	$54,084	$1,466,110
Total	$26,068,601	$19,225,588	$6,046,748	$5,895,364	$525,807	$25,646,759

Summary of Smart Start SFY 96 Expenditures as of June 30,1997

Year 3 Counties	1996/97 Allocation	Payment to Contractors	Subsidy Allocation	Payment for Subsidy	Payment for DSS Admin.	Total Expenditures
**Alleghany	$173,625	$3,798	$22,087	$6,101	$0	$9,899
Buncombe	$1,326,390	$614,187	$419,575	$402,643	$0	$1,016,830
New Hanover	$1,159,863	$712,708	$421,933	$307	$24,974	$737,989
Pamlico	$209,495	$98,800	$35,329	$35,329	$0	$134,129
**Robeson	$1,342,047	$32,500	$311,365	$310,459	$28,689	$371,648
Rutherford	$646,717	$423,842	$0	$0	$0	$423,842
Stokes	$395,896	$257,227	$45,496	$33,975	$1,372	$292,574
**Surry	$589,966	$31,719	$143,240	$67,492	$0	$99,211
*Wake	$2,044,818	$1,627,616	$0	$0	$0	$1,627,616
**Washington	$321,419	$1,912	$66,000	$66,000	$14,635	$82,547
Wilson	$701,761	$178,696	$167,154	$127,136	$32,354	$338,186
Total	$8,911,997	$3,983,005	$1,632,179	$1,049,442	$102,024	$5,134,471
*Wake County's Allocation includes $124,497of private funds from NCPC.						

Year 4 Counties	1996/97 Allocation	Payment to Contractors	Subsidy Allocation	Payment for Subsidy	Payment for DSS Admin.	Total Expenditures
Anson	$100,000	$100,000	$0	$0	$0	$100,000
Bertie	$100,000	$71,383	$0	$0	$0	$71,383
Brunswick	$100,000	$100,000	$0	$0	$0	$100,000
Columbus	$100,000	$59,119	$0	$0	$0	$59,119
Dare	$100,000	$49,938	$0	$0	$0	$49,938
Guilford	$100,000	$55,187	$0	$0	$0	$55,187
Hoke	$100,000	$93,464	$0	$0	$0	$93,464
**Iredell	$100,000	$0	$0	$0	$0	$0
**Lee	$100,000	$0	$0	$0	$0	$0
McDowell	$100,000	$80,529	$0	$0	$0	$80,529
**Moore	$100,000	$0	$0	$0	$0	$0
Rowan	$100,000	$76,967	$0	$0	$0	$76,967
TOTAL	$1,200,000	$686,587	$0	$0	$0	$686,587
**North Carolina Parntership for Children are monitoring these counties and will report expendtiures quarterly.						
GRAND TOTAL	$63,742,861	$39,503,783	$17,198,281	$16,318,886	$1,328,783	$57,151,452

P.M
10-22-97
(1)

VISITOR REGISTRATION SHEET

Joint Appropriations Subcommittee On Health & Human Services 10/21-23/97

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patricia A. Yancey	APPCNC, State Council for Social Legislation.
Kevin FitzGerald	NCDHHS – DSS.
[illegible]	DMH/DD/SAS
Susan E Robuesa	DMH/DD/SAS
Luya Aylock	DHHS– DSS
~~David~~ Simmons	ZDA, PA
Walter Stolk	DMH/DD/SAS
Kerri Ryan	DHHS - Div. of Women's and Children's Health
Carrie Woolfe	DHHS Div of Women's and Children's Health

P.M.
10-22-97
(2)

VISITOR REGISTRATION SHEET

Joint Appropriations Subcommittee On Health & Human Services 10/21-23/97
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Schmidt	NCJCDC
Suzanne Williams	Bonner Associates / BC/BS
Paula A. Wolf	NC Child Advocacy Institute
Tom Vitagliano	NC DHHS DIV. OF WOMEN'S & CHILDREN'S HEALTH
NELS ROSELAND	STATE BUDGET OFFICE
Becky Strut	Parker Poe Adams & Bernstein
Roz Savitt	NC Child Care Coalition
Sarah Ewart	Legislative Drafting
Connie Mullinix	Flynt Mullinix + Healthy Kids of North Carolina
Jane Pinsky	NC Equity
Joyce Johnson	DHHS Controller's Office

P.M.
10-22-97
(3)

VISITOR REGISTRATION SHEET

Joint Appropriations Subcommittee On Health & Human Services 10/21-23/97

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roslyn Savitt	NC Child Care Coalition
Pheon Beal	DHHS/DSS
Jane Smith	DHHS/DSS
Adam Searing	NCHAC
Myrna Miller	NASW-NC
S. Lynne Humlet	Senator Ellie Kinnaird
Maureen Otta	Lt. Gov Walker
	OSPL
John Bowdish	Zeb Alley P.A.
Tommy Watts	Carolina Alliance for Children
Barbara Matula	NC Med Soc Foundation
John Rustin	NCFPC

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES — 10/22/97 pm
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Lou Wilson	NCALTCP,
Kim Wallace	NCHA
Phillip Hoffman	DMHDDSAS
Charles Davis	DMHDDSAS
Robert Harper	Halifax County MH
John Tote	MHA/NC / C2001
Janet Smoreau	NCARF/C2001
Megan Snyster	Easter Seals/Coalition 2001
Don Willis	DMHDDSAS
Pat Porter	DMHDDSAS
Keith Letchworth	Community Living Assn.
Beth Melcher	NC AMI
Ann Schwindaman	NC Council of Community MH/DD/SA Programs
Roy Wilson	Neuse Center P.O. Box 1635 New Bern, NC 28563

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES — 10/22/97 PM
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
J. WILBUR EDGERTON	MHA/NC
Tony Mulvihill	Alcohol/Drug Council of NC
Janice Peterson	Comm on Substance Abuse
Catherine Clabby	News & Observer
Adam Searing	NC Health Access Coalition
Roy Haddock	Lee-Harnett MH/DD/SAS
Clarette Johnson	" " " " "
Barbara Mashula	NCMS-Foundation
Steve Davis	DHHS/Personnel Services
Dave Richard	Archer
AL DEITCH	YOUTH ADVOCATE VOLUNTEER OFFICE
Terry Stelle	DMHDDSAS
Mary Eldridge	DMH DD SAS/Crisis Services
DAN JONES	ONSLOW County Behavioral Healthcare
Dale Armstrong	Brown Mon Behavioral Healthcare / NCHA.
Meagan	OSBM
DAVE BEARTON	DHSS

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES — 10/22/97 PM
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Angie McMillan	DHHS
Beryl E Wade	Gov's Off
Tom Keenan	Durham Area MH/DD/SAS
Lee Kittredge	~~DHR~~ DHHS
Jim Edgerton	DHHS
Tara Laison	Div of MH/DD/SAS
Allen Gambill	DHHS / DMA
P. R. Penuzzi	DHHS / DMA
J. Colin Eddins	Chiatrs / APNe / CSW's
John Burdick	zeb alley PA,

MINUTES

JOINT APPROPRIATION SUBCOMMITTEE ON HEALTH AND HUMAN RESOURCES

OCTOBER 23, 1997

The Joint Appropriation Subcommittee on Health and Human Resources met on Thursday, October 23, 1997, at 9:00 a.m., in Room 643 of the Legislative Office Building.

Representative Cansler presided and introduced Dr. Ron Levine,.Co-Secretary of the Department of Health and Human Services Dr. Levine began with the history of the Health Department across the state and how the first health department began in Robeson County as a result of a Hook Worm epidemic. Dr. Levine then proceeded with a presentation of the overview of the report on re-organization of New Public Health Divisions. Three Divisions were represented in his presentation. Dr. Levine presented last the present specific activities the Division of Health is involved in.

Senator Dannelly asked on the re-organizational chart why there is a Women's Health Section and not a Men's Health Section? Dr. Levine said it began sometime ago because of concern for prenatal care and focus on children for maternal care.

Senator Martin asked if Dr. Levine could see any significant changes in the Department with the new organization. Dr. Levine said he would address this shortly.

Representative Watson asked Dr. Levine if he could for see a significant health problem for eastern North Carolina in light of sewage or water problems? He stated that he does and expounded on this issue citing a need for improvement and explaining there are serious nitrate levels.

Senator Martin asked Dr. Levine to describe the mechanism that exists from Environment and Human Resources. Dr. Levine said they are trying to devise a model now that would enable the two departments to interact, to address both health and environmental issues.

Representative Watson asked if the county health boards have power to demand that the water or soil be tested over industry? Dr. Levine said they do.

Representative Cansler interrupted Dr. Levine to permit Chuck Barham, Associate Vice-President of Academics and Student Services for Community Colleges to do his presentation on Pathways to Employment.

Representative Gardner asked Mr. Barham if Pathways is looking into placing Women in non-traditional roles/jobs? He confirmed that they are looking into jobs that are not minimum wage jobs.

Senator Phillips asked, what is it about Community Colleges now that is different from when they were given the Cedar Program from which they did not produce any successful graduates? Mr. Barham stated he felt it was because of the time frame (2 year) factor limitation.

Senator Martin expressed concern for child care, family time, etc. and wondered if the program is taking into consideration those special programs in looking at the location of the training? Mr. Barham said relative to transportation they are taking their training to local Social Services Departments which are usually downtown providing access to public transportation.

Ben Watts, DSS, said they support Work First in providing transportation to colleges and jobs in collaboration effort.

Senator Martin asked if the Department of Community College is keeping track of individual college levels to be effective in assessing the outcome? Mr. Barham said they are trying to devise a means in which to do that.

Representative Adams asked how are colleges handling faculty and staff to provide training? Mr. Barham said they are using staff and faculty they already have for this type of community development.

Representative Watson asked what budget is being used for this program? Mr. Barham said they are using the existing budget but also some resources which the General Assembly made available.

Dr. Levine continued with his presentation. He spoke on epidemiology explaining that the needle repository and distribution has actually decreased the percentage of I-V drug abusers and HIV infections.

In response to Senator Martin's question, Mental Health is under DHR as opposed to being an individual entity, to be a more effective agency. Dr. Bruton

said they merged with Dr. Levine's Division and rather than there being a Deputy Secretary, he would prefer that they be Co-Secretaries and the organizational chart reflects no line between he and Dr. Levine as you would normally see reflected in chain of command.

Dr. Levine introduced the following personnel in the Department: Ann Wolfe, Director of Women and Children's Division, and Dr.Leah Devlin, Director or the Division of Community Health. Dr. Devlin gave a presentation on Risk Factor Reduction, including proper nutrition as well as the importance of being active, injury prevention, chronic disease prevention and control.

There was a follow up discussion between the committee members and presenters.

Representative Cansler adjourned the meeting at 11:55 a.m.

Representative Cansler, Co-Chair
Joint Subcommittee on Health and Human Resources

Sarah J. Murphy, Acting Committee Clerk (From tapes)
Joint Subcommittee on Health and Human Resources

WORK FIRST AREA MEETINGS

AGENDA

REGISTRATION

WELCOME AND PURPOSE

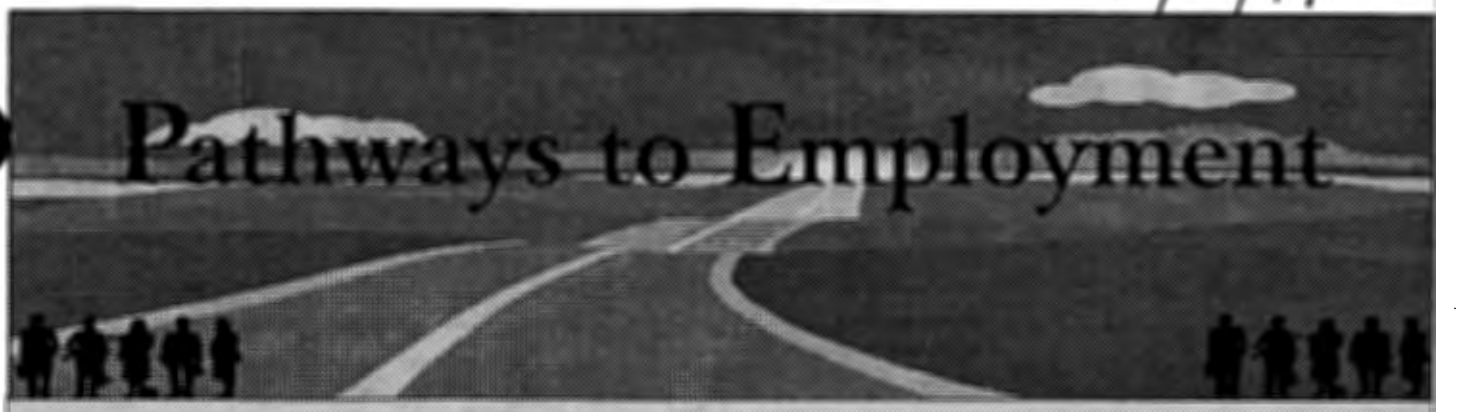
OVERVIEW OF WORK FIRST MODEL

APPLYING A COLLABORATIVE MODEL

QUESTIONS AND RESPONSES

SUMMARY AND ADJOURNMENT

10/23/97



WORK FIRST TRAINING PROGRAM

Developed by:

North Carolina
Community College System

North Carolina
Division of Social Services

North Carolina Association of
County Directors of Social Services

JULY 11, 1997

TABLE OF CONTENTS

EXECUTIVE SUMMARY

North Carolina's Work First program, implemented in July 1995, is one of the nation's toughest, most comprehensive welfare reform efforts. It demands work and personal and parental responsibility in exchange for temporary support as families move off welfare. Work First, a statewide welfare reform initiative, replaced a fragmented welfare system with a coordinated program that focuses on employment and economic self-sufficiency. Through Work First, welfare rolls are dropping; taxpayers are saving money; welfare parents are getting help with child care, transportation, and medical expenses; and welfare parents are signing binding personal responsibility contracts, pledging to get jobs and take care of their children.

WORK IS REQUIRED:

- Welfare parents are required to get a job - paid or unpaid - or be in short-term job training within 12 weeks.
- Welfare parents receiving intensive employment services must move off welfare in two years. After three years, they may reapply for benefits.

EVERYONE MUST TAKE PERSONAL RESPONSIBILITY:

- All welfare parents must sign a personal responsibility contract that spells out their plans for moving off welfare.
- Benefits are cut when families don't meet their Work First obligations.
- Teen parents are required to stay in school and live at home, or under approved adult supervision.
- No additional cash payments are provided for children born after a family has been in Work First longer than 10 months.

HELP IS AVAILABLE:

- Work First eases the transition into the work force through help with child care, transportation, job search, and short-term job training. Participants can get Medicaid to cover medical expenses up to a year after they leave welfare for work.
- For families at risk of going on welfare, one-time grants (called diversion grants) of up to three months of cash benefits can help families stay on their feet and off the welfare rolls.
- Families can save up to $3,000.
- Families can invest in a car valued up to $5,000 for reliable transportation to work.

EXPLORING STRATEGIES TO SUPPORT WORK FIRST:

In the Fall of 1996, staff from the North Carolina Department of Human Resources and the North Carolina Community College System came together for discussions aimed at developing ways to support the Work First effort by enhancing coordination of workforce training for Work First participants. One outcome of these planning discussions is a proposed training plan which includes elements deemed essential by those involved in providing services to Work First participants. This proposed plan places emphasis on:

- short-term training (job skills, workplace skills, and occupational basic skills) which is tied directly to employment outcomes;
- training components which are integrated; and
- training flexibility which allows Work First participants to move in and out of training streams as needed.

Key elements of this "model" include offering integrated training in the following areas in four-, eight-, or twelve-week segments.

- HRD (self-directed or classroom pre-employment training)
- Basic Skills (family/workplace/employment related literacy)
- Occupational Extension (short term skills geared to identified job markets)

Training components would be structured as concurrent rather than sequential in order for individual Work First participants to receive pre-employment, basic skills, and skills training in an integrated training system. All training in this effort will be focused on employment outcomes for the students.

LIFELONG LEARNING AND CAREER SERVICES

Work First participants, as all members of society, need access to the following services throughout their work career.

- Workplace Literacy
- Upgrading/Retraining Services
- Career Services
- JobLink Career Resource Center
- Others

Pathways to Employment

PART I
North Carolina Division of Social Services (NCDSS)

Work First
Orientation
Assessment
Personal Responsibility
Referral
Tracking

PART II
North Carolina Community College System (NCCCS)

Work First Training Options
Orientation to the Work Place
Orientation to Non-traditional Careers
Skill Assessment
Goal Setting/Study Skills

Work First Integrated Training Components
Self-Paced Individualized Instruction
Job Skill Development
Workforce Basic Skills
Human Resources Development

PART III
Employment and Training Agencies

Community-Based Organizations
Employment Security Commission
JobLink
Job Training Partnership Act
Vocational Rehabilitation
Others

NCDSS
Individual Case Management

PART IV
NCDSS and Departments of Social Services

Individual Case Assessment

Program Evaluation

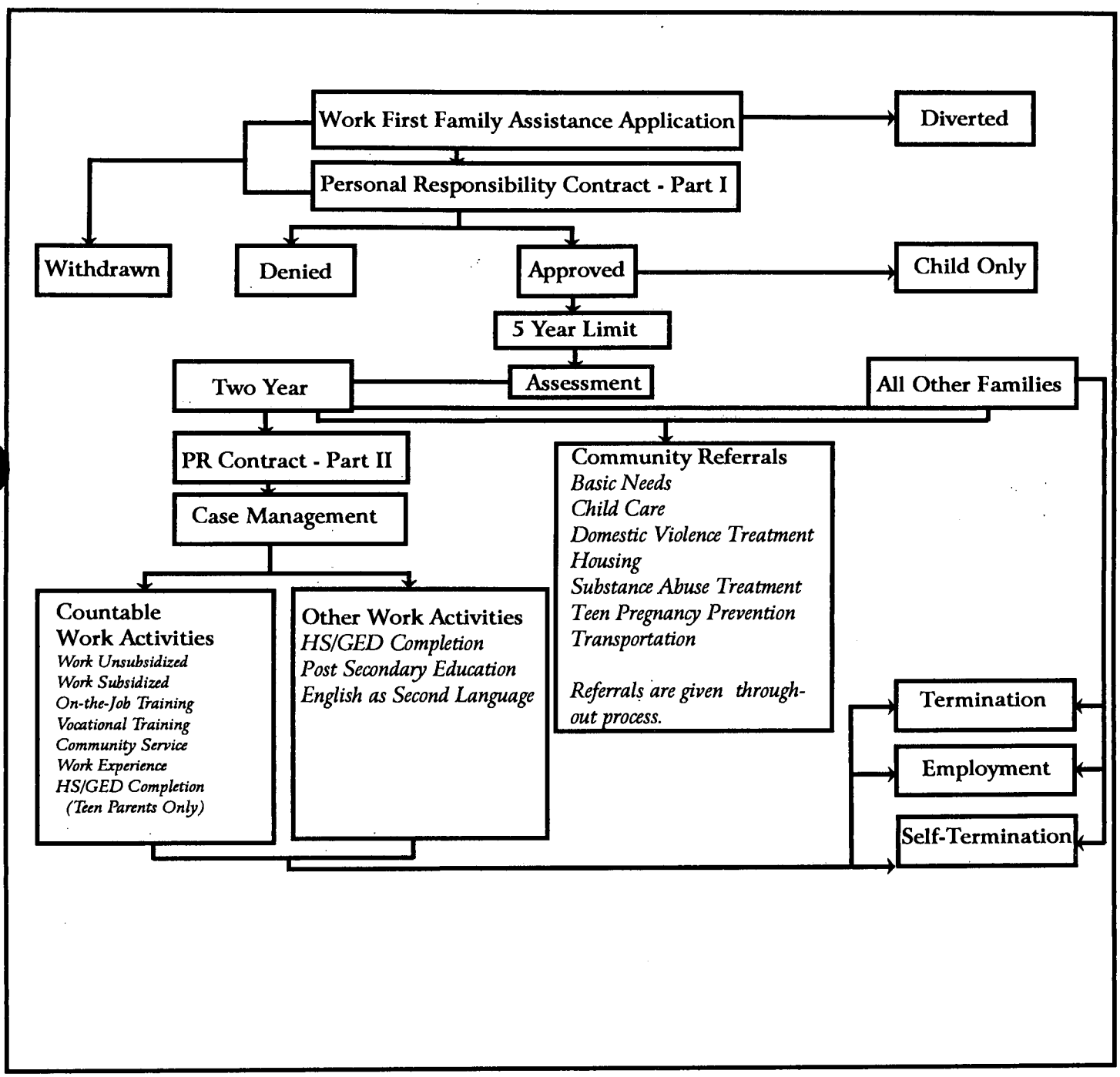
PART V
NCCCS and Employment and Training Agencies

Lifelong Learning and Career Services
Workplace Literacy
Upgrading/Retraining Services
Career Services
JobLink Career Resource Center
Others

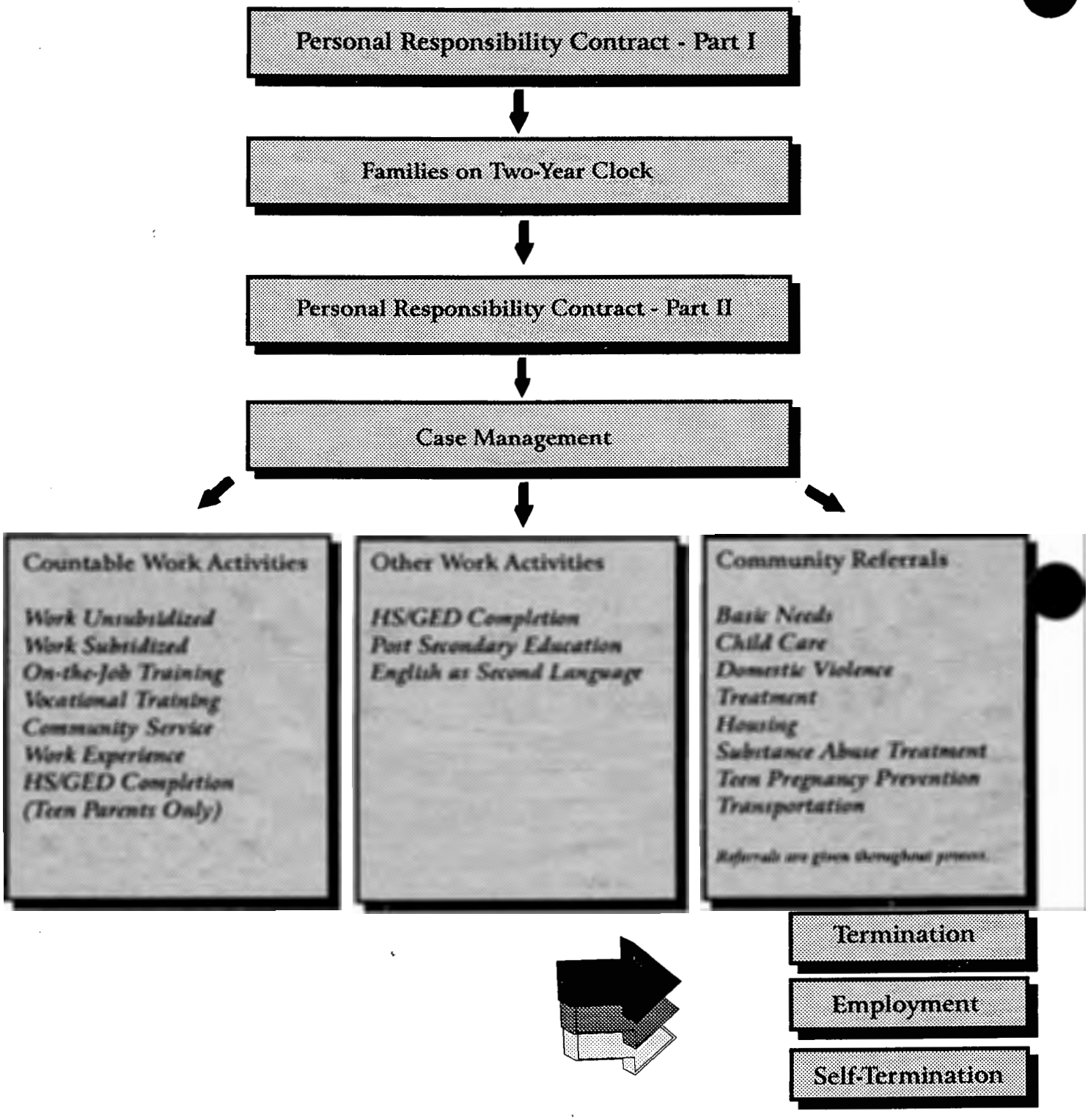
PART I

North Carolina Division of Social Services

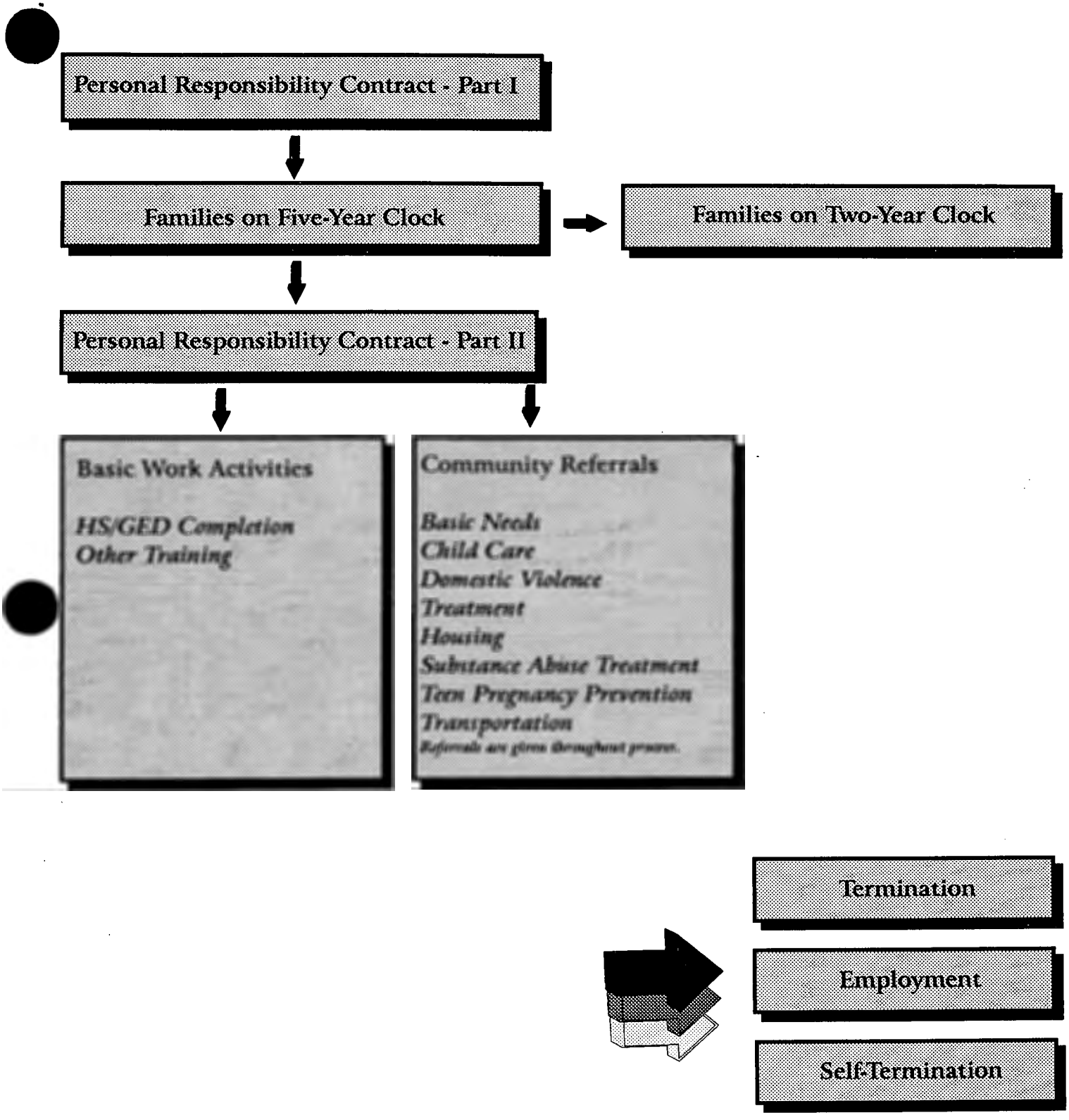
Work First Family Assistance Process



Work First Family Assistance Two-Year Clock Requirements



Work First Family Assistance Five-Year Clock Requirements



PART II
North Carolina Community College System

Work First Training Options

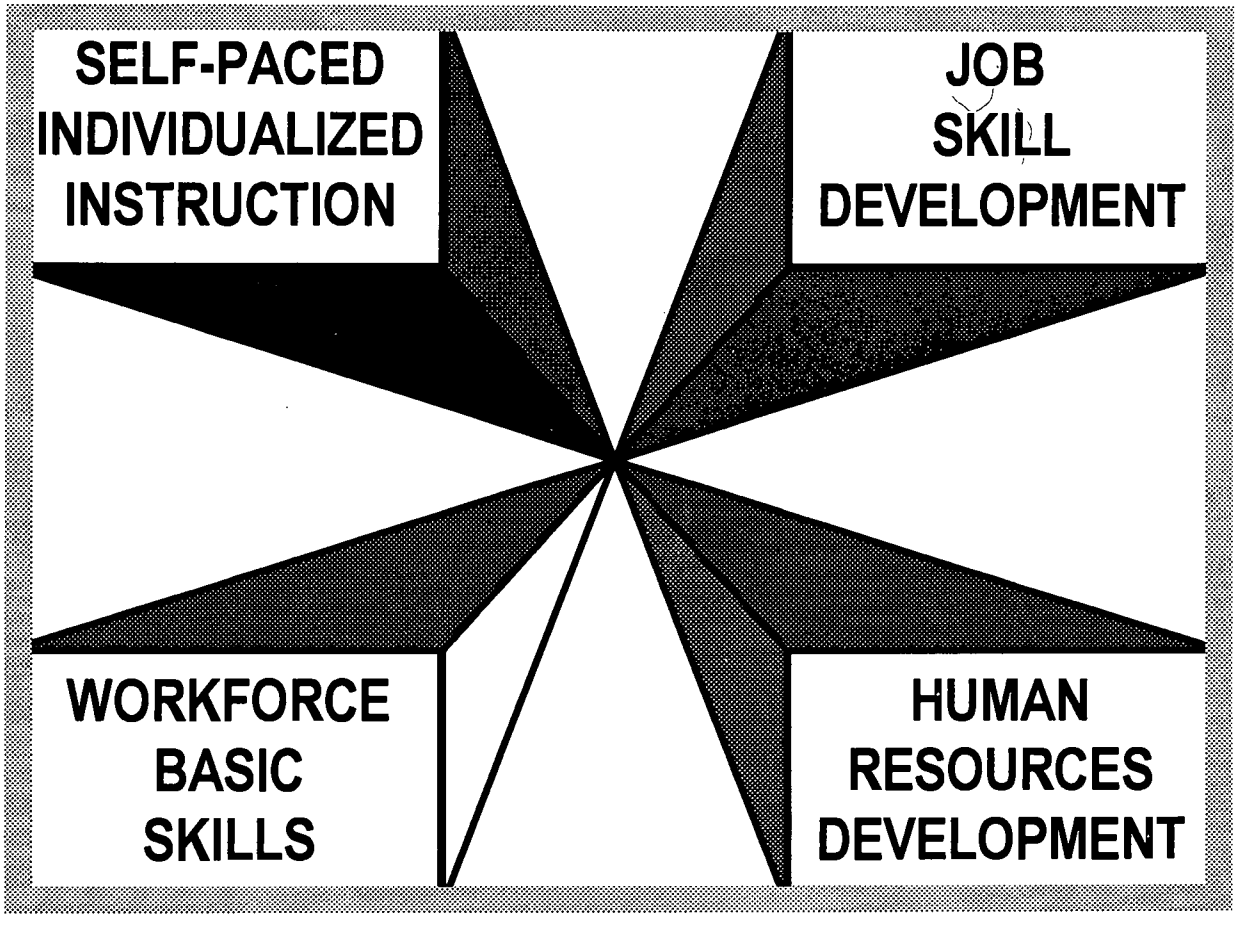
Orientation to the Work Place

Orientation to Non-traditional Careers

Skill Assessment

Goal Setting/Study Skills

Work First Integrated Training Components



Work First Integrated Training Components

Self-Paced Individualized Instruction

- *Assessment*
- *Learning Skills*
- *Individualized Instruction*

Job Skill Development

Possible Options for Job Skill Development Training (Based on Labor Market Analysis)

- *Office Assistant Skills (Basic, Intermediate, Advanced)*
- *Custodial Training*
- *Adult Care Aide*
- *Carpenter Assistant*
- *Radio/TV/VCR/CD Repair*
- *Computer Repair*
- *Bank Teller*
- *Basic Cashiering*
- *Forklift Operator*
- *Nursing Assistant*
- *Shipping/Stock Clerk*
- *Food Service*
- *Child Care Aide*

Workforce Basic Skills

- *Reading Skills*
- *Writing Skills*
- *Mathematical Skills*
- *Communication Skills*
- *Critical Thinking & Problem Solving Skills*

Human Resources Development

- *Self-Management*
- *Job Hunting*
- *Employment Expectations*
- *Communication Skills*

WORK FIRST PARTICIPANT'S INTEGRATED WEEKLY SCHEDULE

Day	SELF-PACED INDIVIDUALIZED INSTRUCTION	Hours	JOB SKILL DEVELOPMENT	Hours	WORKFORCE BASIC SKILLS	Hours	HUMAN RESOURCES DEVELOPMENT	Hours
Monday *Tuesday* *Wednesday* *Thursday* *Friday*								
TOTAL HOURS *Grand Total Hours: 30-35*								

SELF-PACED INDIVIDUALIZED INSTRUCTION

Assessment

- *Basic Skills, Reading, Writing, Mathematics*
- *Learning Styles*
- *Reading Interest Inventories*
- *Career Interest Inventories*
- *Study Skill Inventories*

Learning Skills

- *Listening Skills*
- *Notetaking Skills*
- *Test-taking Skills*
- *Organizational Skills*
- *Skills for Utilizing Resources*

Individualized Instruction

- *Generic Basic Skills*
- *Generic Job-Seeking, Job-Searching Skills*
- *Generic Marketplace Skills*
  - *Understanding the Workplace*
  - *The Impact of New Technology*
  - *The Marketplace*
  - *The Changing Workplace*
  - *Responsibility on the Job*
  - *Quality*
  - *Profit*
  - *Mobility*
  - *Teamwork*
  - *The Culture of the Workplace*
  - *Health and Safety on the Job*

JOB SKILL DEVELOPMENT

Possible Options for Job Skill Development Training
(Based on Labor Market Analysis)

FOUR-WEEK COMPONENT	TOTAL HOURS	EIGHT-WEEK COMPONENT	TOTAL HOURS	TWELVE-WEEK COMPONENT	TOTAL HOURS
1. *Office Assistant Skills - Basic*	80	1. *Nursing Assistant I*	140	1. *Food Service*	360
2. *Bank Teller Training*	43	2. *Office Assistant Skills -- Intermediate*	160	2. *Office Assistant Skills -- Advanced*	360
3. *Basic Cashiering/ Customer Service*	40	3. *Carpenter Assistant (Metal Building Assembler/Roofing/ Welding/Drywall)*	150	3. *Computer Repair*	288
4. *Custodial Training*	72	4. *Shipping/Stock Clerk*	100	4. *Child Care Aide*	360
5. *Forklift Operator*	55	5. *Radio & TV Repair and Servicing/VCR & CD Repair and Servicing*	100		
6. *Adult Care Aide* - *Family Home Care* - *Group Home Care*	 40 20				

FOUR-WEEK COMPONENT Possible Options for Job Skill Development Training (Based on Labor Market Analysis)		Total Hours
1.	**Office Assistant Skills - Basic** Prepares graduates to be aware of most common general office practices including basic keyboarding, filing procedures, mail handling, telephone-answering and message-taking procedures, and duplicating processes.	80
2.	**Bank Teller Training** Graduates of this course will have learned competencies for entry-level bank teller and/or customer service representative. Students will learn teller operations, customer relations, security, credit applications, credit ratings and collecting accounts.	43
3.	**Basic Cashiering /Customer Service** Graduates of this course will have learned the competencies required for entry-level employment requiring customer service and cashiering skills. Students will learn computerized cash register training, guides to crime prevention, retail procedures, customer relations, and written and oral communication.	40
4.	**Custodial Training** Prepares graduates to know the proper techniques of building custodial care. Students will learn proper procedures for using tools, cleaning techniques and chemical agents, basis mechanical information, and basic building repair techniques.	72
5.	**Forklift Operator** Prepares graduates to safely and efficiently operate an industrial forklift truck. The emphasis will be on the safe operation of the forklift truck. Students will learn the basic operating procedures for using a forklift, basic maintenance of the forklift and basic safety driving and moving procedures.	55
6.	**Adult Care Aide** Graduates of this course (s) will be prepared for entry-level employment in family care or group homes. Students will learn the competencies required by DHR for working with clients of these facilities.	40 Family Home Care 20 Group Home Care

EIGHT-WEEK COMPONENT Possible Options for Job Skill Development Training (Based on Labor Market Analysis)		Total Hours
1.	**Nursing Assistant I** Prepares graduates to provide personal care and perform basic nursing skills for the elderly and other adults. Emphasis on patient rights, nutrition management, elimination procedures, safe environment, personal and special care procedures and activities, human body structure and function and related common disease/disorders, communication and death and dying and roles of the nursing assistant.	140
2.	**Office Assistant Skills -- Intermediate** Prepares graduates to have competencies in increased word processing skills, filing skills, and mail handling. Students will learn document formatting and preparation of specialized documents, and various ways to file documents and sorting, packaging, and delivery of mail and mail handling equipment.	160
3.	**Carpenter Assistant (MetalBuildingAssembler/Roofing/Welding/Drywall)** Prepares graduates to handle skills required for an assistant in construction trades. Students will learn safety procedures and tool identification, basic terms, review of basic math, the proper use of various measuring instruments, and how to use a variety of hand and stationary power tools.	150
4.	**Shipping/Stock Clerk** Prepares graduates to handle skills required for stocking produce/inventory in retail stores and for shipping and receiving merchandise. Students will learn basic inventory procedures, pricing mechanisms, shipping procedures and customer service.	100
5.	**Radio & TV Repair and Servicing/VCR & CD Repair and Servicing** Prepares graduates of this course to have sufficient understanding of the various components of equipment to diagnose operating problems. Theory is covered in a practical manner with heavy emphasis on symptoms and trouble shooting diagnosis techniques when a failure occurs. Students will also learn make/model cross reference and installation guidelines.	100

TWELVE-WEEK COMPONENT Possible Options for Job Skill Development Training (Based on Labor Market Analysis)		Total Hours
1.	**Food Service** Prepares graduates for employment in the food service industry. Emphasis is placed on attitude development; sanitation and safety; food service terminology and procedures; tools and equipment; and basic food preparation.	360
2.	**Office Assistant Skills -- Advanced** Prepares graduates to have competencies in advanced word processing skills, filing skills, and mail handling. Students will learn advanced document formatting and preparation of specialized documents, and various ways to file documents and sorting, packaging, and delivery of mail and mail handling equipment.	360
3.	**Computer Repair** Prepares graduates of this course to have sufficient understanding of the various components of equipment to diagnose operating problems. Course is a hands-on approach to installing, upgrading, and maintaining IBM and IBM compatible computers. Students will learn how to identify and define various components of a microcomputer system; operate the test equipment necessary for troubleshooting; locate and correct defective components; and perform preventive maintenance and alignment procedures.	288
4.	**Child Care Aide** Prepares graduates to handle the responsibilities and skills required for working in a child care setting. Students will learn developmental activities, positive reinforcement techniques, health and safety issues, methods of appropriate guidance, CPR and planning skills needed in the classroom setting.	360

WORKFORCE BASIC SKILLS

Reading Skills

Learning Objective/Performance Indicator:
Upon completing this competency, the student will be able to:

1.	Read and interpret vocational vocabulary.	▸ Read and interpret general vocational vocabulary. ▸ Identify abbreviations and symbols specific to the job.
2.	Read and interpret job-specific materials.	▸ Read and perform work described in job description. ▸ Read and follow written instructions and directions. ▸ Read and interpret workplace manuals and written materials (messages, reports, etc.) ▸ Read and interpret charts, graphs, tables, and forms.
3.	Read and interpret basic safety manuals.	▸ Read and understand safety rules, posters, signs, and procedures. ▸ Read and interpret instructions for the safe use of equipment and machines.
4.	Read and interpret personnel materials.	▸ Read and interpret benefits materials. ▸ Read and interpret company policies and procedures (policies for leave, grievance, behavior, attendance, etc.) ▸ Read and understand employer evaluation materials.

Writing Skills

1.	Use legible writing and appropriate grammar.	▸ Print or write legibly. ▸ Use appropriate mechanics of standard English.
2.	Use job specific forms.	▸ Record date, time, and other requested information on forms. ▸ Write appropriate abbreviations specific to the job.
3.	Communicate appropriately in writing.	▸ Write information in clear, logical and complete manner. ▸ Take accurate telephone messages. ▸ Write short notes and simple messages. ▸ Write letters, memos, and/or reports. ▸ Use computer for simple word processing.

Mathematical Skills

1.	Use job specific math skills.	▸ Perform addition, subtraction, multiplication and division computations. ▸ Perform computations using common or mixed fractions, decimals, and percents. ▸ Compute averages using whole numbers, fractions, decimals or percentages. ▸ Convert U. S. Standard to International Metric System of Measurement and/or vice versa. ▸ Perform mathematical operations using equipment such as a calculator, cash register, business machine, and/or computer operated equipment.
2.	Understand job specific use of mathematical symbols.	▸ Interpret ratio and proportion for preparing mixtures, calculating pay rate, etc. ▸ Interpret data from graphs.
3.	Use job specific measurement skills.	▸ Calculate with units of time. ▸ Perform basic measurement tasks determining length, width, height, weight, including the use of conversion tables. ▸ Read and interpret basic measurement and numerical readings on instruments.

Communication Skills

1.	Communicate verbally.	▸ Follow spoken directions. ▸ Use the telephone to make and receive business calls. ▸ Formulate and ask questions. ▸ Engage in appropriate interaction with supervisors, the public, co-workers, and instructors. ▸ Verbally communicate ideas and opinions about job tasks. ▸ Orally communicate with supervisor for clarification of job tasks. ▸ Initiate action in response to requests. ▸ Use English that is acceptable on the job.
2.	Communicate in writing.	▸ Demonstrate effective written communication skills.
3.	Communicate nonverbally.	▸ Use appropriate non-verbal communications.

Critical Thinking and Problem Solving Skills

1.	Use critical thinking and problem solving skills.	▸	Identify effective problem-solving strategies and solve problems and arrive at decisions individually and as a team.
2.	Transfer skills.	▸	Demonstrate ability to apply skills learned in one job situation to another.

HUMAN RESOURCES DEVELOPMENT

Self Management	Hours	Job Hunting	Hours	Employment Expectation	Hours	Communication Skills	Hours
1. *Self-Motivation*		5. *Job Exploration*		10. *Personal Responsibility*		15. *Listening Skills*	
2. *Self-Esteem*		6. *Job Seeking*		11. *Time Management*		16. *Inter-personal Skills*	
3. *Self-Assessment*		7. *Job Application/ Resume*		12. *Interpersonal Relationships*		17. *Problem-Solving Conflict Manage-ment Skills*	
4. *Self-Advocacy*		8. *Job Interviewing*		13. *Workplace Attitudes/ Behaviors*		18. *Leadership Develop-ment*	
		9. *Job Selection Process*		14. *Job Performance*			
Total Hours		**Total Hours**		**Total Hours**		**Total Hours**	

Self-Management

Competency Area	Learning Objectives/Performance Indicators *Upon completing this training, the student will be able to:*
1. **Self-Motivation**	▸ prepare mentally to look for a job. ▸ recognize reasons why people work.
2. **Self-Esteem**	▸ identify characteristics of high and low self-esteem. ▸ explore positive and negative attitudes/behaviors. ▸ understand what shapes a person's self-esteem.
3. **Self-Assessment**	▸ assess personality traits, interest and work values. ▸ evaluate past, present and future strengths and accomplishments.
4. **Self-Advocacy**	▸ accept personal responsibility for self-sufficiency. ▸ maintain a positive view of self worth. ▸ recognize and address his/her emotional needs. ▸ develop positive support systems for work and family life. ▸ set short and long term goals for personal success. ▸ strive for continuous self-improvement.

Job Hunting

5. **Job Exploration**	▸ discuss personal career and employment aspirations. ▸ explore job opportunities and local labor market information through JobLink Career Centers and other resource networks. ▸ match job opportunities with prospective employers. ▸ set short and long term goals in relation to realistic job choices.
6. **Job Seeking**	▸ identify sources for job leads. ▸ develop a realistic job search plan.
7. **Application/Resume** . . .	▸ compile documents necessary to complete an application package. ▸ accurately complete personal data profile and job application. ▸ develop a well-written resume and cover letter.
8. **Interviewing**	▸ understand what constitutes satisfactory preparation for a job interview. ▸ exhibit appropriate behavior during a job interview. ▸ deal effectively with questions asked or answers given in a job interview. ▸ identify reasons why people don't get hired.
9. **Job Selection Process** . .	▸ identify factors to be considered before accepting a job. ▸ make responsible employment decisions.

Employment Expectations

10. Personal Responsibility

make satisfactory arrangements for childcare and transportation to work.

- understand basic information concerning Wage and Labor Laws.
- understand basic information contained on a check stub.
- understand basic information concerning a company's fringe benefit package.
- identify reasons why people are fired.
- exhibit appropriate behavior in case of job termination.
- explore other job opportunities upon leaving or being terminated from a job.

11. Time Management . . . .

- apply effective time management techniques.
- understand the importance of being at work on time.
- understand the importance of maintaining regular attendance on a job.
- understand the importance of giving timely notice to employers for absences or changes in work schedule.

12. Interpersonal Relationships

- recognize verbal and non-verbal clues and signals.
- interact and cooperate effectively with co-workers and general public.
- react appropriately to directions and criticisms.
- respond appropriately to various supervisors.

13. Work Attitudes/Behaviors

- follow workplace standards of behavior.
- accept responsibility for his/her actions.
- demonstrate reliability and dependability.
- follow job safety and health rules.
- apply learning strategies when adapting to new technology and skills.
- work effectively under pressure.

14. Job Performance . . . . . .

- complete job duties as directed.
- anticipate and accept job responsibilities beyond job description.
- ask for clarification of directions as needed.
- perform work tasks that meet quality control standards.
- monitor and evaluate job performance for continuous improvement.

15. Listening Skills . . . . . .

- understand the difference between listening and hearing.
- give and receive information that is clear and logical.
- distinguish information as fact or opinion.
- eliminate blocks to effective listening.

PART IV

North Carolina Division of Social Services
and
Departments of Social Services

Individual Case Assessment

Program Evaluation

PART V
North Carolina Community College System
and
Employment and Training Agencies

LIFELONG LEARNING AND CAREER SERVICES

Workplace Literacy

Upgrading/Retraining Services

Career Services

JobLink Career Resource Center

Others

Published July 1997
North Carolina Community College System
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NORTH CAROLINA
DIVISION OF SOCIAL SERVICES

Work First

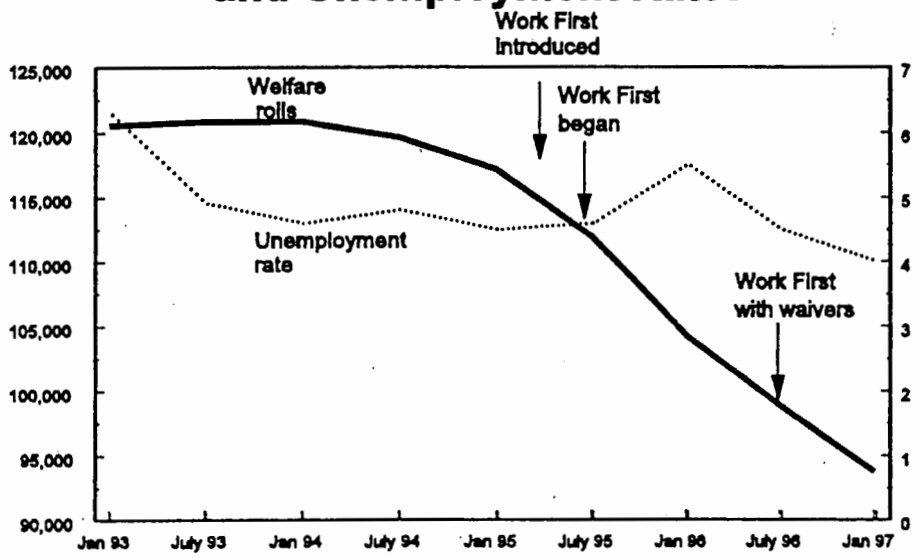
The First 18 Months of Welfare Reform in North Carolina

North Carolina's Work First program, implemented in July 1995, is one of the nation's toughest, most comprehensive welfare reform efforts. It demands work and personal and parental responsibility in exchange for temporary support as families move off welfare. Work First, a statewide welfare reform initiative, replaced a fragmented welfare system with a coordinated program that focuses on employment and economic self-sufficiency.

Through Work First:

- ✔ Welfare rolls are dropping.
- ✔ Taxpayers are saving money.
- ✔ Welfare parents are getting help with child care, transportation, and medical expenses.
- ✔ Welfare parents are signing binding personal responsibility contracts, pledging to get jobs and take care of their children.

Comparison of Welfare Rolls and Unemployment Rates



Despite fluctuations in the unemployment rate, Work First cuts the welfare rolls.

Changing the face of welfare

Work First's focus on employment is working. After 18 months, welfare rolls have dramatically decreased. The number of North Carolina families receiving welfare checks has declined by 17.4 percent—down from 113,485 families in June 1995 to 93,755 in January 1997.

While the welfare rolls were declining before Work First began (26,806 fewer families since January 1993), 73 percent of this reduction occurred since Work First began. Even when the unemployment rate sharply increased in January 1996, Work First kept cutting the welfare rolls.

A healthy economy creates a strong foundation for moving families into jobs, but changing the emphasis from a welfare check to a paycheck played the key role in reducing welfare rolls.

Moving from a welfare check to a paycheck

The cornerstone to Work First is the belief that ***families are better off working and every job has value.*** Families are clearly responding. In the first 18 months, 29,944 Work First parents got jobs that took them off welfare—they are now earning paychecks instead of welfare checks. Each of these jobs represents a triumph for the family, their caseworker, ***and*** for the community where they live.

Banks, state agencies, hospitals, nursing homes, county governments, restaurants, day care centers, manufacturers and law firms are hiring Work First participants. Some earn minimum wage, but others earn far more and have benefits such as health insurance.

Saving taxpayer dollars

In just 18 months, Work First has saved taxpayers $75 million. At the end of the first two years of Work First, savings are estimated to be $115.8 million ($75 million in federal taxes, $21.1 million in state taxes, and $19.7 million in county taxes).

Savings come not only from the declining welfare rolls, but also from the smaller welfare checks, since Work First participants are working more and earning more. In January 1997, the average welfare check was down by more than $2 since Work First began, saving taxpayers $200,000 a month, or $2.4 million a year.

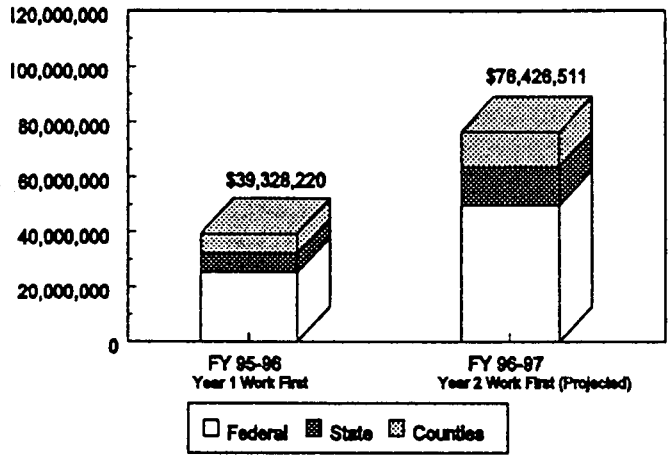
State and local governments can reinvest savings back into programs or services (such as transportation or child care) to help more families get jobs.

Federal Welfare Reform

Federal welfare reform took effect in North Carolina on January 1, 1997. Because the law mirrors much of N.C.'s welfare reform initiative, it has little impact on how Work First operates; however, it places almost all welfare recipients on a five-year lifetime limit for cash assistance.

Because of Work First's focus on employment, welfare families in North Carolina have a head start in beating the new federal lifetime limit.

Taxpayer Savings



Work First is saving money in welfare payments that can be reinvested in child care and other services for children and families.

Helping welfare parents go to work

Many families receiving cash assistance need help to return to the work force. To meet that need, all Work First participants have access to basic employment services, such as help with child care expenses, assistance with job applications, referrals to short-term job training and transportation assistance.

- ✔ About 20,000 children from Work First families receive help with child care expenses, which allows their parents to get jobs and participate in training and work-related activities.
- ✔ Approximately 15,000 Work First families receive transitional Medicaid that helps them cover health care costs, so they can stay independent.
- ✔ About 26,000 Work First participants a year receive transportation help so they can go to work or their children can go to child care.

Basic Employment Services

- ✔ Help with child care expenses
- ✔ Transportation assistance
- ✔ Health insurance through Medicaid for up to one year after leaving welfare for work
- ✔ Referrals to short-term job training
- ✔ Career counseling
- ✔ Assistance with job applications

Community colleges, local Employment Security Commission offices, vocational rehabilitation centers, temporary employment agencies, non-profit organizations, and faith communities help county departments of social services provide these services.

More than a third of Work First parents are targeted to receive additional, intensive employment services. These families are subject to the two-year time clock. They are assigned special case managers who work with the family to help them find a job. Case managers weigh the skills, job experiences and career goals of Work First parents, and send them to short-term training and GED programs if needed. Parents who need only minimal help are directed to immediately start their job search and may be sent to a five-day class to prepare them for the work force.

In the first six months of this fiscal year, more than 20,000 families received intensive employment services. By June 1997 (the end of the state fiscal year), an estimated 42,000 families will receive these services—an increase of 55 percent from fiscal year 1993 - 94.

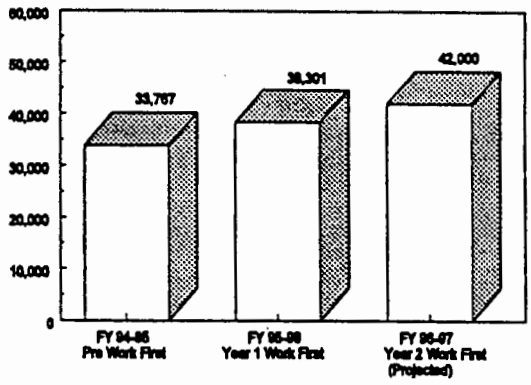
In the early months, Work First focused on families with school-aged children. Now, ***all*** able-bodied adults whose children are over one-year old are considered for intensive employment services. As more families move into the work force, additional Work First families will receive intensive services and be subject to the two-year time clock.

Keeping costs down

While the number of Work First participants receiving intensive employment services has increased by 55 percent, the cost per participant has ***decreased*** by 16.7 percent. This means that Work First is moving more families into jobs while keeping costs down. As county social services departments find more ways to collaborate with community groups, more low-to-no-cost training, transportation, and child care services become available for families trying to re-enter the work force. This collaboration continues to lower the cost of moving families off the welfare rolls.

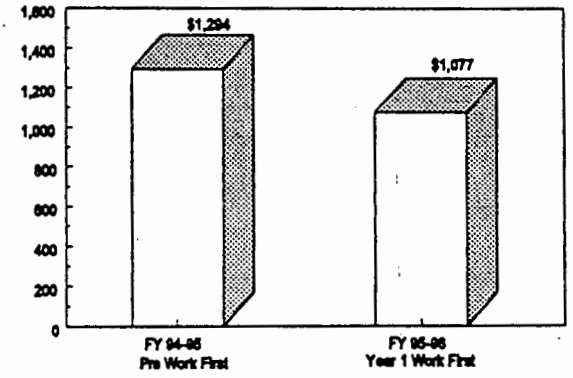
The church donating a car for a Work First participant to get to work and the business sponsoring a training class are not only helping Work First participants succeed, they are also lowering the cost of welfare!

People Receiving Employment Services



More Work First participants are receiving intensive employment services to help them get jobs.

Costs for Employment Services



In the first year of Work First, the cost of intensive employment services decreased more than $200 per Work First participant.

Encouraging responsibility

Families are getting the message that Work First means business. Beginning July 1, 1996, families were required to sign personal responsibility contracts that described how they planned to become self-sufficient and that promised to keep their children in school, to ensure that their children receive regular immunizations and medical check ups, and to comply with the work requirement. Since that date, 3,458 families were sanctioned for failing to meet their contracts. Each of these violations amounts to a deduction of at least $50 for three months, or over $500,000 in reduced cash assistance payments.

Making strides in child support enforcement

A welfare parent who receives child support from an absent parent is one step closer to economic self-sufficiency. That's why the Work First personal responsibility contract requires cooperation with child support enforcement agencies. Together with the Governor's Crackdown for Children, Work [illegible] helped establish 28,000 paternities for Work First families in the first 18 months. Establishing paternity is the first step to ensuring parents take financial responsibility for their children.

When a Work First parent receives cash assistance, the child support payment goes to reimburse taxpayers, up to the amount of their cash benefit. In the first year of Work First, 17.7 percent of welfare payments were reimbursed with child support payments. That's a 3 percent increase over previous years.

Monthly child support payments are transferred back to parents when they leave welfare. These payments help them stay on their feet and off the welfare rolls.

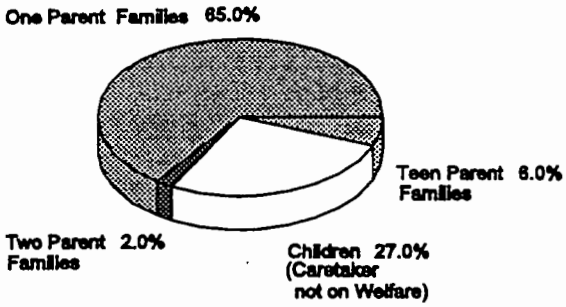
History of Work First

September 1994	**Governor's Welfare Reform Task Force** is established to develop recommendations for reforming welfare in NC.
March 1995	**Governor Hunt unveils his** Work First proposal.
July 1, 1995	**Work First officially begins,** shifting the focus from a welfare check to a paycheck and introducing the "Personal Responsibility Agreement."
September 14, 1995	**North Carolina submits request for waivers from federal rules** to U.S. Dept. of Health and Human Services so the state can fully implement Work First, with work requirements, time-limited benefits, family cap, binding personal responsibility contracts, sanctions and incentives. Waivers were approved February 5, 1996.
March - June 1996	**DHR retrains 4,000 county & state staff.**
July 1, 1996	**Work First's tougher requirements and incentives take effect,** requiring work and personal responsibility and limiting benefits.
July - Sept. 1996	**In six public forums, Governor Hunt enlists employers and churches** in the state's efforts to move families from welfare to work.
September 1996 - February 1997	**The Human Services Task Force** considers recommendations on how to make Work First better.
January 1, 1997	**All Work First** participants subject to federal 5-year lifetime limit for cash assistance.

Describing Work First families

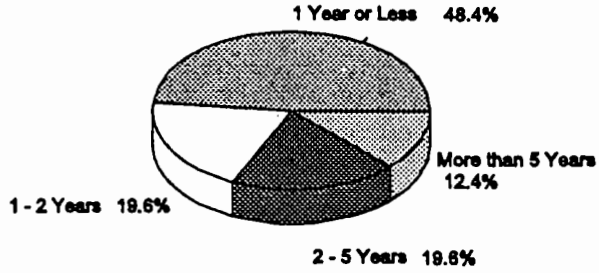
The typical Work First participant is a woman (95 percent), 24 years old, minority (70 percent) with two children. The average participant receives food stamps and Medicaid. Twenty-four percent of Work First participants receive housing assistance and 28 percent receive child support.

Work First Families



In a quarter of N.C.'s welfare families, only the children receive cash benefits.

Length of Stay on Cash Assistance



July 1, 1995-
November 30,1996

Two-thirds of Work First participants stay on welfare less than two years.

Most families are headed by one parent (65 percent). In slightly more than a quarter of the families (27 percent), only the children—not adults—are on public assistance. These families typically consist of children who live with their grandmother or other family member. Families headed by teen parents (under age 20) make up 6 percent of NC's welfare rolls, while two-parent families comprise only 2 percent.

Most families receive Work First cash benefits for less than two years. Only 12.4 percent of the families receive assistance for more than five years.

Looking to the future

In its first 18 months, Work First cut welfare rolls, saved millions of dollars and improved the lives of thousands of families. Now, the challenge is to continue that success.

Communities across the state can lend a hand to Work First participants. Businesses can hire and help meet the transportation and training needs of welfare parents. Faith and community groups can help with these issues, plus find other creative ways to support families trying to leave welfare. To achieve the goal of economic self-sufficiency for all North Carolinians, we must work together.

Call 1-800-724-0583 for more information on Work First.

Division of Social Services
Economic Independence Section
325 N. Salisbury Street
Raleigh, NC 27603
919 733-2873

Work First at a Glance

Work is required.

- ✔ Welfare parents are required to get a job—paid or unpaid—or be in short-term job training within 12 weeks.
- ✔ Welfare parents receiving intensive employment services must move off welfare in two years. After three years, they may reapply for benefits.

Everyone must take personal responsibility.

- ✔ All welfare parents must sign a personal responsibility contract that spells out their plans for moving off welfare.
- ✔ Benefits are cut when families don't meet their Work First obligations.
- ✔ Teen parents are required to stay in school and live at home, or under approved adult supervision.
- ✔ No additional cash payments are provided for children born after a family has been in Work First longer than 10 months.

Help is available.

- ✔ Work First eases the transition into the work force through help with child care, transportation, job search, and short-term job training. Participants can get Medicaid to cover medical expenses up to a year after they leave welfare for work.
- ✔ For families at risk of going on welfare, one-time grants (called diversion grants) of up to three months of cash benefits can help families stay on their feet and off the welfare rolls.
- ✔ Families can save up to $3,000.
- ✔ Families can invest in a car valued up to $5,000 for reliable transportation to work.

March 1997

7500 copies of this public document were printed at a cost of $690.00 or .092 per copy.
NC Division of Social Services.

Community College and Work First Populations

College	Counties	Work First Population 6/1/97	College	Counties	Work First Population 6/1/97
Alamance Community College	Alamance	539	Catawba Valley Community College	Alexander, Catawba	926
Anson Community College	Anson, Union Consortium	766	Central Carolina Community College	Chatham, Harnett, Lee	1357
Asheville-Buncombe Technical Community College	Buncombe, Madison	1494	Central Piedmont Community College	Mecklenburg	4797
Beaufort County Community College	Beaufort, Hyde, Tyrrell, Washington	910	Cleveland Community College	Cleveland	932
Bladen Community College	Bladen	417	Coastal Carolina Community College	Onslow	937
Blue Ridge Community College	Henderson, Transylvania	689	College of the Albemarle	Camden, Chowan, Currituck, Dare, Gates, Perquimans, Pasquotank	1300
Brunswick Community College	Brunswick	449	Craven Community College	Craven	793
Caldwell Community College & Technical Institute	Watauga, Caldwell	503	Davidson County Community College	Davidson, Davie	794
Cape Fear Community College	New Hanover, Pender	1498	Durham Technical Community College	Durham, Orange	3020
Carteret Community College	Carteret	323	Edgecombe Community College	Edgecombe	1163

Community College and Work First Populations

College	Counties	Work First Population 6/1/97	College	Counties	Work First Population 6/1/97
Fayetteville Technical Community College	Cumberland	3171	Martin Community College	Martin, Bertie (3)	739
Forsyth Technical Community College	Forsyth, Stokes	2681	Mayland Community College	Mitchell, Avery, Yancey	181
Gaston College	Gaston, Lincoln	2262	McDowell Technical Community College	McDowell	200
Guilford Technical Community College	Guilford	3277	Mitchell Community College	Iredell	596
Halifax Community College	Halifax, Warren (1), Northampton(2)	1954	Montgomery Community College	Montgomery	213
Haywood Community College	Haywood	364	Nash Community College	Nash	644
Isothermal Community College	Polk, Rutherford	529	NC Center for Applied Textile Technology	Statewide	
James Sprunt Community College	Duplin	636	Pamlico Community College	Pamlico	117
Johnston Community College	Johnston	1282	Piedmont Community College	Person, Caswell	1586
Lenoir Community College	Greene, Lenoir, Jones	1772	Pitt Community College	Pitt	2157

(1) Townships of Fishing Creek, River, Roanoke, & Judkins
(2) Townships of Gaston, Occoneechee, Pleasant Hill, & Seaboard
(3) Townships of Indian Woods & Merry Hill

Community College and Work First Populations

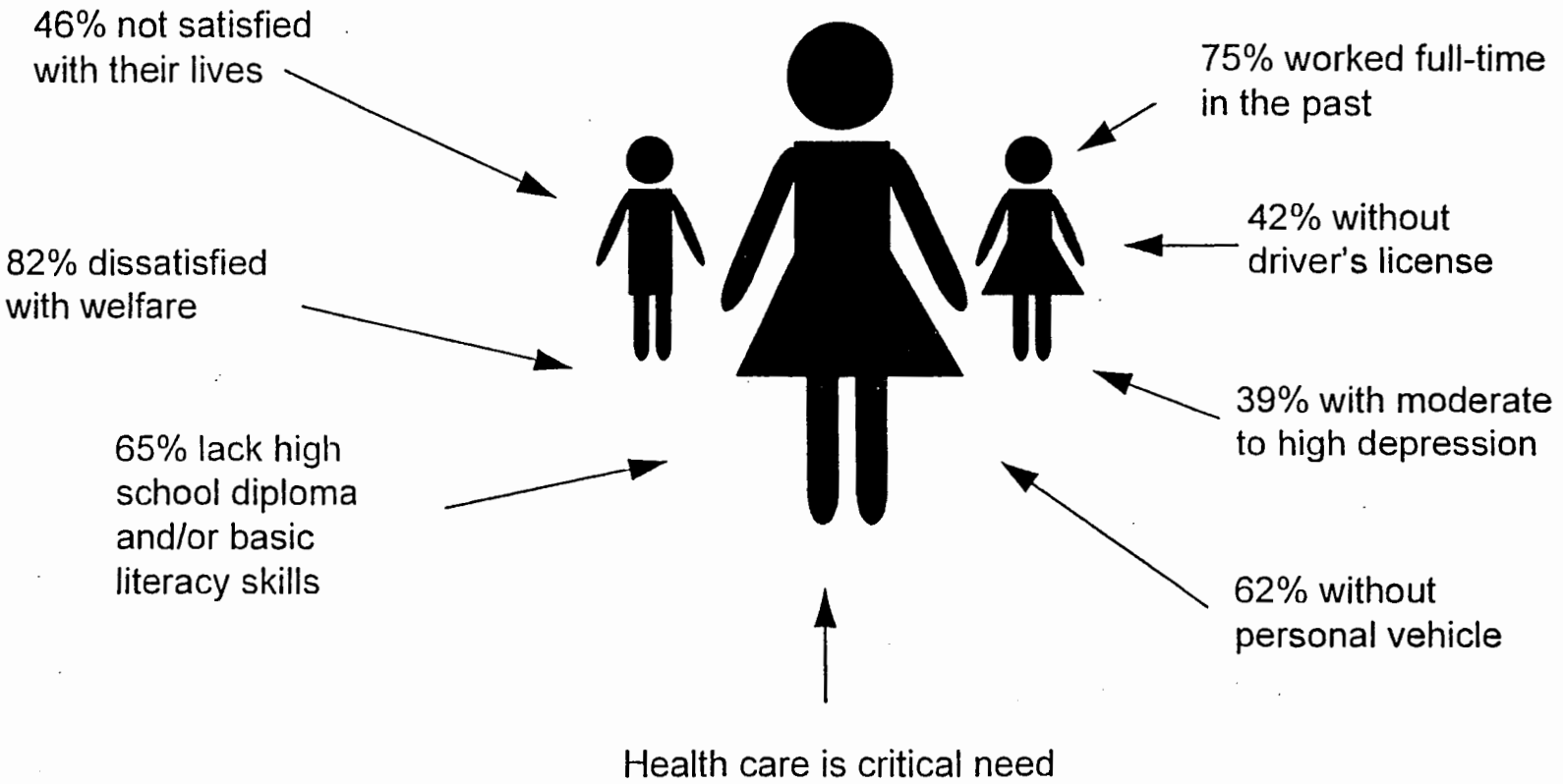
College	Counties	Work First Population 6/1/97	College	Counties	Work First Population 6/1/97
Randolph Community College	Randolph	452	Stanly Community College	Stanly, Union Consortium	715
Richmond Community College	Richmond, Scotland	1419	Surry Community College	Surry, Yadkin	343
Roanoke-Chowan Community College	Hertford, Bertie (4), Northampton (5)	1109	Tri-County Community College	Cherokee, Clay, Graham	220
Robeson Community College	Robeson	1831	Vance-Granville Community College	Vance, Franklin, Granville, Warren (6)	1680
Rockingham Community College	Rockingham	732	Wake Technical Community College	Wake	2731
Rowan-Cabarrus Community College	Cabarrus, Rowan	1147	Wayne Community College	Wayne	1173
Sampson Community College	Sampson	486	Western Piedmont Community College	Burke	458
Sandhills Community College	Hoke, Moore	975	Wilkes Community College	Alleghany, Ashe, Wilkes	667
Southeastern Community College	Columbus	571	Wilson Technical Community College	Wilson	869
Southwestern Community College	Jackson, Macon, Swain	439	Total	Statewide	61,376

(4) Townships of Colerain, Mitchells, Roxobel, Snakebite, Whites, and Woodville)

(5) Townships of Jackson, Kirby, Rich Square, Roanoke, & Wiccacanee

(6) Townships of Smith Creek, Nutbush, Sandy Creek, Shocco, Hawtree, Warrenton, Six Pound, & Ford

Work First Parent Characteristics: Participants Entering Former JOBS Program



Source: UNC-CH Human Services Research and Design Laboratory

ANNUAL WORK PARTICIPATION RATE REQUIREMENTS

States must meet the following annual work participation rates with respect to all families that include an adult or minor child head of household receiving assistance.

	ALL FAMILIES		TWO-PARENT FAMILIES	
Fiscal Year	Part. Rate	Hours of Work per Week to Count Toward Rate	Part. Rate	Hours of Work per Week to Count Toward Rate
1997	25%	20	75%	35
1998	30%	20	75%	35
1999	35%	25	90%	35
2000	40%	30	90%	35
2001	45%	30	90%	35
2002	50%	30	90%	35

CALCULATING THE WORK PARTICIPATION RATE

FAMILY SUPPORT ACT (JOBS PROGRAM)	P.L. 104-193 (TEMPORARY ASSISTANCE TO NEEDY FAMILIES BLOCK GRANT/TANF)
Adults (mandatory participants and volunteers) with satisfactory participation in JOBS (work, education, training, job readiness and job search) / JOBS mandatory* (Those required to be in JOBS less exempted families, including those with young children under age 3, those who are ill or incapacitated or are caring for an ill or incapacitated household member, those in remote areas, and more). = % participating	Families that include an adult engaged in federally-specified work activities for the requisite number of hours (20 increasing to 30) per week / All families with an adult or minor child head-of-household receiving assistance, less the number of families sanctioned for three months* (State option to exclude families with children under age one). = % participating
* Jobs eligibles are a much smaller percentage of the entire caseload. To count as participating, an individual must attend at least 75% of scheduled hours.	* This is a much larger pool of participants than the JOBS program.

LABOR MARKET INFORMATION DIVISION

of the

Employment Security Commission of North Carolina

The Human Resource Information System is easy to use. Mouse support, pull down menus and navigation buttons create a user friendly, intuitive interface.

Hardware Requirements

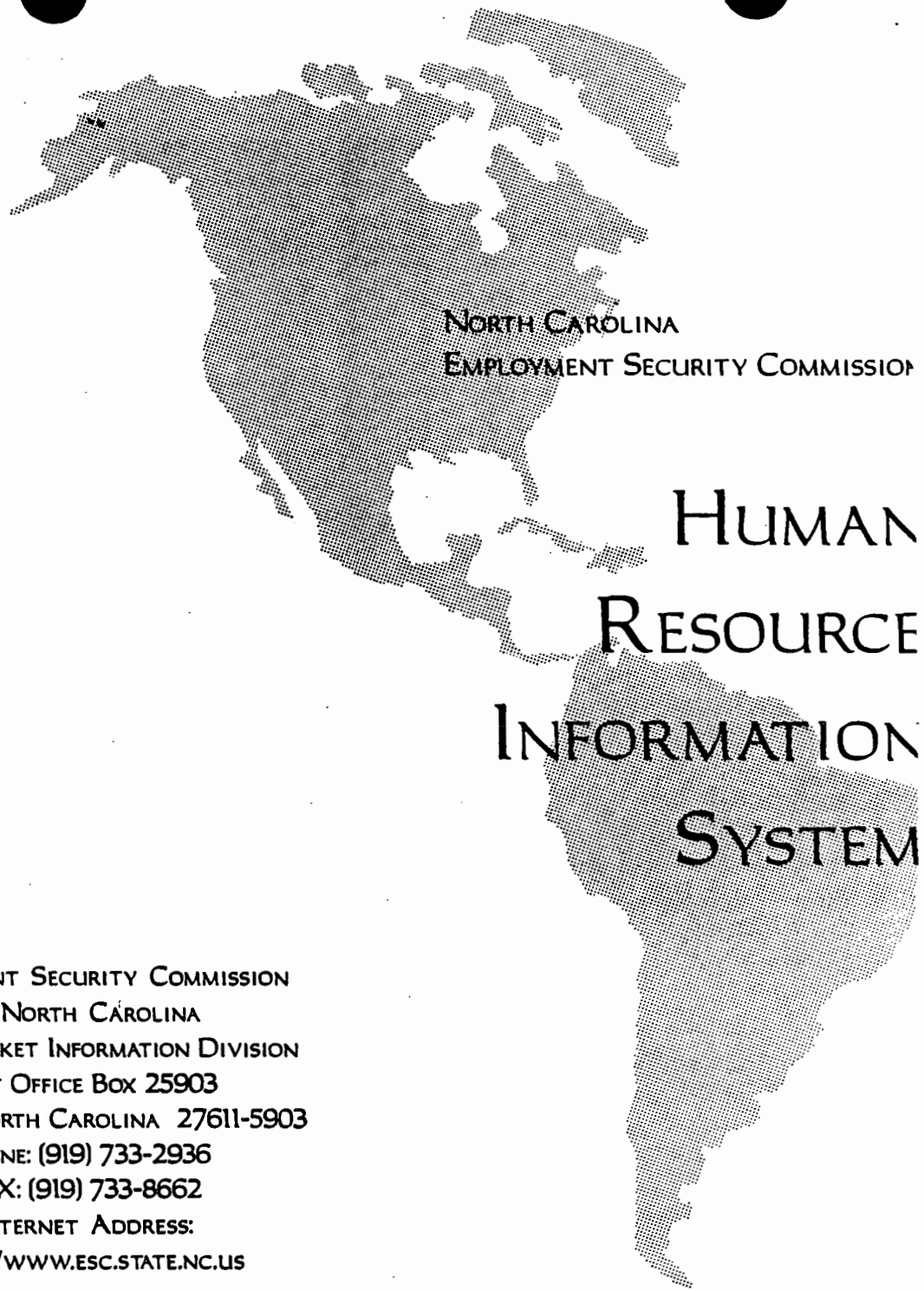
Minimum: The Human Resource Information System runs on a Windows 3.1 computer. A Windows system requires a 486/66 or higher processor running Windows 3.1, DOS 5.0 or higher, 16 MB of RAM, 250 MB free space on the hard drive and a VGA monitor. Note—DOS Share.exe must be loaded for proper performance.

Recommended: Windows System — Pentium 90 MHz. processor running Windows 3.1 and DOS 5.0 or higher; with 300 MB of hard disk; 17", 1024 x 768 color monitor; and, at least 16 MB of RAM.

If you would like more information on the Human Resources Information System contact:

Labor Market Information Division
Employment Security Commission
Post Office Box 25903
Raleigh, North Carolina 27611

Phone: (919) 733-2936
Fax: (919) 733-8662
E-Mail: Parker.Steve@esc.state.nc.us



North Carolina
Employment Security Commission

Human Resource Information System

Employment Security Commission
of North Carolina
Labor Market Information Division
Post Office Box 25903
Raleigh, North Carolina 27611-5903
Phone: (919) 733-2936
FAX: (919) 733-8662
Internet Address:
http://www.esc.state.nc.us

Answering Data Needs

Researchers, analysts and developers have long needed a single source for demographic and labor market information. With current computer technology, up-to-date information can be made readily available.

The multitude of demographic and labor market information available can be confusing. This is especially true when dealing with a state the size of North Carolina, which has 18 Planning Regions, 11 Metropolitan Statistical Areas, four Broad Geographic Regions, 100 counties and 26 Service Delivery Areas. Locating and extracting the data can require extensive computer skills.

The North Carolina Human Resource Information System (HRIS) was developed to provide a convenient, flexible way to display summary and comparative data.

. . . . . Convenient

. . . . . Easy to Use

. . . . . Flexible

The user is not required to have extensive geographic information system abilities nor database management skills to successfully operate the HRIS. This system displays:

- Population
- Income
- Industry Data
- Industrial Projections
- Industrial Development
- Occupational Wages
- Occupational Projections
- Labor Force
- Labor Cost
- Local Sales & Tax Revenues
- Local Property Values
- Local Building Permits
- Local Government Payments
- ESC Applicants
- Returning Military
- Educational Completions
- Listings of North Carolina Firms
- Mass Layoff Statistics

Employment Security Commission

Geographic Areas . . . . .

Data are provided for various geographic areas including:

- BLS Southeast Region
- North Carolina Statewide
- Broad Geographic Regions
- Economic Development Regions
- Metropolitan Statistical Areas
- Service Delivery Areas
- Planning Regions
- Counties
- Custom Selectable Regions

The system incorporates a graphical user interface which displays the states in the BLS Southeast Region, North Carolina and areas within North Carolina. This interface allows an analyst to select the geographic area and data element of interest.

Descriptive tables are provided for analysis. Summary information for many data elements may be displayed on color coded maps.

Client Server Hardware Requirements

Server

Minimum: The State & Area Research & Analysis System operates under Windows NT 3.51 and Microsoft SQL Server 6.0. The system requires a minimum of 32 MB of RAM and 2GB hard disk space with a minimum of a 486/66 processor.

Recommended: A similarly configured Pentium class machine with a 90 MHz or faster processor running Windows NT.

Individual Workstation

Minimum: The State & Area Research & Analysis System runs on a Windows compatible computer. The application is compiled in Visual Basic running under Windows 3.1, Windows 95 or Windows NT. The system requires a 486/66 or faster processor, 16 MB of RAM, 20 MB free space on the hard drive and a VGA monitor.

Recommended: A Windows compatible Pentium class machine with a 90 MHz or faster processor with 30 MB of hard disk space, a 17", 1024 x 768 color monitor and at least 16 MB of RAM.

If you would like more information on the State & Area Research & Analysis System contact:

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Raleigh, North Carolina 27611

Phone: (919) 733-2936
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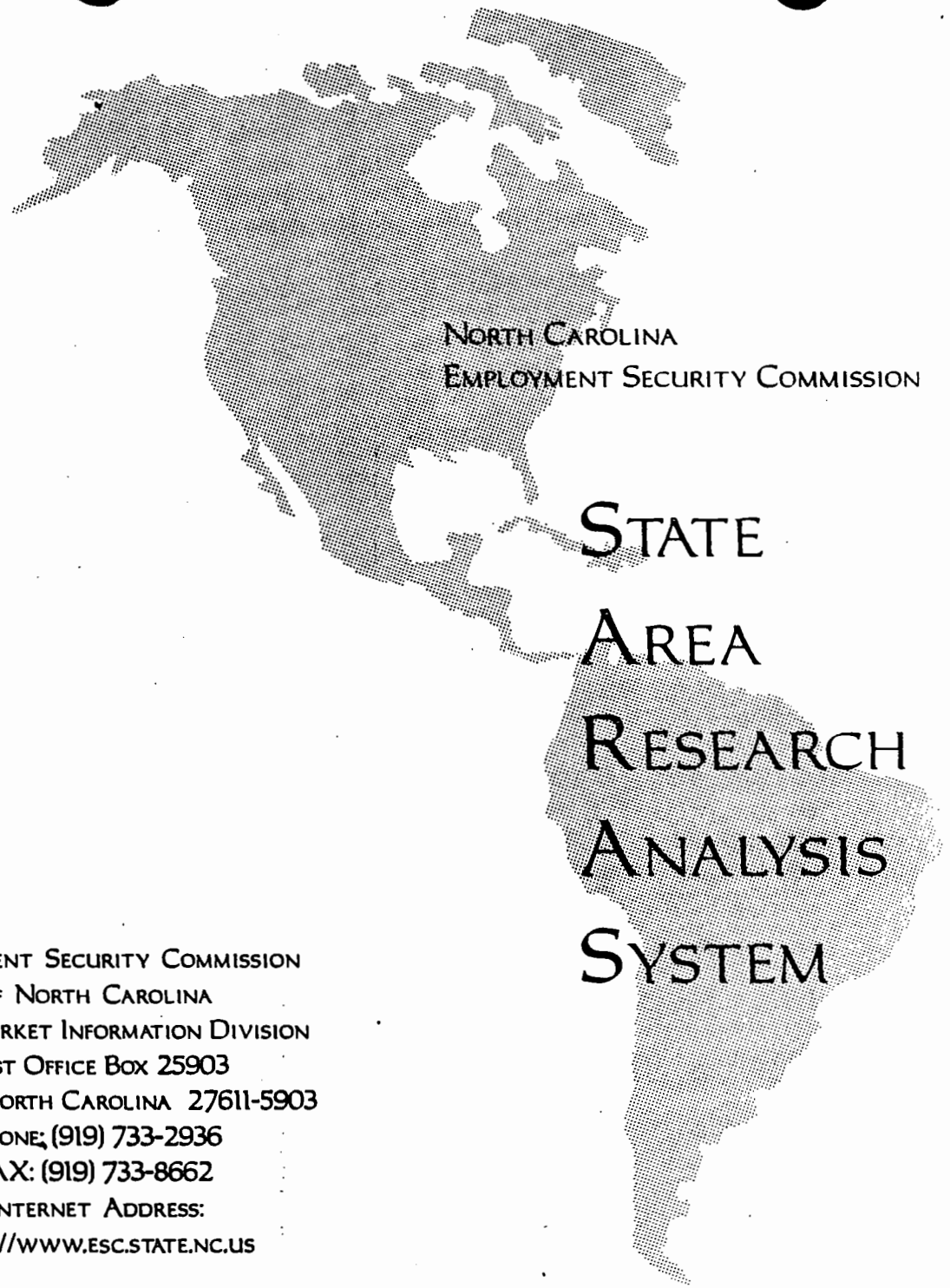

North Carolina
Employment Security Commission

State Area Research Analysis System

Employment Security Commission
of North Carolina
Labor Market Information Division
Post Office Box 25903
Raleigh, North Carolina 27611-5903
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FAX: (919) 733-8662
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Answering Data Needs

Researchers, analysts and developers have long needed a single source for demographic and labor market information. With current computer technology, up-to-date information can be made readily available.

The multitude of demographic and labor market information available can be confusing. This is especially true when dealing with a state the size of North Carolina, which has 18 Planning Regions, 11 Metropolitan Statistical Areas, four Broad Geographic Regions, 100 counties and 26 Service Delivery Areas. Locating and extracting the data can require extensive computer skills.

The North Carolina State & Area Research & Analysis System (SARAS) was developed to provide a convenient, flexible way to display summary and comparative data.

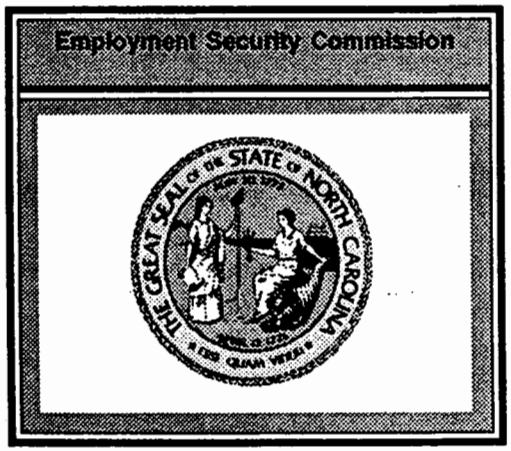
. . . . . Convenient

. . . . . Easy to Use

. . . . . Flexible

The user is not required to have extensive geographic information system abilities nor database management skills to successfully operate the SARAS. This system displays:

- Population
- Income
- Industry Data
- Industrial Projections
- Industrial Development
- Occupational Wages
- Occupational Projections
- Labor Force
- Labor Cost
- Local Sales & Tax Revenues
- Local Property Values
- Local Building Permits
- Local Government Payments
- ESC Applicants
- Returning Military
- Educational Completions
- Listings of North Carolina Firms
- Mass Layoff Statistics



Geographic Areas . . . . .

Data are provided for various geographic areas including:

- BLS Southeast Region
- North Carolina Statewide
- Broad Geographic Regions
- Economic Development Regions
- Metropolitan Statistical Areas
- Service Delivery Areas
- Planning Regions
- Counties
- Custom Selectable Regions

The system incorporates a graphical user interface which displays the states in the BLS Southeast Region, North Carolina and areas within North Carolina. This interface allows an analyst to select the geographic area and data element of interest.

Descriptive tables are provided for analysis. Summary information for many data elements may be displayed on color coded maps.

The State Area Research Analysis System is easy to use. Mouse support, pull down menus and navigation buttons create a user friendly, intuitive interface.

LABOR MARKET INFORMATION DIVISION

of the

Employment Security Commission of North Carolina

ONLINE

The mission of the Labor Market Information Division of the Employment Security Commission of North Carolina is to develop, refine, and manage a comprehensive system of state and local market information. The information generated by this system is designed to meet the needs of policy makers and planners in both the public and private sectors. Though intended for use in economic, education, manpower, and fiscal planning, the system also serves as a valuable tool for marketing, research, and individual career planning.

To obtain information relating to the following categories, access the Labor Market Information Division's web site: http://www.esc.state.nc.us/html/lmi.html

GENERAL INFORMATION
Labor Market Information Directory
Map of County Unemployment Rates
Map of Labor Force Distribution

APPLIED RESEARCH
Occupations Requiring a License in North Carolina
Reference Catalog

CURRENT EMPLOYMENT STATISTICS (CES)

EMPLOYMENT AND WAGES (ES-202)
*Employment and Wages in North Carolina
North Carolina's Largest Employers

LOCAL AREA UNEMPLOYMENT STATISTICS
Civilian Labor Force Estimates

NORTH CAROLINA
STATE OCCUPATIONAL INFORMATION COORDINATING COMMITTEE
(NC SOICC)

ADDITIONAL RESOURCES
Bureau of Labor Statistics Home Page

**A sample of statewide/county data on "Insured Employment and Wages in North Carolina by 2-digit SIC Industry for Year 1995" is provided on the following pages.*

Refer comments/questions to the North Carolina Labor Market Information Division at (919) 733-2936, 1-800-262-0516, or fax: 919-733-8662.

STATEWIDE

INSURED EMPLOYMENT AND WAGES IN NORTH CAROLINA
BY 2-DIGIT SIC INDUSTRY FOR YEAR 1995

INDUSTRY	SIC CODE	NO. OF UNITS	ANNUAL AVERAGE EMPLOYMENT	ANNUAL WAGES PAID	AVERAGE ANNUAL WAGE PER WORKER	TOTAL TAXABLE WAGES
TOTAL ALL INDUSTRIES		198,485	3,439,018	$ 83,821,562,109	$ 24,374	$ 31,053,821,970
PRIVATE TOTAL		190,922	2,905,468	69,991,175,446	24,089	31,029,095,413
AGRICULTURE, FORESTRY AND FISHING		4,829	42,332	693,303,356	16,378	451,827,829
AGRICULTURAL PRODUCTION-CROPS	01	1,023	11,720	146,476,421	12,498	110,331,147
AGRICULTURAL PRODUCTION-LIVESTOCK	02	542	10,172	212,052,308	20,847	124,777,469
AGRICULTURAL SERVICES	07	3,098	19,259	311,124,106	16,155	204,210,766
FORESTRY	08	151	1,109	22,074,471	19,905	11,737,181
FISHING, HUNTING AND TRAPPING	09	15	72	1,576,050	21,890	771,266
MINING		181	3,644	132,121,323	36,257	44,866,843
METAL MINING	10	5	17	466,582	27,446	180,498
COAL MINING	12	0	0	0	0	0
OIL AND GAS EXTRACTION	13	11	58	1,924,189	33,176	855,251
NONMETALLIC MINERALS, EXCEPT FUELS	14	165	3,569	129,730,552	36,349	43,831,094
CONSTRUCTION		23,161	174,889	4,216,564,177	24,110	2,245,949,889
GENERAL BUILDING CONTRACTORS	15	7,291	47,083	1,235,502,868	26,241	620,493,064
HEAVY CONSTRUCTION, EXCEPT BUILDING	16	1,578	25,980	673,096,629	25,908	350,963,257
SPECIAL TRADE CONTRACTORS	17	14,292	101,826	2,307,964,680	22,666	1,274,493,568
MANUFACTURING		12,160	862,290	23,928,006,929	27,749	10,359,253,168
FOOD AND KINDRED PRODUCTS	20	502	56,149	1,270,095,116	22,620	677,944,773
TOBACCO PRODUCTS	21	29	18,109	839,473,047	46,357	212,885,185
TEXTILE MILL PRODUCTS	22	1,396	197,939	4,492,513,987	22,696	2,395,849,345
APPAREL AND OTHER FINISHED PRODUCTS	23	847	63,702	1,063,833,459	16,700	682,187,549
LUMBER AND WOOD PRODUCTS	24	1,878	41,713	924,168,205	22,155	491,297,715
FURNITURE AND FIXTURES	25	800	78,808	1,712,668,605	21,732	942,970,449
PAPER AND ALLIED PRODUCTS	26	260	24,571	896,497,134	36,486	311,187,777
PRINTING AND PUBLISHING	27	1,552	32,312	860,252,327	26,623	368,985,809
CHEMICALS AND ALLIED PRODUCTS	28	374	49,798	2,174,603,550	43,668	613,740,650
PETROLEUM AND RELATED INDUSTRIES	29	23	779	23,631,936	30,336	8,589,373
RUBBER AND MISC. PLASTICS PRODUCTS	30	438	38,956	1,162,642,350	29,845	481,944,992
LEATHER AND LEATHER PRODUCTS	31	44	2,563	55,469,659	21,642	29,583,481
STONE, CLAY, GLASS, AND CONCRETE PROD.	32	508	23,061	688,984,902	29,877	283,699,394
PRIMARY METAL INDUSTRIES	33	151	15,976	525,699,487	32,906	196,170,163

FABRICATED METAL PRODUCTS	34	723	31,572	876,698,924	27,768	390,035,475
INDUSTRIAL MACHINERY AND EQUIPMENT	35	1,399	68,764	2,613,318,589	38,004	$ 847,652,091
ELECTRONIC & OTHER ELECTRICAL EQUIPMENT	36	385	60,883	1,998,584,242	32,827	736,977,234
TRANSPORTATION EQUIPMENT	37	331	33,434	1,060,453,954	31,718	409,890,311
INSTRUMENTS AND RELATED PRODUCTS	38	212	14,990	509,367,136	33,980	179,156,065
MISCELLANEOUS MANUFACTURING INDUSTRIES	39	308	8,211	179,050,320	21,806	98,505,337
TRANSPORTATION, COMM. & UTILITIES		7,329	162,419	5,461,314,280	33,625	2,020,601,076
LOCAL AND INTERURBAN PASSENGER TRANSIT	41	372	4,146	62,027,794	14,961	38,551,680
TRUCKING AND WAREHOUSING	42	4,008	68,139	1,801,587,082	26,440	846,501,686
WATER TRANSPORTATION	44	159	1,646	29,659,579	18,019	18,850,495
TRANSPORTATION BY AIR	45	249	21,304	835,975,106	39,240	256,664,641
PIPELINES, EXCEPT NATURAL GAS	46	9	108	5,182,358	47,985	1,315,390
TRANSPORTATION SERVICES	47	862	7,279	297,562,854	40,880	106,633,569
COMMUNICATIONS	48	1,190	32,401	1,228,706,512	37,922	414,540,092
ELECTRIC, GAS, AND SANITARY SERVICES	49	480	27,397	1,200,612,995	43,823	337,543,523
WHOLESALE TRADE		19,561	181,371	5,982,628,826	32,986	2,245,840,104
WHOLESALE TRADE-DURABLE GOODS	50	11,488	103,235	3,540,540,264	34,296	1,294,752,233
WHOLESALE TRADE-NONDURABLE GOODS	51	8,073	78,136	2,442,088,562	31,254	951,087,871
RETAIL TRADE		46,527	620,223	8,637,427,468	13,926	5,430,547,979
BUILDING MATERIALS & GARDEN SUPPLIES	52	2,557	32,285	698,756,289	21,643	379,530,685
GENERAL MERCHANDISE STORES	53	1,619	79,187	999,387,370	12,621	705,916,135
FOOD STORES	54	6,145	103,853	1,298,382,081	12,502	853,587,924
AUTOMOTIVE DEALERS & SERVICE STATIONS	55	6,323	60,924	1,546,674,948	25,387	726,962,555
APPAREL & ACCESSORY STORES	56	3,677	30,082	356,142,116	11,839	236,874,606
FURNITURE AND HOME FURNISHINGS STORES	57	4,354	32,068	660,052,896	20,583	349,174,433
EATING & DRINKING PLACES	58	12,159	215,061	2,012,268,905	9,357	1,569,124,767
MISCELLANEOUS RETAIL	59	9,693	66,765	1,065,762,863	15,963	609,376,874
FINANCE, INSURANCE AND REAL ESTATE		15,346	144,901	4,807,408,886	33,177	1,763,895,191
DEPOSITORY INSTITUTIONS	60	2,881	53,817	1,621,927,784	30,138	654,340,837
NONDEPOSITORY INSTITUTIONS	61	1,603	13,329	504,118,848	37,821	181,212,292
SECURITY AND COMMODITY BROKERS	62	538	6,020	430,000,865	71,429	77,830,846
INSURANCE CARRIERS	63	1,369	27,080	1,004,397,105	37,090	335,860,409
INSURANCE AGENTS, BROKERS & SERVICE	64	3,000	13,764	428,771,213	31,152	164,781,602
REAL ESTATE	65	5,715	28,446	649,711,974	22,840	316,502,232
HOLDING AND OTHER INVESTMENT OFFICES	67	240	2,445	168,481,097	68,908	33,366,973
SERVICES		61,828	713,399	16,132,400,201	22,613	$ 6,466,313,334
HOTELS AND OTHER LODGING PLACES	70	1,647	32,779	395,199,928	12,056	298,471,903
PERSONAL SERVICES	72	4,816	30,477	445,085,556	14,604	287,694,508
BUSINESS SERVICES	73	11,505	186,056	3,415,818,134	18,359	1,938,392,714
AUTO REPAIR, SERVICES AND PARKING	75	4,680	23,557	462,298,069	19,625	262,101,491
MISCELLANEOUS REPAIR SERVICES	76	2,059	9,034	204,502,284	22,637	106,938,150
MOTION PICTURES	78	1,124	8,308	76,351,323	9,190	54,070,319
AMUSEMENT & RECREATION SERVICES	79	2,504	28,954	419,501,764	14,489	241,404,552
HEALTH SERVICES	80	9,859	208,623	6,242,274,225	29,921	1,631,440,128
LEGAL SERVICES	81	3,131	16,111	566,492,887	35,162	197,614,371
EDUCATIONAL SERVICES	82	672	30,593	808,836,411	26,439	105,569,127

SOCIAL SERVICES	83	4,105	58,749	776,361,301	13,215	479,152,457
MUSEUMS, BOTANICAL & ZOOLOGICAL GARDENS	84	70	1,680	26,935,775	16,033	12,660,890
MEMBERSHIP ORGANIZATIONS	86	1,559	14,989	235,974,094	15,743	115,474,068
ENGINEERING & MANAGEMENT SERVICES	87	6,917	54,423	1,959,817,943	36,011	659,345,808
PRIVATE HOUSEHOLDS	88	7,085	8,684	84,269,794	9,704	70,761,637
MISCELLANEOUS SERVICES	89	95	383	12,680,713	33,109	5,221,211
NONCLASSIFIABLE ESTABLISHMENTS	99	0	0	0	0	0
GOVERNMENT		7,563	533,550	13,830,386,663	25,921	24,726,557
FEDERAL GOVERNMENT		1,832	61,070	2,103,510,715	34,444	0
STATE GOVERNMENT		2,180	143,587	3,928,227,837	27,358	181,933
LOCAL GOVERNMENT		3,551	328,894	7,798,648,111	23,712	24,544,624

"*" IN TABLES INDICATES DISCLOSURE SUPPRESSION.

COUNTY DATA

INSURED EMPLOYMENT AND WAGES IN NORTH CAROLINA
BY 2-DIGIT SIC INDUSTRY FOR YEAR 1995

INDUSTRY	SIC CODE	NO. OF UNITS	ANNUAL AVERAGE EMPLOYMENT	ANNUAL WAGES PAID	AVERAGE ANNUAL WAGE PER WORKER	TOTAL TAXABLE WAGES
TOTAL ALL INDUSTRIES		17,672	303,619	$ 8,055,361,884	$ 26,531	$ 2,699,217,849
PRIVATE TOTAL		17,309	244,470	6,288,015,639	25,721	2,698,871,105
AGRICULTURE, FORESTRY AND FISHING		366	2,837	48,486,830	17,091	30,160,228
AGRICULTURAL PRODUCTION-CROPS	01	37	356	5,511,467	15,482	3,518,796
AGRICULTURAL PRODUCTION-LIVESTOCK	02	5	133	2,858,527	21,493	1,605,776
AGRICULTURAL SERVICES	07	314	2,327	39,398,221	16,931	24,683,706
FORESTRY	08	10	22	718,615	32,664	351,950
FISHING, HUNTING AND TRAPPING	09	0	0	0	0	0
MINING		12	430	22,980,957	53,444	7,210,992
METAL MINING	10	*	*	*	*	*
COAL MINING	12	0	0	0	0	0
OIL AND GAS EXTRACTION	13	0	0	0	0	0
NONMETALLIC MINERALS, EXCEPT FUELS	14	*	*	*	*	*
CONSTRUCTION		2,073	18,166	490,681,259	27,011	240,429,401
GENERAL BUILDING CONTRACTORS	15	723	4,656	150,546,936	32,334	62,535,305
HEAVY CONSTRUCTION, EXCEPT BUILDING	16	122	1,858	50,260,119	27,051	25,109,934
SPECIAL TRADE CONTRACTORS	17	1,228	11,652	289,874,204	24,878	152,784,162
MANUFACTURING		635	28,243	902,762,276	31,964	346,437,545
FOOD AND KINDRED PRODUCTS	20	21	2,458	68,812,167	27,995	30,300,664
TOBACCO PRODUCTS	21	0	0	0	0	0
TEXTILE MILL PRODUCTS	22	20	1,514	35,869,736	23,692	16,810,344
APPAREL AND OTHER FINISHED PRODUCTS	23	28	1,405	19,806,591	14,097	15,845,535
LUMBER AND WOOD PRODUCTS	24	52	662	15,615,419	23,588	8,127,763
FURNITURE AND FIXTURES	25	18	281	7,599,586	27,045	4,703,844
PAPER AND ALLIED PRODUCTS	26	14	654	20,510,081	31,361	7,635,644
PRINTING AND PUBLISHING	27	184	3,008	86,886,868	28,885	35,017,242
CHEMICALS AND ALLIED PRODUCTS	28	19	2,492	104,120,694	41,782	27,477,426
PETROLEUM AND RELATED INDUSTRIES	29	*	*	*	*	*
RUBBER AND MISC. PLASTICS PRODUCTS	30	18	1,382	46,655,841	33,760	17,296,516
LEATHER AND LEATHER PRODUCTS	31	*	*	*	*	*
STONE, CLAY, GLASS, AND CONCRETE PROD.	32	30	1,210	31,660,394	26,166	15,376,769
PRIMARY METAL INDUSTRIES	33	8	338	15,017,013	44,429	5,001,343

FABRICATED METAL PRODUCTS	34	46	2,091	68,718,626	32,864	27,258,828
INDUSTRIAL MACHINERY AND EQUIPMENT	35	48	2,390	99,512,694	41,637 $	31,918,257
ELECTRONIC & OTHER ELECTRICAL EQUIPMENT	36	64	6,369	216,703,027	34,025	79,118,309
TRANSPORTATION EQUIPMENT	37	8	348	10,191,787	29,287	4,550,015
INSTRUMENTS AND RELATED PRODUCTS	38	29	1,324	45,387,684	34,281	16,198,678
MISCELLANEOUS MANUFACTURING INDUSTRIES	39	22	230	7,160,273	31,132	2,707,428
TRANSPORTATION, COMM. & UTILITIES		516	17,821	584,286,968	32,786	221,814,144
LOCAL AND INTERURBAN PASSENGER TRANSIT	41	33	592	9,972,000	16,845	6,160,585
TRUCKING AND WAREHOUSING	42	212	4,712	109,685,022	23,278	52,715,183
WATER TRANSPORTATION	44	0	0	0	0	0
TRANSPORTATION BY AIR	45	32	3,958	96,319,526	24,335	47,579,399
PIPELINES, EXCEPT NATURAL GAS	46	3	16	750,620	46,914	176,268
TRANSPORTATION SERVICES	47	84	714	23,038,523	32,267	9,062,224
COMMUNICATIONS	48	126	3,745	149,480,882	39,915	49,903,537
ELECTRIC, GAS, AND SANITARY SERVICES	49	26	4,083	195,040,395	47,769	56,216,948
WHOLESALE TRADE		1,721	17,449	662,155,627	37,948	227,986,935
WHOLESALE TRADE-DURABLE GOODS	50	1,105	12,151	487,203,767	40,096	162,058,416
WHOLESALE TRADE-NONDURABLE GOODS	51	616	5,298	174,951,860	33,022	65,928,519
RETAIL TRADE		3,639	56,208	846,935,206	15,068	511,954,781
BUILDING MATERIALS & GARDEN SUPPLIES	52	165	2,880	64,540,838	22,410	32,489,622
GENERAL MERCHANDISE STORES	53	100	7,633	98,083,334	12,850	69,984,864
FOOD STORES	54	388	7,798	107,823,874	13,827	68,651,845
AUTOMOTIVE DEALERS & SERVICE STATIONS	55	335	4,554	135,504,259	29,755	56,095,718
APPAREL & ACCESSORY STORES	56	315	3,288	35,986,107	10,945	25,058,541
FURNITURE AND HOME FURNISHINGS STORES	57	412	3,382	82,647,061	24,437	38,036,552
EATING & DRINKING PLACES	58	1,070	19,947	213,376,801	10,697	161,789,414
MISCELLANEOUS RETAIL	59	854	6,727	108,972,932	16,199	59,848,225
FINANCE, INSURANCE AND REAL ESTATE		1,529	16,544	553,186,363	33,437	205,559,017
DEPOSITORY INSTITUTIONS	60	211	4,583	131,507,292	28,695	55,927,876
NONDEPOSITORY INSTITUTIONS	61	135	1,564	52,884,154	33,813	19,298,092
SECURITY AND COMMODITY BROKERS	62	69	475	31,852,441	67,058	6,416,255
INSURANCE CARRIERS	63	180	4,859	187,166,062	38,519	62,992,868
INSURANCE AGENTS, BROKERS & SERVICE	64	314	1,394	43,174,056	30,971	16,949,135
REAL ESTATE	65	594	3,420	96,134,168	28,109	41,014,866
HOLDING AND OTHER INVESTMENT OFFICES	67	26	249	10,468,190	42,041	2,959,925
SERVICES		6,818	86,773	2,176,540,153	25,083 $	907,318,062
HOTELS AND OTHER LODGING PLACES	70	85	3,530	47,790,152	13,538	35,535,100
PERSONAL SERVICES	72	423	3,092	45,482,927	14,710	29,708,430
BUSINESS SERVICES	73	1,657	33,943	755,304,218	22,252	385,020,861
AUTO REPAIR, SERVICES AND PARKING	75	400	2,745	54,702,314	19,928	31,388,810
MISCELLANEOUS REPAIR SERVICES	76	154	562	13,481,648	23,989	6,944,143
MOTION PICTURES	78	86	825	8,338,431	10,107	5,566,642
AMUSEMENT & RECREATION SERVICES	79	225	2,874	34,439,594	11,983	22,271,213
HEALTH SERVICES	80	938	14,856	526,376,423	35,432	142,065,023
LEGAL SERVICES	81	314	2,524	100,144,523	39,677	31,830,950
EDUCATIONAL SERVICES	82	97	2,634	55,434,009	21,046	10,419,505

SOCIAL SERVICES	83	329	6,269	87,356,093	13,935	49,532,778
MUSEUMS, BOTANICAL & ZOOLOGICAL GARDENS	84	4	22	288,297	13,104	168,927
MEMBERSHIP ORGANIZATIONS	86	219	2,460	49,372,714	20,070	20,647,685
ENGINEERING & MANAGEMENT SERVICES	87	1,140	9,632	388,403,804	40,324	128,902,309
PRIVATE HOUSEHOLDS	88	724	772	8,430,694	10,921	6,792,679
MISCELLANEOUS SERVICES	89	23	34	1,194,312	35,127	523,007
NONCLASSIFIABLE ESTABLISHMENTS	99	0	0	0	0	0
GOVERNMENT		363	59,149	1,767,346,245	29,880	346,744
FEDERAL GOVERNMENT		88	3,675	154,549,311	42,054	0
STATE GOVERNMENT		126	33,809	1,029,958,128	30,464	181,933
LOCAL GOVERNMENT		149	21,666	582,838,806	26,901	164,811

"*" IN TABLES INDICATES DISCLOSURE SUPPRESSION.

WORK FIRST: PATHWAYS TO EMPLOYMENT
QUESTIONS AND ANSWERS

This document has been developed by the North Carolina Community College System and the North Carolina Division of Social Services in response to questions regarding Work First training. It is intended to provide assistance in the coordination and implementation of the Work First "Pathways to Employment" training model. If you need further clarification or have additional questions, please contact the appropriate individual listed on page 9 of this document.

I. NORTH CAROLINA DIVISION OF SOCIAL SERVICES (DSS)

A. PROGRAM COORDINATION, IMPLEMENTATION, AND PARTICIPATION

Q1. ***Who at each local DSS will be responsible for coordinating the "Pathways to Employment" model?***

A1. The county DSS director will identify a staff person to coordinate this model, and will inform their local community college. Under most circumstances, the Work First Employment Supervisor will be responsible for overseeing this model. In larger counties, a program manager or administrator may assume this role. In our smaller counties, the county director or a Work First Employment Case Manager may coordinate directly with their community college partners.

Q2. ***How will case management be accomplished at the local level to ensure success?***

A2. Local case managers will work closely with community college staff to ensure successful participation in these short-term training programs. Case managers will communicate frequently with the classroom instructor to monitor attendance, overall performance, and compliance with the client's Personal Responsibility Contract.

Q3. ***Is Basic Skills an allowable activity for Work First clients?***

A3. Basic Skills training <u>is</u> an allowable activity under Work First.

Q4. ***Is Adult High School (AHS) and General Educational Development (GED) eligible Work First activities?***

A4. Participation in AHS and GED programs <u>are</u> eligible Work First activities.

Q5. ***How is HRD classified under "allowable" activities...Job Readiness Training or Vocational Educational Training?***

A5. HRD, as a stand-alone activity, is considered a DSS Job Readiness/Job Search activity. If HRD is integrated with a training component (i.e., Nurse's Aide Training and HRD), that combined activity should be classified as DSS Vocational Educational Training.

Q6. ***What are the time limitations for Work First clients to participate in a training component?***

A6. There are no time limitations for Work First clients to participate in a training component. Local DSS staff begin stressing the importance of obtaining a high school diploma, GED, and other short-term training activities at the initial application for assistance. That message is continually reinforced as families prepare for more intensive employment services.

Since January 1997, all Work First families are limited to a lifetime of five years of cash assistance. Families receiving intensive employment services are restricted to two-year periods of eligibility of cash assistance (within their lifetime cap of five years). Understandably, these time limits should be considered when developing a training plan.

The new federal, welfare reform law establishes a limitation on the length and type of training activities that "count" toward the mandated participation rates. While the new federal law restricts the length in some training activities, local departments of social services are free to support training beyond the federal limitations.

Q7. ***Are all Work First clients required to be registered for work at the Employment Security Commission (ESC) or JobLink Center for placement?***

A7. Not at this time; however, the policy to implement this change in state law is under development.

Q8. ***How is Work First different from the JOBS Program?***

A8. The former JOBS Program was a "human capital investment" model that focused upon long-term training, while Work First is a "labor-force attachment" model that focuses upon a combination of work and work-related activities. Participation in Work First is more intensive - requiring a minimum of 30 hours of weekly participation (the JOBS Program encouraged 15-20 hours of participation). Under Work First, more case managers are serving more families. And, these case managers work as a team in an agency-wide effort to prepare families for work and "life without welfare."

B. REFERRALS (From DSS to Community Colleges)

Q1. ***How will clients be referred to the program?***

A1. Clients will be referred by the DSS coordinator to the local community college coordinator.

Q2. ***How will DSS ensure that the clients referred to the program will be able to be successful in the program? Will DSS develop any suitable criteria for the target population?***

A2. Prior to referral to an outside agency, Work First clients undergo an intensive assessment. That effort examines a client's educational, work, social, and medical histories. It also identifies an array of vocational interests, aptitudes, and limitations. When completed, this assessment data is used to develop an individual self-sufficiency contract with each client. That contract identifies a realistic (*and attainable*) employment goal; services to be provided by the agency; and a mix of work and training activities to move that family toward independence and improved self-sufficiency. In essence, this contract is their "road map" while receiving time-limited cash assistance.

While no one can guarantee that a client will be "successful" in a training program, local staff will screen each client prior to referral to the local community college. That screening will be based upon assessment data, observed client motivation and interest, and local labor market demands.

Q3. ***When will clients with major problems (i.e., substance abuse, domestic violence, etc.) be referred?***

A3. This will be determined by each local DSS. Each case will be evaluated individually. It is very likely that substance abusers will be first referred to a local treatment program. In those cases, participation in a training activity may be deferred until a qualified substance abuse counselor determines that participation in a training program would more likely be effective and successful.

Q4. ***Will Work First "applicants" be referred prior to approval of their application?***

A4. Yes, applicants will be referred.

Q5. ***Can only Work First clients participate?***

A5. Local DSS staff will screen and refer numerous individuals for participation. The majority of those individuals will be Work First, others may be food stamps, Medicaid, and Child Support Enforcement clients. We also feel that these classes should be available to non-DSS clients such as JTPA, Vocational Rehabilitation, and JobLink; however, the local DSS would not cover the cost of their participation.

C. TRAINING COSTS

Q1. ***Who pays the training cost for Work First clients who are referred by DSS to a local community college?***

A1. The local DSS will cover the $35 occupational extension registration fee and all other applicable fees/costs associated with special training requirements for Work First clients who are referred by their agency to the local community college. The total cost of participation, when possible, should be limited to $100 or less, per client *(see North Carolina Community College System section, item E, page 6).*

II. NORTH CAROLINA COMMUNITY COLLEGE SYSTEM (NCCCS)

A. PROGRAM COORDINATION, IMPLEMENTATION, AND PARTICIPATION

Q1. ***Who in each community college will be responsible for coordinating the Work First model?***

A1. College presidents have been asked to identify a Work First contact at each college. Each college should inform their local DSS after the Work First contact has been selected.

Q2. ***Who determines what skill training areas should be offered?***

A2. Training needs should be determined based on the local labor market analysis. Local offices of the Employment Security Commission, Department of Social Services, and Service Delivery Area should jointly determine which training areas are appropriate for the community, based on current job openings. Input from local employers should be included in this process.

Q3. ***What happens if there are not enough clients referred at the same time to fill a class?***

A3. Clients may be referred to the "Self-Paced Individualized Instruction" component of the college to be assessed and begin individualized work until there are enough clients to fill a class. Consideration should also be given to individually placing Work First clients into regularly scheduled continuing education offerings.

Q4. ***Who will be responsible for organizing the "Self-Paced Individualized Instruction" component?***

A4. It depends on the individual college structure and the instruction needs of the Work First client. Based on identified need, it should be a collaborative endeavor involving the appropriate college personnel.

Q5. ***What if a client only needs one of the components of the "Pathways to Employment" training model?***

A5. Work First clients are not required to participate in all components of the training model. Training provided to a Work First client should be based on the workforce training needs of that client.

B. BASIC SKILLS

Q1. ***How does the NCCCS determine which job-specific basic skills competencies will be taught?***

A1. A job task analysis of the Occupational Extension courses should be conducted and appropriate competencies should be selected for instruction.

Q2. ***Who should conduct the job task analysis?***

A2. Job task analyses should be conducted by Basic Skills staff, preferably the instructors.

Q3. ***Can instructors be paid out of Basic Skills funds to conduct job task analyses and develop job-specific curricula?***

A3. Instructors may be paid to conduct job task analyses and develop job-specific curricula.

Q4. ***Who will train Basic Skills staff in conducting job task analyses and developing job-specific curricula?***

A4. Community college Basic Skills staff should contact Dr. Jay Camp at the System Office for free training in conducting job task analyses and developing job-specific curricula. The state is funding seven trainers to help with competency-based

instruction. These trainers, formerly known as the CASAS trainers, will train Basic Skills staff in these areas, even if the college does not use or plan to use CASAS.

Q5. ***Who will develop the curricula for the job-specific basic skills competencies?***

A5. Curriculum materials are already available for specific career areas (i.e., career curriculum by Thomas Sticht is published by Glencoe-McGraw-Hill). CASAS also has an index of published materials that cover job-specific competencies. Linda Ray and Mary Lou Garrison from Wake Technical Community College have written a book of generic curriculum, Basic Skills Workplace Lesson Plans, that can be adapted to many different occupations. The book is free of charge and will be distributed to all colleges. Basic Skills staff should also develop curricula for the programs.

C. HUMAN RESOURCES DEVELOPMENT (HRD)

Q1. ***What type of assessments (suitability, job readiness, academic, occupational) are needed to better serve Work First clients?***

A1. Either HRD or Basic Skills programs have the ability to provide various types of assessment for Work First clients. Local DSS programs should contact the director of either program for more details.

Q2. ***Should "Survival Skills for Women" be taught as a separate training component from the "Pathways to Employment" model?***

A2. Survival Skills for Women may either be a stand-alone training component or incorporated into existing HRD curriculum components depending on the time allotted for Work First clients to participate in a training activity.

D. OCCUPATIONAL EXTENSION

Q1. ***What is the cost of training for Occupational Extension courses?***

A1. The cost of training for Occupational Extension courses is a $35 registration fee *(see item E).*

Q2. ***Will only Work First clients be enrolled in Occupational Extension courses which have been designed as part of the "Pathways to Employment" training model?***

A2. Many of the courses designed for Work First training will include students from the general public as well as Work First referrals. If DSS identifies special training needed for Work First clients only, this can be developed through collaboration between the community college and DSS staff.

Q3. ***Are colleges limited to the job skills training courses listed in the "Pathways to Employment" training model?***

A3. No. The job skills training courses listed in the training model are only examples of the types of job-related training which could be offered. Colleges should develop

specific training courses based on a labor market analysis of their service area and in collaboration with DSS, ESC, SDA, and local employers.

E. TRAINING COSTS

Q1. ***What is the training cost for Work First clients and for non-Work First clients who are referred by DSS to a community college?***

A1. The cost is the same for both Work First clients and non-Work First clients. Any student registering for an Occupational Extension course will have to pay a $35 registration fee ***(which has been set by the General Assembly and approved by the State Board of Community Colleges),*** and additional fees/costs associated with special training requirements such as textbooks, accident/liability insurance, supplies, uniforms, immunizations, etc. **Students enrolling in Human Resources Development and Basic Skills programs will not have to pay a fee for training.**

F. UTILIZING OTHER RESOURCES

Q1. ***What other resources are available and how can they be utilized to assist with Work First Training?***

A1. The State's customized training programs -- Focused Industrial Training (FIT) and New and Expanding Industry Training (NEIT) -- are resources that can be used to provide customized job training for Work First clients. Both programs are employer-based, meaning that the programs are developed to meet the training needs of North Carolina employers.

The **FIT** program provides job-specific retraining in the manufacturing sector, and provides a funding resource for community colleges to provide manufacturing-related training to companies in cases where it would not be economically feasible through traditional continuing education programs. This is particularly the case when the training is either highly technical, or when there are small class sizes. If a manufacturing company requires customized job training for only a handful of new employees, who may be Work First clients, FIT resources provide a way in which the local college can provide that job-specific training.

The **NEIT** program provides training for companies hiring new production workers. To qualify for this program, a company must be creating 12 or more new production jobs. If any of those positions are filled by Work First clients, the local community college will provide free job training to support those new positions, and that training could be customized to meet any special needs required by Work First clients.

The Small Business Center Network **(SBCN)**, which is comprised of a Small Business Center at each of the community colleges, provides support for the growth of existing businesses and the development of new businesses by delivering business training, counseling, and information.

The SBCN offers *Education and Training* (free or low cost seminars/workshops and courses on business startup, management, marketing, advertising, record keeping, taxes, and finances; and training for small business employees in computer/software, communications, and interpersonal skills development); *Consultation and Referral* (one-on-one, confidential business counseling on business startup and business plan development with linkage to other local state and federal resources); *Resource and Information Center* (printed and audiovisual materials, computer software, computer network linkages, and teleconferencing capability for the existing or startup entrepreneur). For information on the Small Business Center nearest you, call your local community college.

The Work Opportunities Tax Credit **(WOTC)** program offers employers a credit against their tax liability for hiring individuals from seven target groups (Qualified IV-A Recipients, Qualified Veterans, Qualified Ex-Felons, High Risk Youth, Vocational Rehabilitation Referral, Qualified Summer Youth Employee, and Qualified Food Stamp Recipient) who have traditionally had difficulty obtaining and retaining jobs. For more information, contact your local Employment Security Commission.

The Worker Training Tax Credit **(WTTC)**, enacted by the North Carolina General Assembly in 1996 as part of the William S. Lee Quality Jobs Act, provides an incentive to companies to grow jobs and make investments in North Carolina. The WTTC provides a credit against State franchise or corporate income taxes for expenditures incurred by eligible companies in training their workers for new jobs, or for training workers as a result of investments in machinery and equipment. For more information, contact Scott Ralls at (919) 733-7051.

Low income working families can qualify to get more take home pay through the Earned Income Tax Credit **(EITC)**. The amount of EITC a family can receive depends on their income and the number of children in the household. A family can receive some portion of the EITC in advance with each paycheck and the rest when they file their tax return. The employer adds a portion to the credit to the paycheck. The amount of the credit is then subtracted from the federal withholding deposit. For more information, contact your local Department of Social Services.

G. COORDINATED JOB PLACEMENT

Q1. ***How will colleges know if local employers will hire Work First clients upon completion of the program?***

A1. Employers are crucial to the success of the "Pathways to Employment" model. It is suggested that local offices of DSS, ESC, and SDA engage in employer focus group discussions and that emphasis be placed on ensuring that Work First clients possess the skills employers want them to have before job referrals are made. JobLink Career Centers may assist in job placement and job development activities, as well as the Employment Security Commission and the SDA. Clearly, a locally-driven coordinated job placement strategy must be developed by the local partners.

Job development should be viewed as an ongoing effort. Meaning, these short-term training activities should include continual access to prospective employers, such as local employers' visits to the classroom and periodic "Job Fairs."

A critical strategy is to involve employers in the design of skills training classes offered and other planned activities. This will help to ensure the employers' commitment to hire trainees up front.

Q2. ***How does the "Pathways to Employment" model interact with the JobLink Career Center?***

A2. The JobLink Career Center (where available) should be used as a resource for job placement or job development upon completion of training by Work First clients. The JobLink Career Center may also refer clients to the college to participate in the "Pathways to Employment" training model.

If you need further clarification or have additional Work First questions pertaining to this document, please contact the appropriate individual listed below.

NORTH CAROLINA DIVISION OF SOCIAL SERVICES
325 N. Salisbury Street, Raleigh, NC 27603-5905 Tele: 919/733-7831 Fax: 919/715-5457
Contacts:
Ben Watts, Chief
Economic Independence Branch

Jane Smith, Chief
Work First Local Support

NORTH CAROLINA COMMUNITY COLLEGE SYSTEM
200 W. Jones Street, Raleigh, NC 27603-1379 Tele: 919/733-7051 Fax: 919/733-0680
Contacts:
Chuck Barham, Associate Vice President
Academic and Student Services

Barbara Boyce, Coordinator
Human Resources Development (HRD)

Stephanie Deese, Associate Director
Job Training Partnership Act (JTPA)

Peggy Graham, Associate Director
Continuing Education Services

Scott Ralls, Director
Economic Development (*which includes NEIT, FIT, SBCN*)

Randy Whitfield, Associate Director
Basic Skills and HRD Programs

Lynda Wilkins, Social Research Assistant
Academic and Student Services

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES — 10/23/97
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Thomas Vance Bennett	NCCFTF - Raleigh
J.Y. Mahoney	DHHS-Epid. Div.
Steve Cline	DHHS - Dental Health
J.D. Butts	DHHS - Medical Examiner
Earl Stewart	DHHS - DWCH
Lewis Woods	DHHS - DWCH
Jack Dewitt	" "
John Bowdish	Zeb Alley P.A.
Steve Martin	Div. of Epidemiology - DHHS
Stan Music	Occup & Environmental Epidemiology
Bill Pate	" " "
Lou Turner	State Laboratory of Public Health
Peter Andersen	DHHS - Div. of Community Health
Richard House	State Health Director's Office
Elizabeth Moore	DHHS - DWCH
Shirley J Ballard	DHHS - Off State Hlth Dir
Kevin Ryan	DHHS - DWCH

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES — 10/23/97
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Kaye Hunter	DHHS- DWCH
Jerry Wilkerson	DHHS - DWCH - RALEIGH
BARRY GOLDSTEIN	DHHS - DWCH - Raleigh
Dawn Comeau	NASW-NC
NELS ROSELAND	STATE BUDGET OFFICE
GL Holleday	DHHS - DCH
Alice Keith	DHNS - DWCN
Mary Greene	STATE BUDGET OFFICE
Bob CANUPP	DHHS - Epidemiology
Evelyn Foust	DHHS - Epidemiology
Barbara Fuller-Smith	DHHS - DCH
Joy Reed	DHHS - DCH
John Rustin	NCFPC

AGENDA

Joint Appropriations Subcommittee on Health & Human Services

December 16-18, 1997

Room 544 - Legislative Office Building

Tuesday, December 16th, 10:00 - 4:00 pm

10:00	State Children's Health Insurance Program Summary of the New Federal Program	Carol Shaw Fiscal Research Division
11:00	State Children's Health Insurance Program Other States' Proposals	Carol Shaw Fiscal Research Division

LUNCH (12:00 - 1:00)

1:00	Task Force on Child Health Insurance Final Report	Dr. Gordon DeFriese NC Institute of Medicine
2:00	Department of Health & Human Service's Proposal for Implementing the State Children's Health Insurance Program	Dr. H. David Bruton, Secretary Health & Human Services
3::30	State Employee's Health Plan - A Potential Option Authorized by Federal Law	Dave DeVries State Employee Health Plan

Joint Appropriations Subcommittee on Health & Human Services

December 16-18, 1997

Room 544 - Legislative Office Building

Wednesday, December 17th, 9:00 - 4:00 pm

9:00	Smart Start Program Update	Ashley Thrift, Chair NC Partnership for Children Board of Directors David Walker, Executive Director NC Partnership for Children, Inc. Karen Ponder, Program Director NC Partnership for Children, Inc.
11:00	Smart Start Program Evaluation	Donna Bryant, Ph.D., Director Family and Child Care Research Program Frank Porter Graham Child Development Center

LUNCH (12:00 - 1:00)

1:00	Child Care Subsidy: An Investment Strategy for NC	Sue Russell, Executive Director Day Care Services Association, Inc.
2:00	Child Care and Work First	Peter Leousis, Assistant Secretary for Human Services and Education Policy
3:00	Implementation of Senate Bill 929 ("Enhance Child Care")	Stephanie Fanjul, Director Division of Child Development

Joint Appropriations Subcommittee on Health & Human Services

December 16-18, 1997

Room 544 - Legislative Office Building

Thursday, December 18th , 900 - 12:00 pm

9:00	Medicaid Growth Reduction Plan Update	Dick Peruzzi, Director Division of Medical Assistance
10:00	Medicaid Dental Program	Dick Peruzzi, Director Division of Medical Assistance
10:45	Pharmaceutical Assistance Programs for the Low-Income Elderly	Stuart Bratesman, Jr. Duke Long Term Care Resources
11:15	Options for Making Prescription More Affordable for Older Adults	Lynne Perrin, Assistant Secretary Health & Human Services Bonnie Crammer, Special Assistant Health & Human Services

MINUTES

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

DECEMBER 16, 1997

Representative Charlotte Gardner chaired and convened the meeting at 10:05 a.m.. There were four Senators present and the following Representatives were present:

Representative Adams
Representative Berry
Representative Cansler
Representative Clary
Representative Earle
Representative Esposito
Representative Gardner
Representative Howard
Representative Hurley
Representative Nye
Representative Watson

Representative Gardner called upon Carol Shaw to give an overview of the Children's Health Insurance Program and a summary of the new federal program (see handout: "Understanding the New Children's Health Program").

Representative Gardner asked that staff research the Healthy Kids Program to compare to North Carolina's.

Sen. Clark inquired about what type of impact federal/state participation would have upon local participation. Carol Shaw stated it would be up to the state as to whether we would cost share. Senator Clark followed up with a question regarding the flexibility of states to do so. Carol confirmed that the state already has such flexibility.

Representative Nye asked if being eligible and having the option was the same. Carol clarified, by stating that a child of a state employee will not qualify.

Senator Phillips asked how many state employees meet the poverty level such that their children would qualify for health assistance or Medicaid. Carol suggested it would be difficult to determine because several factors would need to be established first, such as, if there was another income in the family and the number of children in that family. Senator Phillips suggested that it is deplorable, if we are trying to provide assistance to others, if we have state employees who are in need as well and cannot qualify.

Senator Martin asked if there were some states that looked at such a program/plan, but have not yet acted relative to waivers. Carol suggested that she only knew of Wisconsin as being one state who has not acted upon anything thus far. Senator Martin asked Dr. Bruton, relative to his experience, if he could add anything to what Carol had reported and he could not.

Carol proceeded with her presentation on "The State's Response to the New Children's Health Program" (see handout).

Upon conclusion of Carol's presentation, the committee voted to adjourn for an early lunch at 11:40 a.m., to reconvene at 12:45.

The committee reconvened at 12:45. Dr. DeFreise, with the North Carolina Institute of Medicine, gave a presentation on the Task Force on Child Health Insurance Final Report (see handout: "The North Carolina Institute of Medicine").

Senator Martin inquired about the wrap around insurance pool for children with special needs. There was discussion relative to the best approach to take with regard to outreach.

Tom Vitaglione responded to Senator Martin's question with regard to outreach and confirmed that outreach work is still ongoing, however, a strategy need to be developed on how to improve upon it and increase it.

Representative Cansler expressed concern relative to fairness of the crowd-out aspect of the plan. Representative Cansler suggested that we design a program which encourages people to contribute to program costs and not rely upon the state.

Representative Berry requested a list of the studies be provided to the committee relative to the crowdout.

Dr. DeFreise concluded his presentation, at which point Dr. Bruton began with his presentation of the Department of Health and Human Services proposal for implementing the State Children's Health Insurance Plan, to include a "Primary Recommendation-Implement A Non-Entitlement Insurance Program; Health Insurance and our Children; and Children's Health Insurance Program Cost Projection" (see handout) There were several services cited that the program would provide such as:

-Durable Medical Equipment
-Eyeglasses
-Hearing Aids
-Care Coordination
-Enabling Services

Representative Cansler asked why the plan could not start out at a lower percentage of poverty level for folks to qualify for insurance.

Senator Martin stated relative to eligibility determination, the report states the state should maintain a level of responsibility and he agrees. Dr. Bruton stated that he was talking about maintaining his current program of eligibility determination, but expanding outreach. Senator Martin also asked if it could be expanded to include family coverage. Dr. Bruton cited that it could not.

Senator Clark requested that DHHS prepare a breakout on county-by-county basis relative to county matching funds for Title 19. Representative Gardner suggested that she did not believe it would be possible, especially since the federal government did not require county matching funds, rather this a requirement of the General Assembly Ed Reagan, Deputy Director of the Association of County Commissioners, stated that the issue came before their association approximately three weeks prior to this meeting, and there is always concern about incurring more county costs, but that the program is acceptable as long as there is no county match requirement. Dr. Bruton indicated that no increase in county costs is proposed for the first year of the program.

Dr. DeVries gave his presentation on "State Employees' Health Plan-A Potential Option Authorized by Federal Law" (see handout).

The meeting adjourned at 3:40 p.m.

Charlotte Gardner

Representative Charlotte Gardner, Chairperson
Joint Subcommittee on Health and Human Services

Wanda C. Kay

Wanda C. Kay, Clerk
Joint Subcommittee on Health and Human Services

VISITOR REGISTRATION SHEET

Joint Appropriations Subcommittee on Health & Human Services Dec. 16-18, 1997

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Roz Sawicki	NC Child Care Coalition
Angie McMillan	DHHS
[illegible]	Parker Poe [illegible] & Bernstein
Thomas Vance Bennett	NCCFTF
Adam Searing	NCHAC
Sharon Hirsch	NC Assn of County Directors of Social Services
NELS ROSELAND	OFFICE OF STATE BUDGET
Stacy Flannery	NCANPHA
John Bowdish	Zeb Alley P.A.
John Rustin	NCFPC
Evelyn Hawthorne	NCHA

VISITOR REGISTRATION SHEET

Joint Appropriations Subcommittee on Health & Human Services Dec. 16-18, 1997

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tommy Worth	Carolina HealthCare System
Megan's Oyster	Easter Seals
N Yeager	OSBM
Mary Green	OSBM
Lee Kilbreath	DHHS
Bernard LaPine	SHHHS
Janis Ramquist	NC ADA
Robert Powell	OSBM
Pat Young	APPCNC / SCSL
Ann Wolfe	DHHS

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS - HHS — 12/16/97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR AGENCY AND ADDRESS
Paula A. Hoyt	Covenant W/NC's Children

1997

NORTH CAROLINA
Child Health Report Card

Grade: still C-

The health of North Carolina's children is not as good as it could or should be. However, all of these health problems can be overcome.

NORTH CAROLINA INSTITUTE OF MEDICINE

Citizens dedicated to improving the health of North Carolinians

IN COLLABORATION WITH:

Division of Women's and Children's Health,
North Carolina Department of Health and Human Services
North Carolina Area Health Education Centers Program
North Carolina Child Advocacy Institute
Wellness Council of North Carolina
North Carolina Child Fatality Task Force

HEALTH INDICATOR:	N.C. DATA	CHANGE FROM PREVIOUS YEAR	GRADE
Insurance (1997):[1]			
Number of uninsured children:			
All	222,913		D
Under age 1	7,321	(data	D
Age 1-5	57,595	unavailable)	D
Age 6-18	157,997		D
Access to Preventive Care (1996):[2]			
% of Medicaid-enrolled children (ages 0-18) receiving preventive care	47.8	(from 44.0)	C
Infant Mortality (1996):[3]			
Number of deaths per 1,000 live births:			
All	9.2	no change	C
White	7.1	(from 6.8)	B
Non-white	14.3	(from 15)	
Low Birth-Weight Infants (1996):[4]			
% of infants born weighing 5.5 lbs. or less:			
All	8.7	no change	C
White	6.8	no change	B
Non-white	13.3	(from 13.2)	D
Prenatal Care (1996):[5]			
% of mothers receiving prenatal care during first and second trimesters:			
All	83.4	(from 83)	B
White	87.7	(from 88)	B
Non-white	71.9	(from 71)	B
Immunization Rates (1996):[6]			
% of children with appropriate immunizations:			
At age 2	78	(from 84)	C
At school entry	98	no change	A
Communicable Diseases (1996):[7]			
Number of newly reported cases (ages 0-19):			
Syphilis, Gonorrhea, Chlamydia	12,634	(from 15,178)	
AIDS	24	(from 8)	D
Tuberculosis	34	(from 19)	D

HEALTH INDICATOR:	N.C. DATA	CHANGE FROM PREVIOUS YEAR	GRADE
Vaccine-Preventable Communicable Disease (1996):			
Number of cases:			
Measles	2	(from 0)	B
Mumps	17	(from 28)	B
Rubella	9	(from 0)	B
Diphtheria	0	no change	A
Pertussis	128	(from 115)	C
Tetanus	0	no change	A
Polio	0	no change	A
Environmental Health (1996):[8]			
% of children (age 12-24 months):			
Screened for lead levels	34.2	(from 31.2)	C
Screened having elevated blood lead	5.8	(from 6.7)	C
ntal Health (1996):			
f children:			
With one or more sealants, grades 5 and 6	28	(from 25)	C
With fluoridated water systems	89	(from 87)	B
Developmental Health (1996):[9]			
Number of children (age 0-3) enrolled in early intervention services to reduce effects of developmental delay, emotional disturbance and/of chronic illness	8,454	(from 7,593)	B
Child Abuse, Neglect and Dependency (1996-97)[10]			
	FY 96-97	**FY 95-96**	
Number of reports	60,687	(from 57,907)	D
Number of substantiated reports	19,512	(from 18,241)	D
Number of children affected in reports	102,168	(from 96,175)	D
Number of children affected in substantiated reports	33,133	(from 30,812)	D
	CY 96	**CY 95**	
Number of confirmed child deaths due to abuse	45	(from 18)	F
ildhood Fatality (1996):[11]			
mber of deaths (ages 0-18) per 100,000 children	90.7	(from 89)	C

Notes

1 Insurance: The number of uninsured children in NC was derived from an average of 1995 and 1996 Current Population Survey data which was adjusted to reflect true Medicaid enrollment and extrapolated to 1997 NC Population Projections. The number of uninsured children in low-income families (families below 200% of the Federal Poverty Guidelines) accounts for 62% of all uninsured children. The 1997 Balanced Budget Act included a provision to develop a Child Health Insurance Program designed to cover uninsured children under the age of 19 in low-income families. The NC Child Health Insurance Task Force, under charge by the Secretary of the NC DHHS, has prepared a proposal to the General Assembly that would cover uninsured, low-income children in NC under this new federal block grant matching program.

2 Access to Preventive Care: The percentage of Medicaid-enrolled children (ages 0-18) receiving preventive care increased 9% in 1996 for a three-year improvement of 50%. This increase can be attributed to the outreach efforts of the Health Check Initiative. The increase is even more significant because 150,000 more children have been enrolled in Medicaid over the past three years due to these efforts and the actions of the General Assembly.

3 Infant Mortality: While the total number of deaths per 1,000 live births has remained constant since 1995, it remains the lowest number ever reported in NC. It is still short, however, of the NC goal of 7.4 in the year 2000. In addition, while the number of non-white deaths has *decreased* slightly, the number of white deaths has *increased* slightly.

4 Low Birth-Weight Infants: Low birth-weight is often associated with increased risk of infant mortality. The percent of infants born weighing less than 5.5 lbs. has not changed in the past three years and remains a serious problem.

5 Prenatal Care: Infants whose mothers seek prenatal care in the first trimester (first 13 weeks) of pregnancy are less likely to be low birth-weight and are less likely to fall victim to infant mortality.

6 Immunization Rates: According to the American Academy of Pediatrics, the recommended schedule of immunizations for a child under age two includes: three doses of Hepatitis B, three doses of Diphtheria, Tetanus and Pertussis (DTP), three doses of H influenzae type b, two doses of Polio, one dose of Measles, Mumps and Rubella (MMR) and one dose of Varicella. Though NC showed significant improvement in 1995 of 29%, in 1996 it experienced a decline of 7%.

7 Communicable Diseases: The number of newly reported cases of Syphilis, Gonorrhea and Chlamydia decreased 17% in 1996 after increasing 13% in 1995. The number of reported new cases of AIDS increased an alarming 200% in 1996. Finally, the resurgence in newly reported Tuberculosis cases increased a dramatic 79% after experiencing a decline of 44% in 1995.

8 Environmental Health: Current policy recommends that all children between the ages of 12-24 months be screened for elevated lead levels [elevated defined as 10 micrograms/deciliter (Δ µg/dl) or higher]. The percentage of preschool children age 12-24 months that have been screened for elevated lead levels has increased steadily since 1994 by 34%. Education and intervention programs designed to heighten awareness of the effects of high lead levels on the physical and intellectual development of children has led to a decline in the number of reported cases of elevated lead levels by 13% in 1996.

9 Developmental Health: The number of children (age 0-3) enrolled in early intervention services has increased 11% in 1996 and 38% between 1994 and 1996.

10 Child Abuse, Neglect and Dependency: Data was provided by the NC Central Registry's Reports of Child Abuse, Neglect and Dependency and the NC Medical Examiner's Office. The number of substantiated reports are those investigated and confirmed. However, not all reports are investigated. Also, a single report often involves more than one child, therefore, the total number of children affected each year is significant--almost twice the number of actual reports. Finally, the number of confirmed deaths due to child abuse alone (not including deaths due to neglect) has increased an alarming 150% between calendar year 1995 and 1996.

11 Childhood Fatality: Between 1988 and 1995, childhood fatalities decreased dramatically by 25%. However, in 1996, childhood fatalities increased slightly by 2%. The NC Child Fatality Task Force was established by the General Assembly in an effort to study and make recommendations on ways to prevent childhood fatalities in the future.

12 Deaths Due to Injuries: In 1996, the rates of all unintentional deaths due to injuries increased significantly, with the exception of drownings and motor vehicle-related deaths. For intentional deaths, the number of homicides increased 44%, while the number of suicides remained constant. In 1996, the number of *unintentional* deaths due to firearms *increased* 22%. However, over the four-year period of 1993 to 1996, the number of unintentional deaths by firearms *decreased* 23%.

13 Alcohol, Tobacco and Substance Abuse: The 1995 data were derived from the biennial Youth Risk Behavior Survey conducted by the NC Department of Public Instruction in cooperation with the Centers for Disease Control and Prevention. The percentage of 9th-12th graders who report having used smokeless tobacco and beer in the past 30 days declined 17% and 9%, respectively, between 1993 and 1995. However, the percentage of 9th-12th graders who reported using cigarettes increased 7% and the use of marijuana increased 47%. While the increase in marijuana use is significant, it pales in comparison to the 100% increase reported nationally. The reported use of cocaine by the same group in the same time period remained the same.

Physical Fitness: The percentage of 9th-12th graders who report exercising at least 20 minutes per day, for a minimum of 3 days per week has increased only slightly to 61.3% in 1996.

14 Nutrition: The children represented by these data are those who receive services in a local health department sponsored clinic and may not be representative of the state as a whole. Overweight is conservatively defined as a weight for height (2-4 years old) or a body mass index (5-18 years old) greater than or equal to the 95th percentile. Concern about overweight prevalence occurs when it exceeds 5%. This data shows that for these children, NC has three times the expected number of overweight preschoolers, more than three times the expected number of overweight school-age children and more than four times the expected number of overweight teens.

15 Teen Pregnancy: Overall, the number of pregnancies per 1,000 girls (ages 15-17) dropped 6% in 1996 after a three-year increase between 1993 and 1995 of 11% and is nearing the NC goal of 63. However, the number of nonwhite pregnancies (101.3/1,000) is 107% higher than the number of white pregnancies (49.0/1,000), remaining a cause for concern as it is far from the NC goal of 86.7.

Grading Method: While not statistically derived, letter grades were determined as follows:

A = >25% improvement or current status remains very good

B = <25% improvement or current status remains satisfactory

C = no significant change or current status remains mediocre

D = <25% worse or current status remains unsatisfactory

F = >25% worse or current status remains very bad

HEALTH INDICATOR:	N.C. DATA	CHANGE FROM PREVIOUS YEAR	GRADE
Deaths Due to Injuries (1996):[12]			
Number of deaths (ages 0-18):			
Unintentional			
Motor vehicle-related	182	(from 180)	C
Drowning	35	no change	C
Fire/Burns	33	(from 23)	D
Firearm	11	(from 9)	D
Bicycle	18	(from 10)	D
Intentional			
Suicide	37	no change	D
Homicide	69	(from 48)	F
Alcohol, Tobacco and Substance Abuse (1995):[13]			
% students (grades 9-12) who used the following in the past 30 days:			
Cigarettes	31.3	(from 29.3)	[illegible]
Smokeless Tobacco	9.2	(from 11.1)	
Marijuana	21.7	(from 14.8)	D
Alcohol (beer)	39.7	(from 43.7)	D
Cocaine	2.2	no change	D
Physical Fitness (1995):[13]			
% (grades 9-12) who exercised at least 20 minutes per day for at least 3 days in the past week	61.3	(from 59.1)	C
Nutrition (1996):[14]			
% of low-income children who are overweight:			
Age 0-4	15.0	(from 10.7)	D
Age 5-11	16.5	(from 14.0)	D
Age 12-18 (1988-96)	21.7	(data unavailable)	C
Teen Pregnancies (1995):[15]			
Number of pregnancies per 1,000 girls (ages 15-17):			
All	65.0	(from 69.1)	C
White	49.0	(from 50.7)	C
Non-White	101.3	(from 111.7)	[illegible]

THE 1997 NORTH CAROLINA CHILD HEALTH REPORT CARD

was developed by the North Carolina Institute of Medicine. Data were compiled by Thomas Vitaglione, MPH, with the Division of Women's and Children's Health at the NC Department of Health and Human Services (DHHS). Data sources include the health divisions of NCDHHS and the State Center for Health and Environmental Statistics. Graphic design was by Carolyn Busse, Communications Coordinator at the Cecil G. Sheps Center for Health Services Research of the University of North Carolina at Chapel Hill.

12/16/97 pm

Why Provide Health Insurance?

Studies show the uninsured:

- have no regular source of care
- are more reliant on costly emergency rooms
- have fewer well-child visits
- are less likely to be fully-immunized
- have reduced access to care for illnesses and injuries

Health Care Makes A Difference

- **Decreased low birthweight**
- **Decreased illness**
- **Decreased mortality**
- **Early intervention is more effective**

N.C. Child Health Insurance Task Force

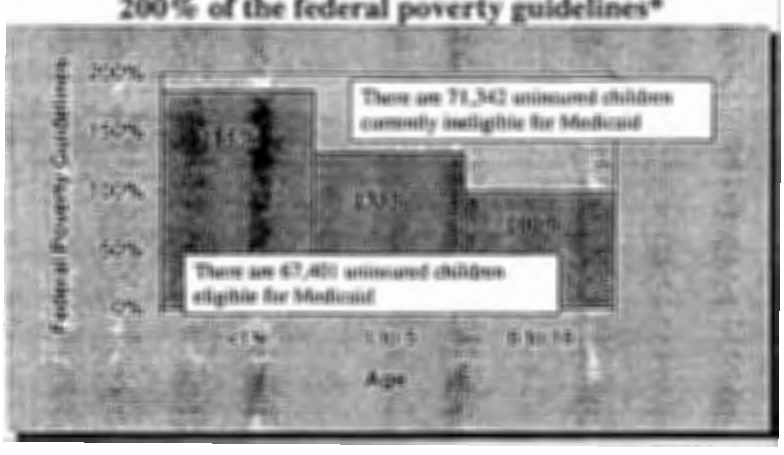
- Secretary Bruton asked N.C. Institute of Medicine to organize a statewide task force.
- Chaired by Gordon H. DeFriese, President., N.C. Institute of Medicine
- Members included more than 60 representatives of:
  - health providers
  - insurers and managed care organizations
  - state and county government
  - private organizations and charities
  - consumer representatives
- Task Force members made recommendations if reached consensus; otherwise presented options to Secretary Bruton

Task Force Guiding Principles

- To create a health insurance program that provides children access to quality, affordable health care
- To create a program that is seamless, simple to understand and use, operates on a statewide basis, builds upon the existing infrastructure, and contains accountability and oversight mechanisms.

Uninsured Children In NC

There are an estimated 138,743 uninsured children below 200% of the federal poverty guidelines*



* There are an estimated 7,800 uninsured children with family incomes below 200% of the federal poverty guidelines who are dependents of state employees or teachers

Task Force Considerations

- Basic Program Options
- Administration
- Benefits Package
- Cost Sharing
- Delivery System
- Access, Quality Assurance and Consumer Protections
- Crowd-out

Basic Program Options

- **Medicaid expansion**
  - can cover dependents of state employees and public school employees
  - low administrative costs (approx. 4%)
  - greater purchasing leverage as Medicaid currently covers approximately 435,000 children
  - easier for families with multiple children
  - can be implemented quickly
- **New Child Health Insurance Program**
  - state's fiscal liability is fixed
- **Combination of both**
  - can focus Medicaid entitlement on those with greatest need, state's fiscal liability is fixed

Administration

- **Task Force members agreed that state should administer CHIP program with primary responsibility for:**
  - planning and program design
  - eligibility, outreach and marketing
  - benefits education
  - quality assurance and evaluation
- **State should simplify Medicaid application and eligibility process and apply same rules to Title XXI program**
  - simplified application form, presumptive eligibility
  - 12 month guaranteed eligibility
- **State can use up to 10% of federal allocation for administration, outreach and marketing costs.**

Benefits Package

- **Task Force examined 5 benefits packages:**
  - Medicaid
  - State Employees Health Plan
  - Federal Employees Health Benefit Plan (BCBS PPO option)
  - Healthsource Advantage and BCBS PCP (most commonly purchased HMO plans in NC)
- **Focused in on Medicaid and State Employees Health Plan**

Benefits Package (cont'd)

Task Force concerned about children with special needs.

- National studies suggest that 10-15% of all children have special needs, including:
  - mental retardation
  - cerebral palsy
  - emotional disorders
  - epilepsy
  - sickle cell
  - vision, hearing impairments
- Medicaid benefits package is most comprehensive, designed largely to meet needs of children, including children with special needs

Task Force Supportive of Using Medicaid Benefits Package

Major Differences between Medicaid and State Employees Health Plan

	Medicaid	State Health Plan
Vision screening	Covered	To be added
Eyeglasses	Covered	Not covered
Hearing Aids	Covered	Not covered
Dental	Covered	To be added
Enabling/home visiting services	Covered	Not covered
Durable medical equipment	Covered	Restricted*
Special Therapies	Covered	Restricted*

* Covered only when child's condition is improving substantially

Medicaid Benefits Package is Better Value

William Mercer, Inc. actuaries found that the Medicaid and the modified State Employees Health Plan cost about the same, but the Medicaid benefits package is more comprehensive.

- Medicaid costs per member per month: $104
- Modified state employees health plan pmpm: $108

Cost Sharing Options

- Federal law establishes different cost-sharing requirements for families with incomes above/below 150% of federal poverty guidelines
- Task Force considered imposition of:
  - monthly premiums
  - one-time annual enrollment fee and/or
  - copayments
- No cost sharing allowed for preventive services
- Total out-of-pocket costs cannot exceed 5% of family's income

Cost Sharing Options (cont'd)

Previous studies suggest that cost sharing may deter unnecessary utilization, but may also deter enrollment and utilization of medically necessary services.

- Even moderately priced premiums tends to deter significant numbers of low and moderate income families from participating in publicly subsidized programs
- Collection of monthly premiums administratively complex and expensive
- Cost sharing deters both necessary and unnecessary care; low income children most likely to suffer from imposition of cost-sharing

Cost Sharing Options (cont'd)

Task Force suggested Secretary consider the following:

- **Families with incomes below 150% FPG**
  - No cost-sharing or premiums of any kind, OR
  - Modest annual enrollment fee to be paid one time each year (federal law prohibits imposition of copayments)
- **Families with incomes at or above 150%**
  - No cost-sharing or premiums of any kind, OR
  - Modest annual enrollment fee; copayments imposed for non-emergency use of emergency room, brand-name medications and outpatient visits

Delivery System Options

Task Force considered three options:

- Operate the program through Medicaid system; state will establish premium price and allow any managed care organization to participate if meets state's quality, access and benefits standards
- Contract out program to lowest cost bidder or bidders
- Create a voucher program and allow recipients to choose from competing health plans

Delivery System Options (cont'd)

Task Force evaluation criteria:

- existence of operational administrative structure
- recipients have choice of plans
- recipients have choice of providers
- ease of implementation
- ability to interface with Medicaid
- cost-effective
- seamless for families
- ability to track utilization and monitor quality
- ability to operate the system statewide
- simple to understand for families

Delivery System Options (cont'd)

Each delivery system had different advantages and disadvantages, however:

- Administering the program through the Division of Medical Assistance with managed care organization participation was generally ranked higher, because easier to implement, cost-effective, and seamless for families.

Access, Quality Assurance and Consumer Protections

Must develop performance mechanisms to assure the program provides accessible, high-quality health care services

- Should build on existing quality assessment tools such as NCQA HEDIS standards or HCFA's Quality Assurance Reform Initiative
- Must include adequate due process measures

Crowd-Out Policies

- States cannot use Title XXI funds to cover children who currently have private health insurance coverage. Must show how state will ensure insurance provided under the plan does not substitute for existing coverage.
- Experience of states with expanded coverage for children have shown very little actual "crowd-out" effect.
  - Minnesota: 7%
  - National study tracking same poor and near poor individuals: negligible
- Other studies which have looked at trends in private health insurance coverage have suggested crowd-out may be much higher (estimates range as high as 50%). However, these studies do not track same individuals over time.

Crowd Out Policies (cont'd)

Difficult to know what portion of drop in private health insurance coverage is attributable to availability of publicly-subsidized health insurance, and what portion is due to external factors:

- changes in the economy (recessions)
- rising costs of health insurance coverage making coverage unaffordable
- changes in the workforce (more employees working in part-time jobs or for employers who do not offer health insurance)

Crowd-Out Recommendations

- **Strict crowd-out policies may have harmful effects**
  - difficult administratively to verify and enforce
  - could defeat purpose of providing coverage to poor and near-poor uninsured children
- **Task Force recommended that state study impact of new coverage on private insurance coverage before imposing strict restrictions.**
  - If significant percentage of new enrollees drop private insurance coverage, then the state can create more restrictive policies

North Carolina Can't Afford to Wait

- State must submit state plan to HCFA and have it approved by September 30, 1998 in order to receive $79.5 million federal allotment
  - HCFA has 90 days to approve state plan after it has been submitted, but the time limit can be extended if HCFA has questions
- Therefore, the state can't afford to wait until the end of the 1998 legislative session to submit the state plan

NC has a Great Opportunity to Expand Health Insurance Coverage to Uninsured Children

North Carolina can design a system which is fiscally prudent while at the same time, providing comprehensive coverage to the greatest numbers of uninsured children.

- The new program should be closely aligned with the Medicaid system, should be simple for families to understand and use, and available statewide.
- The state should conduct extensive outreach and marketing efforts to ensure that families learn about the new program.

12/16/97 pm

FACTS ABOUT UNINSURED CHILDREN

July 1997

National Maternal and Child Health Policy Consortium

Georgetown University
Johns Hopkins University
Maternal and Child Health Bureau
University of California at Los Angeles
University of California at San Francisco

FACTS ABOUT UNINSURED CHILDREN

TEN MILLION CHILDREN (NEARLY 14% OF ALL CHILDREN, AGES 0-17) HAVE NO HEALTH INSURANCE IN THE UNITED STATES*

TRENDS IN HEALTH INSURANCE FOR CHILDREN

- **Employer Insurance Declining:** During the 1987-1995 period there were substantial shifts in the source of health insurance for children. Between 1987 and 1995 the percentage of children with employer-based health insurance declined from 66.7% to 58.6% of all children, while in the same period the percentage of children with Medicaid increased from 15.5% to 23.2%.[2]

- **Long Term Decline Continues:** Current trends represent a continuation of a long-term decline. Between 1977 and 1987 employer-based private health insurance coverage for children declined by 4.8%.[3]

- **Medicaid Holds Uninsurance Rate Constant:** In recent years, as employer-based coverage of children has declined, increases in Medicaid enrollment have held the total number of uninsured children relatively constant.[4] Medicaid may not continue to balance losses of employer insurance in the future, if Medicaid spending is capped through a per capita spending limit or a block grant.

PRIVATELY INSURED CHILDREN (0-17 YEARS)

- In 1995 the number of children who had private insurance (exclusively) was estimated to be 43.1 million (61.2% of all children).[1]

- Most privately insured children (89%) receive insurance through their parents* employer, but such coverage, when available, is increasingly expensive, requiring parental copayments.[1]

- The percentage of medium and large employers fully covering their employee's family coverage has dropped from 54% in 1980 to 21% in 1993.[5]

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* Numbers reported in this fact sheet are for children of the ages 0 to 17, unless otherwise noted. The American Academy of Pediatrics and U.S. government agencies may report values for children of the ages 0 to 21, or for other age ranges, yielding different estimates of the total number of uninsured children.

PUBLICLY INSURED CHILDREN (0-17 YEARS)

- In 1995 the number of children with all forms of public insurance was estimated to be 18.8 million (26.4% of all children). The number of children with Medicaid was estimated to be 16.5 million in 1995.[1]

- About one half of all Medicaid recipients are children but children consume much less than half of all Medicaid dollars.[1]

- Medicaid currently insures 23% of all children and 33% of all infants in the U.S.[1]
- Most children who receive Medicaid (62%) have at least one working parent.[6]

- Children covered by Medicaid often experience problems with continuity of care when eligibility status changes as their parents financial situation temporarily changes.[19] Changes in eligibility are a particularly significant problem as children move into managed Medicaid programs which rely on uninterrupted enrollment to maximize population health.

- Medicaid has played an important role in closing the access gap for many poor children, increasing their utilization of health services to levels similar to those of privately insured children.[20]

UNINSURED CHILDREN (0-17 YEARS)

- It is estimated that 9.8 million children (14%) have no insurance.[1]

- The number of uninsured children increased by 1.2 million children between 1987 and 1994.[6]

- Most (6.9 million) uninsured children live in families below 200% of poverty ($25,960 for a family of three).[1]

- Many (3.6 million) uninsured children live in families between 100% and 200% of poverty, families that have been characterized as the "working poor" and in which parents work in service sector, construction or agriculture jobs that neither provide health insurance benefits, nor enable them to afford insurance.[1]

- A significant number of uninsured children (30%) are eligible for Medicaid, but are not enrolled in the program.[4]

- In 1995 an estimated 80.3% of uninsured children lived in families that had at least one parent who works part-time or full-time, for all or part of the year. Moreover, about 63.4% of uninsured children lived in families whose head of household was employed year round (full-time or part-time).[1]

- In 1992, non-Hispanic white children made up the majority of the uninsured child population.[5]

*The Consequences of Having No Insurance**

Reduced Care When Sick: Uninsured children are less likely to have their health problems treated and less likely to receive medical care from a physician when necessary. For example, uninsured children obtain care half as often for acute earache, recurrent ear infection, pharyngitis, and asthma as do children with public or private coverage.[9]

Reduced Care for Injuries: Children with no insurance are less likely than those with insurance to receive care for injuries.[10]

Reduced Hospital Services: Uninsured sick newborns receive fewer services in the hospital than those with health coverage.[11]

Reduced Medical Visits: Uninsured children are 2.3 times less likely to have obtained a medical care visit in the past twelve months than are insured children.[12]

Reduced Well-Child Visits: During the course of a year fewer than half (44.8%) of uninsured preschool children have any well-child visits, and fewer than one-third receive their age-appropriate recommended schedule of visits.[13]

No Regular Source of Care: Uninsured children are seven times as likely as insured children to be without a source of routine health care,[12] and when they obtain health services they are far more likely than insured children to utilize high cost hospital emergency rooms or clinics as their usual source of care.[14] Health insurance can help assure access to a regular source of care.[15]

Reduced Immunization: Nationwide, uninsured preschoolers are less likely than insured preschoolers to be fully immunized.[14] Every $1 invested in immunizations saves, on average, $10.00 ($2.10-$14.40) in costs for hospitalizations and other treatment.[16]

Reduced Dental Care: Uninsured children are 2.5 times less likely to obtain dental care than are insured children.[17]

The Health Value of Insurance

Decreased Low Birthweight: Expansions of Medicaid in the late 1980s were associated with a decreased number of low birthweight births, with improved access to health care for pregnant women and with declines in infant mortality.[18]

Decreased Illness: Uninsured newborns have been shown to be more likely to be sick than are those newborns with insurance coverage.[11]

Decreased Mortality: In comparison to the insured, uninsured individuals, including children (1-17), are more likely to be sick upon admission to a hospital, to use more resources during hospitalization, and to suffer from higher mortality rates while in the hospital.[22]

* The studies reported in this section rely on cross-sectional data. While longitudinal or experimental data would be preferable, at this time such studies do not exist.

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Maternal and Child Health Bureau

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FINAL REPORT
OF THE
TASK FORCE ON CHILD HEALTH INSURANCE
TO THE
SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

November, 1997

BACKGROUND

In June, 1997, the Secretary of the North Carolina Department of Health and Human Services, the Honorable H. David Bruton, charged the North Carolina Institute of Medicine and the Division of Women's and Children's Health to form a Task Force on Child Health Insurance.[1] The Task Force, chaired by Dr. Gordon H. DeFriese, President of the Institute of Medicine, included representatives of organizations and constituencies around the state having an interest in child health issues (See Appendix A for Task Force listing).[2] The Task Force met six times between the middle of June and the end of October, while subcommittees held additional meetings to deliberate on specific issues.

The work of the Task Force took on more urgency with the passage of the Child Health Insurance Program as part of the Balanced Budget Act of 1997. The number of constituencies represented on the Task Force increased substantially over the course of the meetings, and included representatives of state and local governmental agencies, private health care providers,

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[1] Prior to the Secretary's charge to the N.C. Institute of Medicine, there were two private initiatives to expand health insurance coverage to uninsured children. The N.C. Caring Program, a private-public partnership with Blue Cross Blue Shield, has been operational for ten years. The Caring Program receives approximately $1.0 million each year from the N.C. General Assembly along with private contributions which enables the program to cover approximately 7,000 children with a low-cost limited primary care benefits package. Healthy Kids of North Carolina, Inc. was a separate non-profit initiative aimed at providing low -cost health insurance coverage to children eligible for the free or reduced lunch programs. Healthy Kids, a coalition of consumers, providers and managed care organizations, approached the N.C. Division of Women's and Children's Health to encourage them to apply for a Robert Wood Johnson Foundation grant to replicate the Florida Healthy Kids demonstration program in North Carolina. The group pulled together for the Robert Wood Johnson proposal grew into the Secretary's Task Force.

[2] The Task Force on Child Health Insurance wishes to express its gratitude to Pam Silberman, J.D., Dr.P.H. of the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, and to Tom Vitaglione, MPH, Chief, Children and Youth Section, Division of Women's and Children's Health, North Carolina Department of Health and Human Services, for their staff assistance during the process through which this report was prepared. The Task Force is also grateful to Thomas C. Ricketts, III, Ph.D., Deputy Director for Policy Analysis, and Ms. Ann Howard, Systems Analyst, of the Sheps Center at UNC-Chapel Hill and to Christopher Conover, Ph.D., of the Center for Health Policy, Law and Management at Duke University for their expert and timely analysis of state and federal data pertinent to the number of uninsured children in this state. The Task Force also wishes to thank Aimee Briggs, J.D., Jean Hetherington, J.D., MPH, and Gus Papas, M.D., students at the School of Public Health at UNC-Chapel Hill, for their assistance in providing some of the research used for the Task Force deliberations.

health insurers, managed care organizations, academic health centers, and child advocacy organizations. Although no formal "votes" were cast, genuine efforts were made to ascertain all points of view, to hear about the child health care activities of all public and private agencies and organizations, and to debate the relative merits of all alternative pathways to provide health insurance coverage for North Carolina's uninsured children.

This report presents the major policy choices facing the state in enacting child health insurance coverage. The information provided in this report will enable policy makers to make expeditious and educated decisions on how to implement the provisions of the new Child Health Insurance Program. The Task Force believes that this is the most opportune time in the past 30 years to take such a bold initiative in the interest of North Carolina's children.

PROGRAM GOALS

The Task Force members agreed that the ultimate goal for the new program is to provide children in North Carolina with access to quality, affordable health care. Therefore, the state should define eligible children broadly to reach as many uninsured children as possible. The program should help increase the utilization of preventive health services in order to improve the general health status of children and reduce program costs over the long term. The program should be "seamless" and allow families to participate easily. Adequate information and counseling should be provided so that families understand all their program options, and how to utilize services appropriately. Families should be allowed to enroll all of their children as members of a family unit—therefore, to the extent possible, eligibility and benefits should be consistent for all children in a family and not vary by the age of the child. The program should be built upon the existing state and local infrastructure, so as not to create duplicative administrative structures and higher costs. The new Child Health Insurance Program must include accountability and oversight structures, as well as an evaluation mechanism to assess the effectiveness of the system. Adequate resources should be made available to ensure the success of the program.

OVERVIEW OF THE FEDERAL LEGISLATION

Congress created a new child health insurance block-grant program as part of the Balanced Budget Act of 1997.[3] The program was enacted as Title XXI of the Social Security Act. The federal legislation appropriates $39.6 billion over the next ten years to expand health insurance coverage for uninsured children under age 19 in families with incomes up to 200% of the federal poverty guidelines ($26,600 for a family of three in 1997; this is the equivalent of two workers each earning $6.50/hr.).[4] States are basically given three options: 1) they can

[3] P.L. 105-33.

[4] The legislation authorizes states to cover children up to 200% of the federal poverty guidelines, or 50 percentage points above its current Medicaid income guidelines, whichever is higher. This means that North Carolina could choose to cover infants under age one up to 235% of the federal poverty guidelines (as the state already covers all infants with family incomes up to 185% of the federal poverty guidelines).

expand Medicaid; 2) they can create a new state child health insurance program; or 3) they can implement a combination of both.

Title XXI, like Medicaid, is funded jointly by the federal and state governments. However, states are entitled to an enhanced matching rate under Title XXI to pay for the expanded coverage for children. In North Carolina, the federal government will pay for 74.1% of program costs up to a federal maximum allotment of $79.5 million in FY 1998 (compared to the regular Medicaid matching rate of 63.0%).[5] The state is expected to match the new federal monies.[6] As much as 10% of the federal funds may be used for program administration, outreach efforts, and payment for direct provision of services. If the state chooses to establish a new child health insurance program, it will be limited to the Title XXI federal allotment. However, if the state chooses to expand Medicaid, it may continue to draw down federal monies at the regular Medicaid matching rate if Title XXI enhanced funds are exhausted.

Certain children are ineligible for coverage under the new Title XXI program. States may not use the new money to cover children who presently have private health insurance coverage. Further, states may not use the enhanced federal funds to cover children who are already eligible for Medicaid.[7] In fact, states must screen potential eligibles to determine if they are eligible for Medicaid coverage, and if so, must enroll them in Medicaid. States that choose to establish a new child health insurance program may not use the funds to cover children who are members of a family that is eligible for health benefits coverage under a state health benefits plan, although such limitation does not apply if the state chooses to expand Medicaid coverage.[8]

In order to receive FY 98 federal monies, a state must submit a child health plan to the Secretary of Health and Human Services describing how it will implement the new child health block grant. The plan must describe the state's eligibility standards, the method for delivering services, the benefits package, the outreach plan, and the state's mechanism for monitoring quality and ensuring access. The plan must be approved before September 30, 1998 for the state to receive its 1998 allotment. The state has up to three years to expend each annual allotment of federal funds.

ESTIMATING THE UNINSURED

Low income children, defined as those with family incomes below 200% of the federal poverty guidelines, obtain health insurance coverage through a variety of methods. Some children in North Carolina obtain group health insurance coverage as dependents of working

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[5] The amount of the state's allotment is based on the state's numbers of uninsured children as reported in the Current Population Survey (CPS).

[6] States are expected to match federal Child Health Insurance funds. If the program spent the full $79.5 million in FY 1998, then North Carolina would be expected to provide $27.6 million as the state match. However, the expected expenditures for the first year should be considerably less (see p. 23).

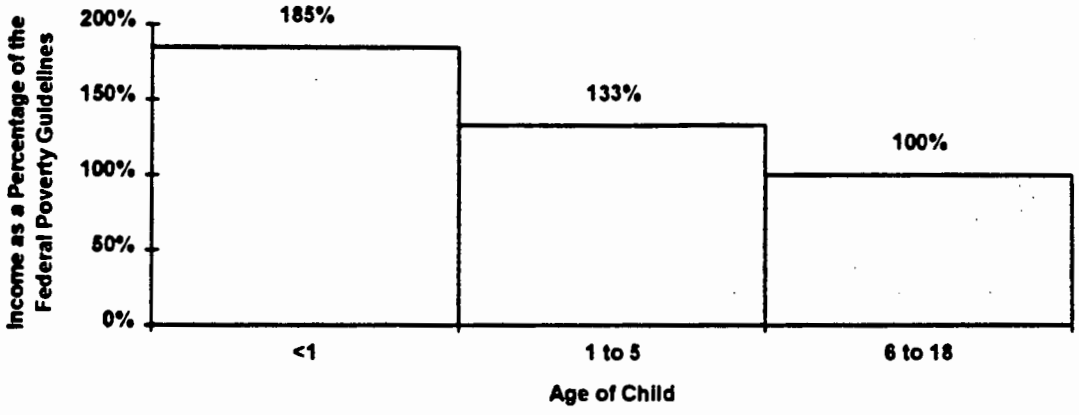
[7] In determining whether the child is eligible for Medicaid, states must use the Medicaid eligibility rules that were in effect in April 5, 1997.

[8] Sec. 2110(b)(2)(B). Children who are inmates of public institutions or patients in mental institutions are also ineligible for coverage.

parents. Some families purchase individual health insurance policies to cover themselves and their children. Other children qualify for publicly-funded programs, like Medicaid or CHAMPUS/VA.

North Carolina's Medicaid program currently covers all infants with family incomes up to 185% of the federal poverty guidelines, children ages one through five with family incomes up to 133% of the federal poverty guidelines, and children ages six through eighteen with family incomes up to 100% of the federal poverty guidelines. (See chart below). This still leaves a large number of uninsured children in families with incomes below 200% of the federal poverty guidelines.

Medicaid Income Guidelines Vary By Age of Child



In North Carolina, there are an estimated 138,743 uninsured children below 200% of the federal poverty guidelines. Of these, 67,401 are estimated to be eligible currently for the Medicaid program and 71,342 would be eligible for the new coverage under Title XXI. There are an estimated 7,800 uninsured children with family incomes below 200% of the federal poverty guidelines who are dependents of state employees.[9]

The basic data source to estimate the numbers of uninsured children in North Carolina is the Current Population Survey (CPS), an annual survey conducted by the U.S. Bureau of the Census. (See next page.) The CPS was chosen as the basic data source because it is the source used by the federal government in determining state allocations under Title XXI. This is the only readily available source of data to estimate the numbers of uninsured children in North Carolina.

[9] The State Health Benefits Office does not collect data on the numbers of uninsured children who are dependents of state employees or teachers, nor does it collect data on total family income (to determine which state employees or teachers have family incomes below 200% of the federal poverty guidelines). Therefore, the Sheps Center for Health Services Research at UNC-CH used 1996 CPS data for the U.S. South to get an estimate of the numbers of state or local employees with family incomes below 200% of the federal poverty guidelines with uninsured children. The Sheps Center applied this percentage to the total number of N.C. state employees and teachers eligible for the state health benefits plan.

Average Daily Health Insurance Coverage, by Poverty Status
North Carolina

(based on 1995-96 Current Population Survey data, adjusted to 1997 NC Population Projections) [10]

Age Category/ Type of Coverage	Total Children	Family Poverty Status (as percent of Federal Poverty Guidelines) <100%	100-124%	125-149%	150-174%	175-199%	200-399%	400%+
				Average Daily Number				
Under 1	98,439	26,303	12,136	5,948	7,740	4,657	23,664	17,992
Group Coverage	38,861	1,509	2,162	662	5,555	1,902	15,347	11,725
Medicare	-	-	-	-	-	-	-	-
Medicaid	43,144	21,627	9,974	4,660	1,559	1,283	*4,041*	-
CHAMPUS/VA	7,683	678	-	626	626	632	4,275	845
Individual Coverage	1,429	-	-	-	-	-	-	1,429
Uninsured	7,321	2,489	-	-	-	840	-	3,992
1 to 5	510,676	139,311	27,174	33,602	28,291	28,584	154,870	98,843
Group Coverage	257,758	9,196	8,960	15,651	12,661	13,275	112,905	85,110
Medicare	-	-	-	-	-	-	-	-
Medicaid	153,381	106,086	10,958	10,365	5,905	7,566	10,874	1,627
CHAMPUSVA	29,648	2,016	1,749	1,784	6,727	4,613	12,139	619
Individual Coverage	12,293	1,275	1,803	-	2,100	-	2,221	4,894
Uninsured	57,595	20,738	3,704	5,803	898	3,129	16,730	6,593
6 to 18	1,290,676	268,871	52,875	67,351	73,853	62,323	479,429	285,975
Group Coverage	766,376	25,896	30,194	22,675	23,523	40,941	368,446	254,701
Medicare	3,863	-	2,630	-	-	1,233	-	-
Medicaid	239,431	185,007	3,623	15,933	13,679	6,638	14,551	-
CHAMPUS/VA	43,676	2,566	2,920	-	8,854	3,274	20,354	5,708
Individual Coverage	79,333	14,932	1,766	9,920	5,425	2,499	31,651	13,139
Uninsured	157,997	40,470	11,742	18,822	22,372	7,736	44,428	12,427
TOTAL CHILDREN	1,899,791	434,485	92,184	106,901	109,884	95,564	657,963	402,810
Group Coverage	1,062,996	36,601	41,316	38,988	41,738	56,118	496,698	351,536
Medicare	3,863	-	2,630	-	-	1,233	-	-
Medicaid	435,957	312,720	24,555	30,958	21,143	15,487	29,467	1,627
CHAMPUS/VA	81,006	5,260	4,669	2,410	16,207	8,520	36,769	7,172
Individual Coverage	93,054	16,207	3,569	9,920	7,525	2,499	33,871	19,462
Uninsured	222,913	63,697	15,446	24,625	23,270	11,705	61,158	23,012

[10] CPS data have some limitations. First, they are based on relatively small sample sizes in each state. Thus, experts at the Sheps Center for Health Services Research (UNC-CH), the Duke Center for Health Policy, Law and Management, and the State Center for Health Statistics combined 1995 and 1996 CPS numbers to gather more reliable estimates. Second, the CPS data were adjusted to reflect the actual number of children in North Carolina in 1997 (as estimated by the North Carolina Office of State Planning). Finally, CPS historically undercounts the number of children receiving Medicaid (thereby overestimating the numbers of uninsured). The Division of Medical Assistance adjusted the CPS numbers to reflect the true numbers of Medicaid enrollees.

PROBLEMS FACED BY UNINSURED CHILDREN

The lack of health insurance is a substantial barrier for low-income families in obtaining timely and appropriate health care. Children with health insurance are more likely to receive regular and preventive health care (GAO, 1996). Children without health insurance have difficulties in obtaining routine services and are less likely to receive childhood immunizations, one of the key preventive measures (Wood, 1990; Oberg,1990; Himmelstein, 1995). These children are more likely to be seen in an emergency room with more severe illnesses and are less likely to get care for injuries (Overpeck, 1995), to see a physician if chronically ill, or to obtain regular dental care (Monheit, 1992).

The lack of appropriate care can affect a child's health status throughout life. The 1987 National Medical Care Expenditure Survey showed that one-third of the uninsured children with recurring ear infections and half of the uninsured children with asthma never saw a doctor (Agency for Health Care Policy and Research, 1987). Children with recurring ear infections may suffer permanent hearing loss, and children with untreated asthma may endure avoidable hospitalizations. Children with undiagnosed vision problems may be unable to see the blackboard, and children in pain or discomfort may have trouble concentrating in school. The lack of health insurance coverage for children has adversely affected North Carolina's children, as is evidenced by these "real-life" examples below:

> Three-year-old Jane developed an earache one night. Since she was not covered by her parents' insurance, the family chose not to take Jane for medical care. After 3 days the earache subsided. Jane experienced five such episodes over the next 18 months. She was diagnosed with a mild hearing loss when she received her kindergarten health assessment.

> Paul was diagnosed with mild cerebral palsy soon after discharge from the newborn nursery. His parents' insurance covered basic medical care, but did not cover special therapies or equipment (such as wheelchairs). Because of their limited income, Paul's parents were unable to pay for these services and equipment out-of-pocket. Five years later, Paul entered school in a stroller. He had a curvature of the spine and joint contractures. The school arranged for special therapies and a wheelchair (to be used only at school). The therapists reported that Paul's disability had progressed too far for therapies to have their maximum positive effect.

> Mary was thirteen and having trouble adjusting to high school. Her grades began to slip and she seemed depressed. The school counselor recommended that Mary receive mental health services. Mary's parents had no insurance coverage. They were reluctant to seek "free" services in their community, and decided to seek second jobs to save money to get services for Mary. In the meantime, Mary attempted suicide.

OVERVIEW OF THE CHOICES

Each state faces a number of choices in designing its child health insurance program. These choices include:

- Basic Program Options
  - Medicaid Expansion
  - New Insurance Program
  - Combination of the Two
- Administration
  - Eligibility Determination/Enrollment
  - Outreach
  - Benefits Education and Advocacy
- Benefits Package
- Cost-Sharing
- Delivery System
- Access, Quality Assurance, and Consumer Protections
- Crowd-Out

The Child Health Insurance Task Force considered these choices over a course of six meetings. Task Force members were generally in agreement on a number of these issues (including outreach and enrollment, administration and eligibility determination, benefits education and advocacy, and support services to promote utilization of preventive health services), but reached less consensus on other topics (including delivery system design). Where consensus was reached, only one set of recommendations is presented. Where consensus was not evident, a number of different options are presented along with the advantages and disadvantage of each.

1) Basic Program Options

The state has three options under the Child Health Insurance Program—it can expand Medicaid, create a new child health insurance program, or design a system that combines the two.

a. Medicaid Expansion:

Under this option, the state would expand Medicaid to cover as many uninsured children under 200% of the federal poverty guidelines as funds would permit. Uninsured children who qualify for the program would be guaranteed coverage (i.e., the program would remain an entitlement program).

One of the chief advantages of using the Title XXI funds to expand Medicaid is that the state can build on an existing infrastructure (Weil, 1997). The state already covers approximately 435,000 low income children through the Medicaid program. The state has a network of providers, systems for handling client and provider issues such as enrollment,

education, outreach, appeals, and mechanisms for rate setting, claims payments, and fraud prevention. In addition, the state's administrative costs for Medicaid are quite low—averaging approximately 4 percent. The system is in place and operational, so it would be the easiest option to implement. Due to the size of the program, Medicaid has significant purchasing power. The addition of the newly-covered children would increase its leverage to the benefit of both the new and current eligibles.

Another advantage is that states can use enhanced Title XXI funds through the Medicaid program to cover the dependents of state employees and teachers. This is the only way currently that North Carolina can cover uninsured dependents of state employees and teachers.[11] This is an exception from the general provisions which prohibit states from using Title XXI funds to cover dependents of state employees. In addition, because Medicaid is an entitlement, the state can continue to draw down federal funds at regular Medicaid matching rates to support health insurance coverage for children if Title XXI funds are exhausted.

Expanding Medicaid eligibility would also be easier for many families. Under current Medicaid rules, some children in a family may be eligible for Medicaid and other siblings not, because of the difference in the state's Medicaid income guidelines for children of different ages. If the state expanded Medicaid to cover all children in the family, all the children in a single family would be eligible for the same benefits package and could obtain care from the same set of providers.

One concern raised by some is that, because Medicaid is an entitlement program, the state may be required to appropriate additional funds if the numbers of uninsured exceed the initial budget estimates. However, the General Assembly always has the option of modifying eligibility rules, payment rates, or services covered to decrease program costs. In addition, the current Medicaid eligibility determination process apparently creates barriers for some families, for many eligible families are not enrolled. (Note: The Task Force recommended that a simplified eligibility determination process be used in both the Medicaid and new Title XXI program.)

b. New Child Health Insurance Program

Another option is a separate child health insurance program. The federal law gives the state flexibility in designing this new program, as long as it creates a benefits package that is actuarially equivalent to one of three benchmarked plans (See Section 3 below).

The chief advantage of this approach is that the fiscal liability of the state is limited The state could set eligibility caps and establish waiting lists if the numbers of eligible uninsured children were higher than initial estimates.

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[11] The October 10, 1997 HCFA Question and Answer communication clarifies that states can use enhanced Medicaid funds to cover dependents of state employees if the state chooses to expand Medicaid (Question 34). However, states are still prohibited from using Title XXI funds to cover dependents of state employees if the state chooses to establish a new child health insurance program.

Disadvantages to this option would include higher administrative costs, the possibility that fewer services might be offered, and difficulties in coordination with the Medicaid Program (both in eligibility determination and in service delivery).

Another disadvantage is that the state cannot cover dependents of state employees if it enacts a separate child health insurance program. Also, under a separate insurance program, federal funds available to cover the uninsured are limited. Therefore, if the state does not want to put a limit on the number of children it covers, a separate program will provide less federal assistance than an entitlement program. See chart below:

	For Each $100 in Coverage Until the Allotment is Used Up		For Each $100 in Coverage After the Allotment is Used Up	
	Medicaid Option	Separate State Program	Medicaid Option	Separate State Program
Federal Share	$74.10	$74.10	$63.00	$0
State Share	$25.90	$25.90	$37.00	$100

c. Combination of Medicaid Expansion and New Insurance Program:

The state can expand Medicaid eligibility and create a new block grant program to cover the children above the state's new Medicaid income guidelines. For example, the state can expand Medicaid to 150% of the federal poverty guidelines, and create a new state child health program for children with family incomes between 150%-200% of the FPG. This limits the state's potential fiscal liability while still providing assurances that the lowest income children in the state will be covered. Also, dependents of state employees with family incomes below 150% of the federal poverty guidelines would be covered.

The program may not be as "seamless" for families if the state creates two programs with two delivery systems or benefit packages. However, this problem can be overcome if the state chooses to create a "Medicaid look-alike" program (which would be a non-entitlement program that offers children the Medicaid benefits package and operates through the Medicaid system).[12] Also, if the state does not want to put a limit on the number of children it covers, a block grant program will provide less federal assistance than an entitlement program.

[12] It is important to note that the state cannot cover uninsured dependents of state employees or teachers as part of a Medicaid look-alike program.

2. *Administration (Including Eligibility Determination/Enrollment, Outreach and Marketing, Benefits Education and Advocacy)*

There was a general consensus among members of the Child Health Insurance Task Force that the state should administer the new Child Health Insurance Program (whether it is a Medicaid expansion or a new block grant program). The state should have primary responsibility for the eligibility determination process, outreach and marketing, benefits education and advocacy, data collection and analysis, quality assurance, planning, and evaluation. The state should also be responsible for monitoring the performance of private managed care organizations (MCOs) if the state chooses to contract with private MCOs. The state can use up to 10% of the federal allocation for administration, outreach and marketing costs and direct provision of health services.

The Task Force recommended that the state simplify the application form (for both Medicaid and any new program), decentralize places where applications can be taken through outstationed staff, and allow mail-in applications. The Task Force also recommended that the state explore the role that others (e.g., public health, private providers, schools, Smart Start, day care, etc.) can play in the eligibility determination process. The same application should be used for the Medicaid program and the new child health block grant program, and ideally, should also allow the state to determine the family's eligibility for other public programs through the same process and portals of entry. In addition, the state should utilize the existing eligibility information system to prevent children from being inadvertently enrolled in two programs, provide a consistent source of enrollment data, and avoid the substantive investment required in creating a new computerized information system.

The state should also implement federal options for simplifying the Medicaid enrollment and re-enrollment process, and use these same strategies if the state implements a new child health insurance program. These strategies include presumptive eligibility for children, and 12 month guaranteed eligibility. Reports indicate that presumptive eligibility, simplified application forms, and outreach activities have been successful in enrolling eligible Medicaid recipients (GAO, 1991; Center on Budget and Policy Priorities, 1997).

The Task Force recommended that the state conduct an extensive outreach and marketing campaign in order to reach as many eligible children as possible. There are three possible sources of money for this effort: 1) a portion of the 10% federal Child Health Insurance Program funds spent in the state; 2) the federal funds available to the state for Medicaid outreach as part of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (90% federal matching rate);[13] or 3) Medicaid funds that are generally available for outreach activities (50% federal matching rate).

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[13] Congress appropriated $500 million to be made available to the states at an enhanced match rate to help pay for administrative activities to ensure that children and families do not lose Medicaid coverage as a result of welfare reform changes. Section 1931(h) of Title XIX of the Social Security Act (Medicaid). North Carolina's share of the allotment is $11,550,703. Federal Register. May 14, 1997. Vol. 62, No. 93.

The Task Force recommended that the state use a single name for both Medicaid and the new child health insurance program to support a simple, seamless marketing approach. (The Task Force recognized that it would be difficult to have a single name if the two programs operated substantially differently). The state should develop a marketing approach that includes the program name, logo, and slogans, through social marketing research with the targeted population. This would be similar to the process used in designing the "Baby Love" campaign, which has been heralded as one of the most successful efforts in the country in reaching out to uninsured pregnant women. The outreach and marketing plan should involve health care providers, consumers and local voluntary organizations with interests in children. Existing resources should be built upon and expanded to support the program, including the First Step Campaign Office, the Health Check Hotline and the system of Health Check Coordinators. The existing telephone hotlines can be used to provide families with program information and referral to community resources.

In addition, the Task Force recommended that the program include health benefits advisors and an Ombuds office. The health benefits advisors would help to educate families about the covered benefits, choice of plans (if any) and provider options. The program should also include a centralized Ombuds office. This office can help advocate on the child's behalf if problems arise in accessing services, can assist in the appeal process and ensure that the program is functioning as intended.

3. Benefits Package

The Medicaid benefits package is the most comprehensive health insurance package currently available for children in North Carolina. Unlike most commercial health insurance plans which are largely designed to meet the needs of commercially-insured adults, the Medicaid benefits package has been fashioned specifically to meet the needs of children, including children with special health care needs. Approximately 10% of the children in this country have special needs.[14] While Task Force members were generally supportive of using the Medicaid benefits package, they recommended that dental reimbursement rates be enhanced (for current Medicaid beneficiaries and for any children covered under Title XXI) to attract sufficient numbers of dentists to participate in the program.

The state can use the Medicaid benefits package in implementing the new child health insurance program (whether or not it chooses to expand Medicaid as an entitlement), or it can design a new benefits package. If the state chooses the latter, the state must create a comprehensive benefits package that is equal to or actuarially equivalent to one of three

[14] National estimates suggest that between 5-10% of children experience some developmental problems sometime during their lives, between 12-15% of children experience behavioral and emotional disorders, and between 3-5% of children have complex physical conditions (such as spina bifida, sickle cell anemia, AIDS, cancer or cystic fibrosis).. Fox H, McManus P. Preliminary Analysis of Issues and Options in Serving Children with Chronic Conditions Through Medicaid Managed Care Plans. Maternal and Child Health Policy Research Center, Washington D.C. 1994 Aug.

benchmarked plans listed in the federal legislation: the State Employees Health Plan, the Federal Employees Health Benefit Plan (Blue Cross Blue Shield PPO option), or the most commonly commercially purchased HMO plan in the state. The Child Health Insurance Task Force analyzed the different benefits available under each of the benchmark plans (Medicaid, State Employees Health Plan, BCBS Federal Employees Health Benefits Plan, Healthsource Advantage,[15] and Blue Cross Blue Shield PCP Option 1).[16] Based on this analysis, it chose two plans (with some modifications) for William M. Mercer, Inc. to cost-out: 1) Medicaid; and 2) the State Employees Health Benefits Plan (See Appendix B).

The Task Force considered using the benefits package available to state employees and teachers, because it is one of the three allowable benchmarked plans and is well understood by the general public. Since this plan was largely designed for an adult population, the Task Force recommended the addition of preventive dental services and a biennial comprehensive vision exam to better meet the needs of children. In addition, the State Employees Health Plan also excludes certain services needed by children with special needs. For example, the State Employees Health Plan will pay for special therapies when a child is showing significant progress, but not to help a child maintain functional status. These services are critical to certain children with developmental disabilities and severe chronic illnesses who may need continuing therapies to ensure that the condition does not deteriorate. Therefore, if the state chooses to use the State Employees Health Benefits package, the Task Force would recommend the creation of a "wrap-around" reinsurance pool. This would enable families to obtain the specialized services that their children with special needs require.[17]

The William M. Mercer, Inc. actuarial data showed that the cost of the Medicaid expansion option (using current N.C. Medicaid reimbursement rates) was actually less expensive than a private option (based on the provider reimbursement rates currently paid under the State Employees Health Plan). The costs are described below:

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[15] According to data obtained from Healthsource, Healthsource Advantage is the most commonly purchased commercial HMO plan sold in North Carolina.

[16] According to data obtained from Blue Cross Blue Shield of North Carolina, PCP Option 1 is the most commonly purchased commercial POS plan sold in North Carolina.

[17] The North Carolina Pediatric Society has created a task force to explore the idea of creating a reinsurance pool to address the health care needs of special needs children who have commercial insurance or are uninsured.

Comparative Costs of the State Employees Health Plan and Medicaid Benefits Packages[18]
(common utilization assumptions with no cost-sharing)

Age/Gender Bands	Modified State** Employees Health Plan (per member per month)	Medicaid Benefits Package (per member per month)	Variance
<1	$318	$281	13%
1-5	95	85	12%
6-18	74	70	6%
14-18 female	159	154	3%
14-18 males	172	175	2%
Total*	108	104	4%

* Does not include administrative costs.

** Services for children with special needs are somewhat limited. Eyeglasses and hearing aids are excluded. Special therapies and medical equipment are not covered when a child's condition is not improving.

4. Cost-Sharing

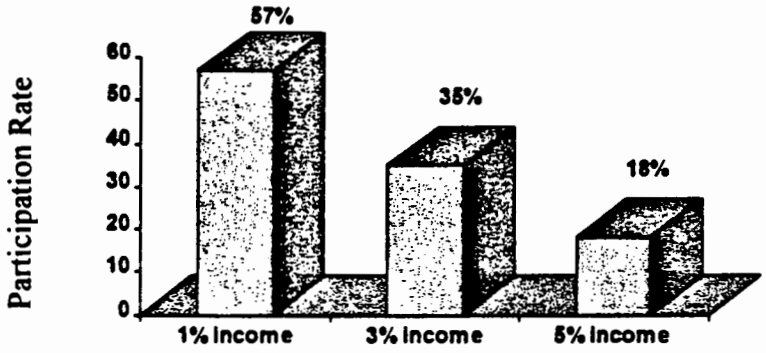
Federal law sets different cost-sharing requirements for families with incomes below 150% of the federal poverty guidelines versus those with incomes at or above 150%. For families below 150% of the federal poverty guidelines, states may impose nominal monthly premiums, but no cost-sharing (i.e., deductibles, copayments, or coinsurance). For families at or above 150% of the federal poverty guidelines, states may impose a premium and/or other cost-sharing, as long as the total out-of-pocket costs do not exceed 5% of the family's income. States may not impose any cost-sharing on preventive services (e.g., well-baby, well-child, or immunizations). Further, states may not use any cost-sharing amounts to finance the state share of the new Title XXI program.

Cost-sharing serves several purposes, such as deterring unnecessary utilization, reducing any potential welfare stigma associated with public programs, and potentially decreasing the possible "crowd-out" effect. However, cost-sharing may deter enrollment and utilization of

[18] William M. Mercer Inc. presentation to the Child Health Insurance Task Force, October 23, 1997. Mercer, Inc. provided actuarial estimates for both the Medicaid benefits package and that of the modified State Employee Health Plan (with dental and vision benefits included). The estimates are based on the reimbursement profiles of each program. Common utilization assumptions were used. The children that will receive coverage under Title XXI, taken as a whole, will be more indigent than the current SEHP child population, and less indigent than the current Medicaid Program child population.

medically necessary services. For example, a recent study from the Urban Institute showed that families are highly sensitive to the cost of health insurance premiums, and that even moderately priced premiums tend to deter significant numbers of low and moderate income families from participating in the publicly subsidized programs. In addition, collecting monthly premiums would be expensive and administratively burdensome.

Participation in Children's Health Programs In Relation To Premium Increases



Premiums as a Percentage of Family Income

(Ku and Coughlin, 1997).

For these reasons, the Task Force identified two policy options for the two income groups defined as targets in the statute: (a) no cost sharing of any kind, or (b) nominal cost sharing (including a one-time annual enrollment fee, and copayments for the higher income families). These options were presented to William M. Mercer, Inc. actuaries to determine the impact of these policies on actuarial costs. In general, the annual enrollment fee reduced the monthly costs by $1 per member. The copayments reduced the monthly costs by approximately $8 per member.

Families with incomes below 150% of the federal poverty guidelines:

Option a: No cost-sharing or premiums of any kind.

A policy of no cost-sharing or premiums would be the easiest to administer, and would eliminate any potential financial barriers which low income families may experience in obtaining needed health services or in participating in the program. However, free programs may carry a "welfare" stigma, and may reduce a family's perceived ownership of the insurance coverage.

Option b: $10 (one child)/$19 (two or more children) annual enrollment fee to be paid one time each year.

The Task Force chose not to recommend a monthly premium since the costs of collecting the premium would exceed any programmatic savings. The experience of some states that imposed monthly premiums in their child health insurance program showed that the premiums were hard to collect, and caused some beneficiaries to drop coverage. For example, approximately 40% of the children enrolled in the Florida Healthy Kids program dropped coverage when premium rates were increased about $15 per month (Shenkman, 1996). Those with the lowest family income were the most likely to drop coverage. Children with the greatest health care needs were the most likely to remain insured, thereby raising the premium costs for the covered children. Initially, Tennessee had great difficulty collecting premiums, and about 40% of the individuals who were required to pay premiums dropped their coverage (Wooldridge, 1996).[19] Because of the difficulties experienced in other states, the Task Force recommended a modest annual enrollment fee instead of a monthly premium.

An enrollment fee helps to reduce program costs and may create more investment in the program by families. However, even this modest annual enrollment fee may reduce program participation, and may be administratively complex to manage. Several members of the Task Force were reluctant to impose any enrollment fee, because of the concerns that this fee might deter program participation.

Families with incomes at or above 150% of the federal poverty guidelines:

Option a: No premium or cost-sharing.

Members of the Child Health Insurance Task Force thought that the same policy reasons for not imposing cost-sharing on the lower-income families also applied to the families with slightly higher incomes. In general, it is easier to design and implement a program without cost-sharing requirements. Without cost-sharing requirements, the state would have no need to monitor a family's out-of-pocket payments to ensure that the cost-sharing did not exceed 5% of the family's income.

Option b: $10/$19 annual enrollment fee. $0/$3 prescription drug copayment (generic/brand name drugs, $3 copayment would be waived if medical reason for brand-name); $3 acute care outpatient visits; $20 for non-"emergency" use of emergency department services.[20]

The combined enrollment fee and copayments reduce the monthly member costs by approximately $9. This would help reduce overall program costs. In addition, the copayments may help deter unnecessary utilization, and may create an investment in the program on the part of program participants and may remove the welfare stigma. However, some of the Task Force members expressed concerns with several aspects of this proposal. First, copayments are

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[19] Tennessee's premiums were based on the families' income, and ranged from 20% of the capitation rates for families with incomes between 100-199% of the Federal Poverty Guidelines to 100% of the capitation rate for families with incomes at 400% of the Federal Poverty Guidelines.

[20] The state would use the new definition of emergency contained in SB 455, enacted as part of the 1997 Session.

effectively "taxes" on *providers*. If the recipient is unable to pay the required copayment, the provider is in the position of having to refuse care or to have their reimbursement effectively cut by the cost of the copayment. This may deter provider participation in the program. Second, studies in the past have shown that cost-sharing helps deter both necessary and unnecessary care (Lohr, 1986). Poor children, those with incomes below 200% of the federal poverty guidelines, were most likely to be adversely affected by the imposition of cost-sharing, particularly for acute conditions where highly effective therapies were available. Third, 86% of the parents of uninsured children are also uninsured (National Association of Children's Hospitals, 1997). These families are already likely to be incurring significant out-of-pocket costs to meet the health care needs of the adult family members, and may have few resources available to pay additional health care costs.

5. Delivery System

The Task Force members generally agreed that private managed care organizations (MCOs), including health maintenance organizations, provider sponsored networks or other forms of managed care, should be allowed to participate in the program. However, there was considerable divergence of opinion on how this could best be accomplished. There were generally three proposals discussed during the Task Force meetings: 1) operate the program through the Medicaid system, with the state setting an established premium price, allowing any MCO to participate as long as it met the state's quality, access and benefits standards; 2) contract out the program to the lowest cost bidder or bidders (with the assumption that bids must be less than Medicaid's cost to care for this population); or 3) create a voucher program and allow recipients to choose from competing health care plans

Because there was such diversity of opinion on these issues, the Task Force created a list of criteria for judging these different approaches, including: a) existence of an operational administrative structure; b) choice of plans; c) choice of providers; d) ease of implementation; e) ability to interface with Medicaid; f) cost-effectiveness; g) seamlessness for families; h) ability to track utilization and monitor quality; i) ability to operate the system statewide; j) simplicity of understanding for families.

Medicaid-administered, private plan participation:

The N.C. Division of Medical Assistance (DMA) would administer the program, but would allow any managed care organization to offer coverage as long as the MCO can deliver services for the same cost, quality and access as the state now provides to Medicaid-eligible children. This is similar to the system offered state employees and teachers, who are given a choice of a traditional fee-for-service indemnity plan or can pick from competing HMOs. Under this option, recipients would be given the option to choose any plan operating in their service area (including the Medicaid delivery system), at no additional cost to the family. Plans could compete on the basis of quality and extra services. This program could be operated even if the state chose not to expand Medicaid, by establishing a Medicaid look-alike program (basically a non-entitlement program that operates like a Medicaid program).

In assessing the Medicaid-administered, private plan participation option, the Task Force found the following:

a) *Existing administrative structure:* The Medicaid system is already operational statewide, and includes mechanisms for accountability, oversight and evaluation. The state would not need to create a new administrative structure, although an additional investment would be required to modify and expand existing systems to meet the broader needs and requirements of the Child Health Insurance Program.
b) *Choice of plans:* This system permits any willing MCO that meets the state's price and quality criteria to participate. This also would enable recipients to have a choice of plans.
c) *Choice of providers:* The lack of providers available to treat children is a concern in the Medicaid program. This problem might be ameliorated if more MCOs offer coverage, as MCOs may have a broader network of providers.
d) *Ease of implementation:* This option would be the easiest to implement, as Medicaid is already operational and has had experience with prior program expansions.
e) *Ability to interface with Medicaid:* Since this option would be implemented by the Division of Medical Assistance, it has the best ability to meet the federal requirements of coordination with the Medicaid program.
f) *Cost-effectiveness:* The program is cost-effective, as the Medicaid benefits costs are actually lower than benefits offered under the State Employees Health Plan, and the Medicaid administrative costs are only 4% of the total costs of the system. Further, the actuarial costs of the Medicaid benefits package, using the Medicaid reimbursement rates, are actually lower than other less comprehensive commercially available plans.
g) *Seamlessness for families:* Another advantage is that having the two programs operate in concert would make it easier to meet the federal requirements that the state coordinate coverage for Medicaid and the Children's Health Insurance Program. Also, as family incomes (and eligibility) fluctuate, eligibility for regular Medicaid or the look-alike plan may vary, but benefits and enrollment would be continuous and seamless.
h) *Ability to track utilization and monitor quality:* The state is enhancing its current computer system to be able to analyze managed care organization utilization data to assure access and quality.
i) *Statewide operation:* The Medicaid program is operational statewide, and allows for flexibility in the design of the delivery system to accommodate regional variations in the private market (for example, the Medicaid agency can operate a fee-for-service system, a primary care case management program, and a capitated program, depending on the availability of managed care organizations).
j) *Simplicity of understanding for families:* The Medicaid system already has experience educating low-income families and children about multiple plan options, which it can draw upon in implementing a further expansion.

Contracting with Lowest Cost Bidder(s):

Under this plan, the state would open the program for competitive bids from managed care organizations. The lowest bidder(s) who meets the state quality, access and benefits

requirements can participate in the program, provided the qualifying bids are less than Medicaid costs for serving the same population.

In assessing the lowest cost bidder option, the Task Force found the following:

a) *Existing administrative structure:* The Department of Health and Human Services would have to establish contracting rules to assure cost, access and quality standards are met.
b) *Choice of plans:* This system potentially offers the recipients the fewest choice of plans.
c) *Choice of providers:* Depending on the MCOs participating, plans may offer recipients an extensive or a more limited choice of providers.
d) *Ease of implementation:* Once basic contracting rules are established, the program would be relatively easy for the state to administer as the program would be contracted out to private organizations to deliver services.
e) *Ability to interface with Medicaid:* It would be more difficult to coordinate with Medicaid.
f) *Cost-effectiveness:* The state could save money if a MCO bid at a lower price than the Medicaid costs. However, it is probable that the overall administrative costs associated with developing efficient and effective linkages with Medicaid would be significant.
g) *Seamlessness for families:* This program would be harder to interface with Medicaid. If a family had one child in the Medicaid program, and another child who was receiving services through the private MCO, the family may have to take their children to different providers. Further, continuity of care might be impeded if family circumstances change so that they move from Medicaid to the separate child health insurance program (or the reverse).
h) *Ability to track utilization and monitor quality:* Most of the larger HMOs have experience tracking utilization data for HEDIS-type performance measures, although it is unclear that other MCOs have similar capacity. The state agency would still be charged with collecting and analyzing the data.
i) *Statewide operation:* Although several of the HMOs are licensed statewide, only about 90 of the counties have an HMO option available to them through the State Employees Health Plan.
j) *Simplicity of understanding for families:* A program with a limited choice of MCOs may be easier for families to understand. However, as noted previously, this program would be more difficult for families with other children covered by Medicaid as the family would need to understand two different program rules.

Vouchers:

Under this option, eligible families would be given a voucher to purchase a private health insurance plan that meets mandated cost, quality, access, and benefits requirements. Because there is an insufficient track record with this type of system operating successfully anywhere in the country, the Task Force was reluctant to recommend this option. However, as there were some Task Force members who expressed an interest in this type of approach, an analysis of this

option is reported below. Given the lack of experience with this type of approach, any suggestions on the impact of this program are largely speculative.

In assessing the voucher option, the Task Force found the following:

a) *Existing administrative structure:* The state would need to establish a new structure to administer the program. This would delay program implementation.
b) *Choice of plans:* Theoretically, this system would afford recipients the greatest freedom of choice among plans, assuming that plans were willing to participate at the state's fixed premium level.
c) *Choice of providers:* Depending on the MCOs or insurers chosen, the plan may offer recipients an extensive or a more limited choice of providers.
d) *Ease of implementation:* There is little existing structure in place to administer the program.
e) *Ability to interface with Medicaid:* As with the private contracting option, this program would be more difficult to coordinate with Medicaid.
f) *Cost-effectiveness:* The program would be relatively cost-effective if the state used the Medicaid actuarial costs as the voucher value.
g) *Seamlessness for families:* This program would be harder to interface with Medicaid. If a family had one child in the Medicaid program, and another child who was receiving services through a private MCO, the family may have to take their children to different providers. Further, continuity of care might be impeded if family circumstances change so that they move from Medicaid to the separate child health block grant program (or the reverse).
h) *Ability to track utilization and monitor quality:* With a multiplicity of participating plans, it would be more difficult to adequately track utilization and monitor quality. The state would need to build in strong marketing and consumer protections to prevent the dissemination of misleading information.
i) *Statewide operation:* It is unclear whether this program could successfully operate on a statewide basis, as it has largely been untested.
j) *Simplicity of understanding for families:* Because of the lack of experience with this approach, its understanding for families is difficult to assess. It seems likely, however, that this approach would require an enormous amount of health benefits advisement.

Based on this analysis, the Task Force developed the following chart comparing the three delivery system approaches:

Evaluation Criteria	Medicaid administration and other plans participating	Contracting out to lowest cost bidder(s)	Vouchers
Administrative structure in place	★★★★★	★★★★	★
Choice of plans	★★★	★★	★★★★★
Choice of providers	★★★	★★★★	★★★★
Ease and quickness of implementation	★★★★★	★★★★	★
Ability to interface with Medicaid	★★★★★	★★★	★★★
Cost-effective system of care	★★★★★	★★★★	★★★★
Seamlessness for families	★★★★★	★★★	★★★
Ability to track utilization	★★★	★★★	★
Statewide delivery system	★★★★★	★★★★	★★★
Simplicity of understanding	★★★★★	★★★★★	★
Average ranking:	4.4★	3.6★	2.6★

(Ranking: 1-5★, with 5★ indicating that the delivery option was most likely to meet the criteria established by the Task Force.)

6) Access, Quality Assurance and Consumer Protections

The Task Force believed that the new Child Health Insurance Program should include mechanisms to assist families in accessing health care services on behalf of their children. Families, particularly of low and moderate income, often experience barriers which make it difficult for them to access needed care. For example, some families lack transportation, have difficulty taking time off work to take their children to the doctor, need translation services, or help understanding how to obtain care within a managed care environment. North Carolina,

through Medicaid's Health Check program, has already had success in helping families obtain needed services. The program has coordinators in 53 counties which helps families access care and coordinates available community resources. This can serve as a model for the state's Child Health Insurance Program.

The federal Balanced Budget Act requires the state's Child Health Insurance Program to include performance measures and report on these measures to the U.S. Secretary of Health and Human Services. Performance measures will assist the state with assuring that the program provides accessible, high-quality health care services to North Carolina's children. Both quality assurance and quality improvement measures will be used. The quality assurance measures will focus on structural issues, such as accreditation and credentialing of providers, provider capacity, and geographic accessibility. These measures also will assess processes, for example the percentage of children and adolescents receiving check-ups and immunizations as called for by the American Academy of Pediatrics. By contrast, the quality improvement measures will focus on outcomes; for example, a quality improvement intervention could look at whether the rates of sexually-transmitted diseases in adolescents decreased over time.

While the "science" of performance measurement is still evolving, there are a number of quality assessment tools that already are available or are under development, including measures from the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS), the Health Care Financing Administration's Quality Assurance Reform Initiative (QARI), and Quality Improvement System for Managed Care (QISMC, which will replace QARI and unify Medicare and Medicaid performance measures), and Foundation for Accountability (FACCT), a set of performance measures developed by a nonprofit coalition of public and private purchaser and consumer organizations. These various measures should be explored in depth for potential use by the state Child Health Insurance Program because: (1) they are already in existence through the efforts of public-private development partnerships; (2) many providers, nationwide, already are familiar with them; (3) they tend to be comprehensive, addressing clinical and non-clinical areas, such as effectiveness of care, access to/availability of care, consumer satisfaction with care, health plan stability, utilization of services, cost of care, and consumer services. In addition, whatever measures are designed for use in the new state Child Health Insurance Program should also be used to measure the performance of the Medicaid program.

The Task Force was also concerned that the state build in adequate due process measures, including written notice of any decision to deny or reduce requested services (or to deny eligibility), expedited review of certain medical decisions, and review by an independent hearing officer. The Medicaid program already has a model grievance process in place for the recipients enrolled in MCOs, which could be used as a model for this new program.

7. *Crowd-Out*

When Congress passed the Child Health Insurance Program, it took steps to ensure that the new federal monies would be used to cover uninsured children rather than to substitute for, or "crowd-out," private coverage. For example, the state cannot create a new child health insurance program which uses Title XXI funds to cover children who already have private health insurance coverage or who are eligible for Medicaid. However, this provision does not prohibit coverage of children who are eligible for, but not actually covered under, an employer plan at the time they apply for child health assistance (with the exception of children eligible for coverage under the State Employees Health Plan). The state plan must describe the procedures the state will use to ensure that the insurance provided under the plan does not substitute for existing coverage (Sec. 2102(b)(3)(c)).

It is impossible to accurately predict how many employees and employers would actually drop dependent coverage in order to enroll dependents in the new public program. Policy experts strongly disagree regarding the amount of crowd-out that states have experienced as a result of the Medicaid expansions for pregnant women and children in the last ten years. Estimates range from virtually no crowd-out effect (Yazici, 1996) to over 50% (Dubay, 1997). Most of the studies were derived from cross-sectional data of different individuals gathered at various points in time.. One study tracked the same poor and near-poor children to monitor the impact of the previous Medicaid expansions on their private insurance coverage and concluded that minimal or no-crowd-out occurred (Yazici, 1996).

It is difficult to ascertain what portion of the drop in private health insurance coverage is directly attributable to the availability of publicly-subsidized health insurance coverage, and what portion of the decline is due to external factors, such as changes in the economy (i.e., recession), the rising cost of health insurance coverage, and/or "changes in the nature of employment and employers' views about the benefits they need to offer to attract workers" (Cutler, 1997; Cutler, 1996; Holahan, 1997). For example, an increasing number of individuals are employed by small businesses which are less likely to offer health insurance coverage (National Association of Children's Hospitals, 1997). The percentage of workers in firms with less than 25 employees increased from 28.8% in 1988 to 31% by 1994. Further, there has been a shift to part-time and temporary employment which are less likely to offer the benefit of insurance coverage. Moreover, there has been a disproportionate increase in premium costs for family coverage as opposed to individual employee coverage. Between 1989 and 1996, cost increases for family premiums were 13-23% higher than for employee-only premiums. (GAO, 1997). Not surprisingly then, the percentage of children with employment-based health insurance coverage nationally declined steadily from 66.7 percent in 1987 to 58.6 percent in 1995 (EBRI, 1997). In North Carolina, there was a 5.2% drop in employer-based health insurance coverage for children between 1990-92 relative to 1988-90 (Holahan, 1995).

In Minnesota, researchers surveyed individual participants in the publicly-subsidized health insurance program to determine the extent of prior health insurance coverage. The study determined that only 7% of the newly eligibles had been previously insured with private

coverage (Call, 1997). "Importantly, there is little evidence that the MinnesotaCare program has resulted in significant erosion from the private market. In fact, most of the uninsured in 1995 reported having no access to insurance through their employer or family members, and those that technically had such access simply found it to be unaffordable" (Call, 1997). The minimal coverage-shifting experienced in Minnesota suggests that extensive precautions against crowd-out may be unjustified.

According to some experts, there are several possible political disadvantages to erecting strict crowd-out policies. First, by restricting the coverage for those children whose parents have had some access to employer-based coverage, the program is penalizing parents for past decisions to obtain coverage. In addition, overly strict policies may ultimately defeat the primary objective of the legislation by preventing coverage of many poor and near-poor uninsured children (Merlis, 1997). In addition to these negative policy implications, severe restrictions would create another serious administrative burden and expense for the new program. Florida's Healthy Kids program dropped its verification of children's previous insurance status largely because of the administrative difficulties in obtaining verification from employers and insurance companies (Gauthier, 1997).

Based on the lack of clear evidence that significant crowd-out will occur, and awareness of the potentially harmful effects that ill-conceived restrictions might have, the Task Force recommends that the state avoid imposing harsh restrictions immediately. As the state plan progresses, the shifts in enrollment should be closely monitored to determine whether any crowd-out is occurring as a result of the expanded coverage. If it appears that a significant percentage of new enrollees have recently dropped private insurance coverage, then the state can design future "firewalls" to avoid this coverage shifting.[21]

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[21] California has completed its proposed state plan and adopted a similar approach. If the federal government requires more restrictive firewalls, it affords the administering agency the discretion to exclude children if they were covered by employer-sponsored insurance within the previous three months. After a "reasonable period" of monitoring or if required by the federal government, the program could extend the exclusion up to six months. California also provides that exceptions will be made for "cases where prior coverage ended [within the previous three or, if applicable, six months] due to reasons unrelated to the availability of the program," and at least under the following conditions: the loss of a job other than as the result of quitting; the unavailability of employer-sponsored coverage; the discontinuation of health benefits for all employees; and the termination of the 18 month COBRA coverage period.

In addition to the construction of firewalls, the California legislation addresses other means of preventing unwanted coverage shifting. It provides for monitoring to ensure that private coverage is not being improperly dropped (sec. 12693.71; 12693.80). Insurance industry personnel who encourage people to terminate their employment-based dependent coverage by referring them to the state plan or arranging for them to apply may be guilty of "unfair competition" for which an employee has a personal cause of action (sec. 12693.81). It is also an unfair labor practice for either insurers or employers to improperly influence enrollment in the state program (sec. 12693.82; 12693.83).

ESTIMATED PROGRAM COSTS

The state's annual allocation of $79.5 million in federal funds, plus the $27.6 million in required state match, appears adequate to cover the entire estimated target of 71,342 uninsured children in families below 200% of the poverty guidelines, using the actuarial estimates presented on p. 13, and assuming 100% participation. The pragmatics of budget estimation for operation of the program for the first several years have been left to the experienced professionals of the Department of Health and Human Services.

In the first year of program operation, it is reasonable to expect less than full participation as the word of the new program and the eligibility requirements are made public. Even in subsequent years, it is unlikely that all eligibles will participate. Experience from the prior Medicaid expansions around the country for children suggest that on average 32-38% of eligible children fail to enroll, and even in the states with the highest penetration between 7-27% of eligibles remain uninsured (Summer, 1997). Therefore, based on past experience, it is reasonable to assume no more than 80% of the program eligibles will participate.

The issue of crowd-out must also be addressed in budget estimates. Given the uncertainty of the level of crowd-out as noted on pages 22 and 23, it seems reasonable to assume (at least initially) a mid-level range of crowd-out between 10% and 30%. Thus, for planning and budgeting purposes, a crowd-out level of 20% is proposed. Since the estimated enrollment of the uninsured is 80%, and the enrollment due to crowd-out is 20%, it seems reasonable to use the original figure of 71,342 uninsured children as the long-term enrollment figure for budget planning purposes.

The Task Force recommends that the outreach, marketing, and health benefits functions be funded as fully as possible. States may use up to 10% of the federal allotment for administration, outreach and direct services.

During the course of its meetings, the Task Force received suggestions regarding the use of the "10 percent money" for direct services. Among those suggestions were: support services for children with special needs; support for school-based health services to enhance access to care by school-age children; support for centers to provide services to traditionally hard-to-reach populations, such as migrants and farmworkers. While the Task Force did not rank these suggestions above the outreach, etc. functions noted above, it seems reasonable to review these suggestions after the initial year of the new program's operation.

Special Note

As noted earlier, an estimated 67,000 children are currently eligible, but not enrolled in the Medicaid Program. As the new program is implemented, its outreach activities will surely lead to the Medicaid enrollment of many of these children. The Task Force did not make specific budget projections in this regard. It was noted that these children are probably relatively

healthier than the children enrolled in Medicaid, and their enrollment will be slow and incremental. DHHS budget planners should use these assumptions in developing budget estimates in this regard.

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APPENDIX A
Child Health Insurance Task Force Participants

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NC Child Advocacy Institute
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NC Academy of Family Physicians
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NC Health Access Coalition
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First Step Campaign
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- Cheryl Jackson (Well Path)
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- Tom Vitaglione (Women's & Children's Health)
- Cheryl Waller (Women's & Children's Health)
- Carolyn Sexton (Medical Assistance)
- Marcia Roth (Women's & Children's Health)

NC Health Alliance Board
- Bob Joyce
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Other Participants
- Vivian Green
- Lynne Hamlet
- Carmen Hooker-Buell

APPENDIX B
Comparison of Benefits Covered by Medicaid and a Modified State Employees Health Plan

Services	Medicaid	Modified State Employees Health Plan
Mandatory Services		
Hospital Services (inpatient and outpatient)	Covers inpatient and outpatient hospital care, including specialty hospitals (pulmonary and chronic diseases).	Covers if precertified, no day limits. Covers room and board in semi-private accommodations (unless hospital has only private rooms), medically necessary supplies, medications, lab tests, radiological services, operating and recovery rooms, hospital staff. Outpatient surgery covered. The state uses a DRG reimbursement system.
Physician Services	Covers physician services and other professional services; 24 visit limits waived for children who require additional visits as result of EPSDT screenings.	Covers office visits, surgical services and anesthesia services.
Laboratory and x-ray services	Covered.	Covered.
Well-baby and well-child care	Health Check (EPSDT) includes periodic physicals, immunizations, and all the follow-up treatment identified by the provider. The Health Check periodicity schedule is 5 times in first year, 3 times in 2nd year, annually in the 3-6 years, and then one checkup every three years thereafter.	Covers well baby and well-child care. Allows all medically necessary care. No limits on well-child visits up to age 1; 3 visits ages 1-2, and 1 visit ages 2-7. Children older than seven can obtain a check-up once every three years.
Immunizations	Covered.	Covered.
Additional Services		
Prescription drugs	Covers prescription drugs and insulin.	Covers prescription legend drugs and insulin. (Legend drugs must have unrestricted market approval by FDA).
Mental health services	Covers, including treatment in state mental hospitals. 24 visit/year limit waived if care provided through Area Mental Health agency, or needed as result of EPSDT screening. No day or dollar limits, but case managed through Carolina Alternatives, which is a carved-out managed care program covering mental health and substance abuse services for children. Operates out of 10 area MHDDSAS program (32 counties).	Covered. No day/dollar limits. Can obtain 26 visits outpatient visits/year without preauthorization. Most other mental health services require preauthorization (including inpatient mental health, urgent admissions, 23-hour observation bed stays, partial hospitalization treatment, psychiatric residential treatment care, care in intensive outpatient program) More than 26 outpatient visits requires preauthorization.
Vision	Vision screening; corrective lenses, eyeglasses and other visual aids covered (prior approval required for visual aids).	One comprehensive eye exam covered every two years.

Services	Medicaid	Modified State Employees Health Plan
Hearing	Covered.	Surgery/services to correct hearing problems are covered; appliances are not covered.
Other Allowable Services		
Eyeglasses	Covers corrective lenses, eyeglasses and other visual aids covered (prior approval required for visual aids).	Excluded.
Dental services	Most general dental services covered, such as exams, cleanings, fillings, x-rays and dentures, and some additional services (prior approval required for certain services).	Covers preventive, oral evaluations, radiographs, tests and lab exams, palliative treatment, space maintenance, amalgam restorations, silicate restorations, filled or unfilled resin restorations, inlay restorations, extractions, surgical extractions, anesthesia, oral and maxillofacial surgery and dental care related to accidental injury. Not more than once every 6 months.
Dental devices	See below.	Excluded (unless due to accidental injury).
Hearing aids	Covered.	Excluded.
Therapy (physical, occupational, and services for individuals with speech, hearing. and language disorders)	Covers audiologists, occupational therapists, physical therapists, and respiratory therapists. Also covers speech and language pathologists. No day or dollar limits; provided for habilitative as well as rehabilitative care.	Physical, limited occupational, inhalation and speech therapy covered when approved in advance. Requirement that condition expected to show significant improvement.[1]
Inpatient substance abuse	Covered. Substance abuse services part of capitated managed care system for children in 32 counties through Carolina Alternatives. No day or dollar limits, but case managed through Carolina Alternatives.	Covered. No day or dollar limits.
Outpatient substance abuse	Covered. Substance abuse services part of capitated managed care system for children in 32 counties through Carolina Alternatives. No day or dollar limits, but case managed through Carolina Alternatives.	See above.
Clinic services and other ambulatory health care services	Covers services at community health centers, rural health centers, migrant health clinics, county health departments, 24 visit limit waived if additional services needed as result of EPSDT screening.	Covered.

[1] If doctor or therapists thinks the patient will get some benefit, then the state will cover services. The state looks for short-term and long-term objectives; if progress is being made then the state will continue to cover the services. For speech therapy, must be able to show potential for cognitive understanding. (Kyle Howard, Medical Review for State Health Plan, Aug. 29, 1997).

Services	Medicaid	Modified State Employees Health Plan
Prenatal care	Covers.	Covered. Prenatal care for child dependents excluded.
Family planning	Covered. Covers Norplant, IUDs, prescription contraceptives, Depo-Provera.	Covers birth control pills, Norplant and Depo-Provera.
Abortion (limited to when necessary to save the life of the mother or if pregnancy result of act of rape or incest)	Limited to when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	Limited to when necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
Durable medical equipment and prosthetic devices, implants, adaptive devices	Prosthetics and orthotics covered.	Covers if reasonable and medically necessary (prior approval required if above $250). Prosthetics and orthotics are covered. Excludes: lifts, blood pressure cuffs and kits, wheelchair accessories, van lifts, ramps, and structural modifications, shoe inserts.
Disposable medical supplies	Under home health, Medicaid pays for medical supplies.	Covers medical supplies designed to serve only a medical purpose.
Over-the-counter medications	Not covered.	Not covered.
Home and community-based services (such as home health nursing, home health aide, personal care, assistance with activities of daily living, chore services, day care services, respite care, training for family members, and minor modification to home)	Covers personal care services such as assistance with dressing, feeding, household tasks, transportation and monitoring self-administered medication. Also covers home health services.	Home care includes private duty nursing, home care aides, skilled nursing visits, hospice care, home IV therapy. Prior approval required. Limited to 60 days, additional day available when approved in advance. To receive services, patient must be homebound, must require skilled services that cannot be provided by or taught to a person with no medical training. Excludes: care provided by family member, care provided by non-skilled or unlicensed caregiver, when patient no longer requires skilled level of care.
Nursing services (nurse practitioner services, nurse midwife services, advanced practice nurses, private duty nursing, pediatric nurse services, and respiratory care services in home, school or other setting	Covers nurse practitioner services, nurse midwifery, private duty nursing in certain instances. Covers home infusion therapy.	Private duty nursing covered when approved in advance.

Services	Medicaid	Modified State Employees Health Plan
Case management services	Covers case management services for pregnant women, children under age of 5 with special needs, mentally ill, chronic substance abusers, and people with HIV. Also provides case management services as part of Carolina Alternatives, Mecklenburg Co. managed care project, and Health Check.	None currently provided.
Care coordination	See above.	None currently provided.
Hospice care	Covered.	Covers.
Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative services (whether in facility, home, school or other setting) if prescribed by physician or other licensed provider, performed under supervision of physician, or furnished by licensed health care facility.	See therapy services above.	Covers up to $650/year in cardiac rehabilitation.
Premiums for private health care coverage	Not covered.	Not covered.
Medical transportation	Covers ambulance services (when other means of transportation would endanger the patient's health).	Covers ambulance services up to 50 miles.
Enabling services (such as transportation, translation, and outreach services) designed to increase accessibility of primary and preventive health services	Covers translation (paid as part of administrative costs or as part of cost-based reimbursement for federally qualified health centers), case management, medically necessary transportation.	None.
Any other health care services allowed by law (see below for examples)	Covers services of podiatrists, osteopaths, chiropractors, and optometrists; 24 visit limitation waived if need identified as part of EPSDT screening.	Covers up to $2000/year chiropractic services, podiatry services.
Other Covered Services by Plan		
Transplants and Dialysis	Covers.	Covers bone marrow for specified diagnoses, corneal, heart, kidney, liver, lung, pancreas and pancreas/ kidney. Requires prior approval. Excludes transplants determined to be experimental or investigational.
Alternative Therapy		Covers acupuncture by American MDs.

Services	Medicaid	Modified State Employees Health Plan
Wellness	Covered under Health Check described above, also covers parenting, childbirth education and other health education services provided as part of an office visit. Smoking cessation not covered (except in Mecklenburg Co. HMO project).	Covers $150 of eligible wellness charges each fiscal year (then covers additional amounts with deductibles/coinsurance). Services include general health check-ups, routine diagnostic exams and tests, x-rays, mammograms, prostate and rectal exams, blood pressure checks, urine tests and tuberculosis tests. There is a periodicity schedule which may be waived if medically necessary.
Other Excluded Services		
Learning disorders	Exclude special education services, but covers health related services.	
Reconstructive Surgery	Not covered if exclusively cosmetic.	Covered, including breast reconstruction following mastectomy. Excluded if purely cosmetic.
Experimental or Investigational Therapies excluded	Excluded if part of a protocol for investigation, not authorized by FDA. (Similar to other plans exclusions).	G.S. 35-40.1(7.1). Similar to other plans' exclusions.
Other exclusions		Cosmetic surgery, radial keratotomy, services to reverse surgical sterilization.
Other unusual provisions		Excludes maternity benefits for dependent children; newborn nursery care when mother not eligible for maternity benefits.
General Provisions		
Medical Necessity defined	Services which are, in the opinion of the treating physician or the DMA consulting physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration and scope to reasonably achieve its purposes; and the amount, duration or scope may not be arbitrarily denied or reduced solely because of the diagnosis, type of illness or condition.	Acceptable medical diagnoses and treatment of disease, injury or illness.
Emergency room or urgent care (coverage and definition; would be included as part of mandatory hospital care)	Covers care in emergency room. Must be pre-authorized if patient enrolled in Carolina Access or Mecklenburg County HMO project.	Covers with copayment (waived if admitted to hospital or no other care reasonably available).

Services	Medicaid	Modified State Employees Health Plan
Primary Care Providers	To participate as a primary care provider in Carolina Access, the provider must be enrolled as a Medicaid primary care provider for the service area; provide patient care coordination (provide or arrange for care), operate the office a minimum of 30 hours/week, provide essential preventive services, provide after hour coverage that does not automatically refer to the ER, establish and maintain hospital admitting privileges or establish formal arrangements with another practice to manage inpatient care, participate with Carolina ACCESS utilization management and quality assessment programs, and refer potentially eligible enrollees to WIC.	NA
Statewide Coverage		
Currently offered	100 counties	100 counties (HMOs offered in 92 counties). Out-of-state and out-of-country also covered.
Sources of Information	Division of Medical Assistance.	Its Your Choice (1997); Your Health Benefits (1996).

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Childrens Health Insurance Program
Cost Projection

- Federal appropriation made for ten years
- Federal appropriation is flat for first four years then drops by 26.3% for years 5,6,7 then increases by 28.6% for years 8, 9, and 23.5% in year 10.
- States have three years to spend each years allotment
- Cost projection takes into account the need to have an inflation increase each year and to smooth out the reduction in federal funds in years 5,6, 7.
- The cost projection is not a budget but assumes full years costs. The budget projection, when made, will account for a phase in of costs depending on when the program is begun.
- Budgeted figures for the first year will be less than the cost projection shown

Title XXI with Copays

Title XXI	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05	SFY05-06	SFY06-07
Funding (in Millions)									
Federal Appropriation for FFY	$ 4,275.00	$ 4,275.00	$ 4,275.00	$ 4,275.00	$ 3,150.00	$ 3,150.00	$ 3,150.00	$ 4,050.00	$ 4,050.00
NC Allotment	79.91	79.91	79.91	79.91	59.54	59.54	59.54	76.55	76.55
Program Costs	$ 77.31	$ 80.40	$ 83.62	$ 86.97	$ 90.44	$ 94.06	$ 97.82	$ 101.74	$ 105.81
Administration*	$ 7.73	$ 8.04	$ 8.36	$ 8.70	$ 9.04	$ 9.41	$ 9.78	$ 10.17	$ 10.58
Total Program & Admin	$ 85.04	$ 88.44	$ 91.98	$ 95.66	$ 99.49	$ 103.47	$ 107.61	$ 111.91	$ 116.39
Total Fed Match	63.20	65.36	67.64	70.00	72.45	74.98	77.60	80.70	83.93
Total State Match	21.84	23.08	24.34	25.66	27.04	28.49	30.01	31.21	32.46

*Administration is based upon 10% of Program Costs

Note: 10th year not shown; Federal allotment increases to $5 billion.

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Title XIX Cost Projection
Eligible But Not Enrolled

Cost projections based on the assumption that 50% of those eligible but not enrolled will enroll

This is not a budget projection but a full year cost estimate. The budget projection will be based on when the program is begun and will be less than the full year cost in the first year.

Title XIX

Title XIX	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05	SFY05-06	SFY06-07
Program Costs	$ 46.22	$ 49.03	$ 52.01	$ 55.18	$ 58.53	$ 62.09	$ 65.86	$ 69.87	$ 74.12
Projected Admin Costs	4.45	4.65	4.86	5.07	5.30	5.54	5.79	6.05	6.32
Total Program & Admin	$ 50.67	$ 53.68	$ 56.87	$ 60.25	$ 63.83	$ 67.63	$ 71.65	$ 75.92	$ 80.44
Total Federal Match	31.66	33.25	34.96	36.75	38.63	40.61	42.69	45.24	47.93
Total County Match*	7.86	8.42	9.01	9.64	10.31	11.03	11.80	12.49	13.22
Total State Match	11.15	12.01	12.90	13.86	14.89	15.99	17.16	18.19	19.29

*includes non-Federal share for Area Mental Health costs

PRIMARY RECOMMENDATION

IMPLEMENT A NON-ENTITLEMENT INSURANCE PROGRAM

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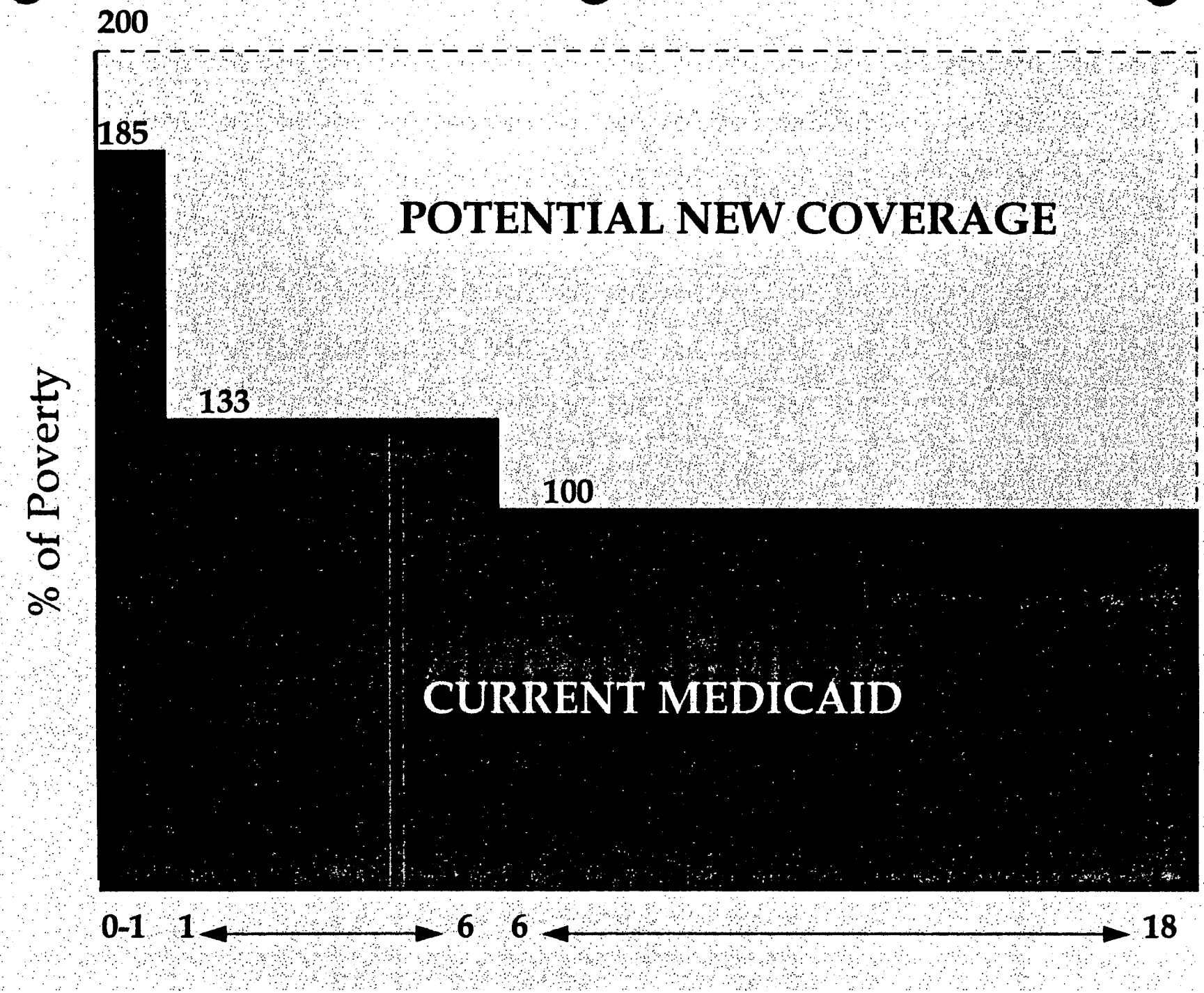
200
185
POTENTIAL NEW COVERAGE
133
100
% of Poverty
CURRENT MEDICAID
0-1
1
6
6
18

PROGRAM FEATURES

- Fiscal liability of state is fixed
- Offers comprehensive benefits package designed for children
  - Best addresses children with special needs
    - Provides access to:
      - Durable medical equipment
      - Eyeglasses
      - Hearing Aids
      - Care Coordination, including home visiting
      - Enabling Services, including translation

PROGRAM FEATURES (continued)

- Uses a Public/Private Delivery System
  - Existing Provider Networks
  - HMO Participation
- Simple for Families and Providers to Use
  - Families with children on Medicaid and new program can receive care from same providers.

PROGRAM FEATURES (continued)

- Administrative structure in DHHS already in place
  - DHHS must assure eligibility in screening for both Medicaid and new program
  - DHHS has infrastructure for:
    - Eligibility/enrollment
    - Payments to providers
    - Quality assurance
    - Contracting for Services

PROGRAM FEATURES (continued)

- Premiums will not be required
  - Costly to administer
  - Deterrent to participation
  - States have had negative experience

- Copayments required for families with incomes above 150% of federal poverty guidelines:
  - $3 for physician visits, clinic visits, dental visits, optometry visits
  - $5 for outpatient hospital visits
  - $3 for brand name drugs
  - $20 for non-emergency visits to the emergency room

<u>Note:</u>

- copayments not allowed for families below 150% FPG
- copayments not allowed for preventive services

PROGRAM FEATURES (continued)

- **Children must be uninsured when applying for the new program:**
  - **Studies indicate significant uncertainty regarding "crowd-out"**
  - **Crowd-out is less of an issue for children's coverage**
  - **Verification and enforcement are expensive**
  - **Experience of other states shows restrictions ineffective**
  - **State will monitor insurance status and take corrective action if necessary**

Medicaid as an Alternative

- Could do all of the above
- Children of state employees can be covered
- Can be used as a supplemental wrap-around payer of last resort

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Health Insurance and Our Children

- **The employer-based health insurance system is collapsing around our children:**
  - Ten million American children have no health insurance.
  - Nine out of ten of those children have working parents.
  - Six out of ten live in two parent families.
  - In 1980, the majority of workers in medium to large companies had employers who paid 100 percent of family health insurance costs. Today, less than 25 percent have those benefits.
  - The number of uninsured children is growing every day. Children are now losing private health coverage at twice the rate of adults.

- **Children are paying the consequences:**
  - More than half of the uninsured children with asthma and a third of the uninsured children with recurring ear infections never see a doctor. Untreated asthma leads to acute asthma attacks and hospitalization. Untreated ear infections can lead to permanent hearing loss.
  - A Pennsylvania survey shows that 20 percent of the uninsured children have untreated vision problems. If you can't see the board, you can't learn.
  - Twenty-five percent of the uninsured children have no regular source of care or use the emergency room as a regular source of care.
  - Children with untreated illness or disease pose a threat to other children.
  - Children sitting in classrooms with untreated pain or discomfort are not ready to learn.

- **There is a solution**:
  - This summer Congress recognized the problem and passed legislation that will give states money to cover uninsured children.
  - North Carolina can get up to $79.5 million annually in federal dollars for this program by providing $21.8 million in state dollars.

Children's Health Insurance Program

The Facts

- More than 71,000 children are eligible for this new program. Most of these children have working parents who are making too much to qualify for Medicaid, but not enough to afford the high cost of health insurance.

- Children would be covered if they come from families earning up to 200 percent of the federal poverty guidelines. For a family of three that's $2,221 a month. For a family of four that's $2,675 a month.

- This is a comprehensive health care package, including dental and vision care and covering durable medical equipment, eyeglasses and hearing aids.

- The Department of Health and Human Services' Division of Medical Assistance would administer the program.

- No premiums would be required, but these copayments would be required for families with incomes above 150 percent of federal poverty guidelines ($1,666 family of three/$2006 family of four):
  - $3 for physician visits, clinic visits, dental and optometry visits
  - $5 for outpatient hospital visits
  - $3 for brand name drugs
  - $20 for non-emergency visits to the emergency room

FAMILY INCOME PROFILE

FAMILY SIZE:	2	3	4
(Minimum Wage: $5.15/hr)			
100% Poverty			
Monthly Income	$ 885	$ 1,111	$ 1,338
Annual Income	$ 10, 610	$ 13,330	$ 16,050
Hourly Wage (1)	$ 5.30	$ 6.65	$ 8.00
Wage Earners(2)			
133% Poverty			
Monthly Income	$ 1,176	$ 1,478	$ 1,779
Annual Income	$ 14,111	$ 17,729	$ 21,347
Hourly Wage (1)	$ 7.05	$ 8.86	(1) $ 10.67
Wage Earners (2)			(2) $5.33
150% Poverty			
Monthly Income	$ 1,327	$ 1,666	$ 2,007
Annual Income	$ 15,915	$ 19,995	$ 24,075
Hourly Wage (1)	$ 7.95	$ 10.00	(1) $ 12.00
Wage Earners (2)			(2) $ 6.00
185% Poverty			
Monthly Income	$ 1,636	$ 2,056	$ 2,475
Annual Income	$ 19,629	$ 24,661	$ 29,695
Hourly Wage (1)	$ 9.81	(1) $ 12.33	(1) $ 14.85
Wage Earners (2)		(2) $ 6.16	(2) $ 7.42
200% Poverty			
Monthly Income	$ 1,770	$ 2,222	$ 2,676
Annual Income	$ 21,220	$ 26,660	$ 32,100
Hourly Wage (1)	$ 10.61	(1) $ 13.33	(1) $ 16.05
Wage Earners (2)	$ 5.30	(2) $ 6.67	(2) $ 8.00

THE STATES' RESPONSE TO THE NEW CHILDREN'S HEALTH PROGRAM

FISCAL RESEARCH DIVISION

DECEMBER 1997

12/16/97 am

Summary of States' Responses

- 11 States are leaning toward a Medicaid expansion (HI, ID, IL, MA, MO, NE, NM, OH, SC, TN, and VT)
- 12 states are looking into creating or expanding a separate state program (AZ, CO, KY, MI, MT, NV, NY, ND, PA, RI, UT, and WY)
- 9 states are likely to adopt a combination of the two approaches (AK, AL, CA, CT, FL, LA, NJ, OR and WI)
- 16 states are exploring their options (DE, GA, IA, IN, KS, ME, MD, MN, MS, NH, NC, OK, TX, VA, WA, and WV)
- AR is not planning to participate and SD has not started planning

States Submitting Plans

- Eight states have submitted state plans to the federal government: Alabama, California, Colorado, Florida, Missouri, New York, Pennsylvania, and South Carolina
- Medicaid Expansion: Alabama (Phase I), Missouri, and South Carolina
- Separate State Program: Colorado, New York, and Pennsylvania
- Combination: California and Florida

Medicaid Expansion

- Alabama's state plan proposes expansion of Medicaid to children ages 14-18 in families with incomes up to 100% federal poverty level (FPL).
- Missouri's state plan proposes expansion of Medicaid through an amended 1115 waiver which would cover children in families with incomes up to 300% of FPL
- South Carolina's state plan proposes expansion of Medicaid to children age 19 or younger in families with incomes up to 150% of FPL.

Separate State Programs

- Colorado's state plan proposes creating a Children's Basic Health Plan which covers children age 0 to 17 in families with incomes below 185% of FPL. Covered services are based on the Standard Plan as defined in Colorado's small group insurance reform law. Services will be delivered through HMO's willing to contract with Medicaid.
- New York's state plan proposes expanding its existing Child Health Plus (CHPlus) program to children under age 19 in families with incomes up to 222% of FPL. CHPlus is not an entitlement and children receive health care coverage through a managed care product.
- Pennsylvania's state plan proposes expanding its existing state program to children on the waiting list and other uninsured children. The Pennsylvania program covers children age 1 to 16 in families with incomes up to 185% of FPL receive free care and children age 0-5 in families with incomes between 185% and 235% of FPL receive subsidized health care.

Combination Programs

- California's state plan proposes expanding Medicaid to children age 14 to 18 in families with incomes up to 100% of FPL. The plan also proposes a separate state program called "Healthy Families" which will provide health coverage to uninsured children age 1 to 18 in families with incomes up to 200% of FPL through a purchasing pool of private insurance plans and a purchasing credit component to help families purchase employer based dependent coverage.
- Florida's state plan proposes proposes expanding Medicaid to children age 14 to 18 in families with incomes up to 100% of FPL. The plan proposes using the existing Florida Healthy Kids program which provides coverage to children age 3 to 18 in families with incomes up to 185% of FPL. The program uses schools as its administrative base.

- 3 States will not be able to use their monies because they have done such a good job of covering their children.

UNDERSTANDING THE NEW CHILDREN'S HEALTH PROGRAM

FISCAL RESEARCH DIVISION

DECEMBER 1997

12/16/97 AM

Overview of the State Children's Health Insurance Program (SCHIP)

- **What:** State Children's Health Insurance Program (SCHIP) was enacted to enable states to implement plans to initiate and expand the provision of health care assistance to uninsured, low-income children via Medicaid expansion or separate state insurance program efforts
- **Who:** Children under age 19 not eligible for Medicaid with family incomes below 200% of Poverty or 50% above the state Medicaid limit (235%)
- **How:** $24 Billion over five years (1998-2002) Grant spending $20 Billion; other spending $4 Billion
- **When:** States could begin program as early as October 1, 1997; must have plans in by June 1, 1998 to assure funding

Federal and State Funding

- State Allotment: Each state receives a portion of the total block grant based on the number of uninsured children in families with incomes at or below 200% of the federal poverty level.
- North Carolina's Block Grant for FY 1998 is $79,528,899 based on 138,000 uninsured children.
- State Match Requirement: Each state is required to match federal funds based on an enhanced Medicaid rate. N.C.'s federal enhanced matching rate is 74.16% , resulting in a $27,710,717 state match.
- States may not use other federal program funds or participant co-pays or premiums as matching funds.
- Use of funds for administration, outreach, and purchasing of direct services may not exceed 10% of the amount providing coverage.
- Allotments remain available for three years.

Eligibility

- Includes children below age 19 who are not covered under Medicaid, as of June 1, 1997, in families up to 200% of the poverty level or 50% above the state Medicaid limit and who are not receiving health coverage under a group or individual plan.
- The following children are ineligible even if they meet the other requirements:
  - Children who are incarcerated
  - patients in psychiatric facility
  - in a family eligible for health insurance coverage under a state health benefits plan on the basis of employment with a public agency

State Plan Requirements

- States applying for funding must submit a state plan with the following information:
  - the current health insurance status of children in the state, including low-income and uninsured children
  - state efforts to insure low-income and uninsured children
  - state efforts to coordinated existing state programs
  - outline of child health assistance to be provided under the plan including describing the delivery and utilization control systems
  - eligibility criteria
  - outreach activities
  - quality assurance

Program Eligibility Requirements

- Procedures established for eligibility must ensure the following:
  - Only low-income children are permitted to receive assistance.
  - Children found to be Medicaid eligible must be enrolled in Medicaid.
  - Coverage is not to substitute existing group health plan insurance.
  - There must be coordination with other public and private programs providing appropriate health insurance coverage to low-income children.

Additional Requirements

- Maintenance of Effort: States may not change Medicaid eligibility standards as of June 1, 1997, must continue to enroll eligible children into Medicaid, and must maintain the the current level of spending on non-federal health insurance programs.
- Substitution: States must submit in their plans a process describing how they assure that they are not replacing existing insurance coverage.
- Reporting and Evaluation: States must report annually on their progress at insuring low-income and uninsured children.
- Fraud and Abuse: Specific Medicaid and Medicare sanctions apply to state programs.

Waivers

- Federal Law allows waivers to some of the limitations on payments for expenditures.
  - A waiver of the limitation that no more than 10% of federal expenditures may be used for outreach, administration and purchasing of direct services if the following can be established:
    - coverage provided to low-income children meet the requirements of the Act;
    - Cost of coverage is not greater; and
    - coverage is provided through the use of a community-based health delivery system.
  - A waiver for the payment of family coverage under a group health plan if the purchase of coverage is more cost effective and does not substitute for coverage otherwise available.

Other Medicaid Options

- Federal law authorizes states to implement two additional options under Medicaid:
  - Presumptive Eligibility
  - Continuous Eligibility

Presumptive Eligibility

- States have the option to allow community health centers, Head Start Programs, WIC, child care programs, and other "qualified entities" to enroll children in Medicaid programs on a temporary basis based on information provided by the family.
- Families must then submit a formal application and be determined as eligible.
- North Carolina (and 29 other states) already has presumptive eligibility for pregnant women.
- The purpose of presumptive eligibility is to allow children to be covered sooner and enroll children who are difficult to reach.

Continuous Eligibility

- States have the option to guarantee twelve continuous months of coverage for children regardless of fluctuations in income during the year.
- Continuous eligibility does not apply to children who lose coverage because they reach the age of 19.
- The purpose of continuous coverage is to provide stability in coverage for children enrolled in Medicaid and to assist in minimizing disruptions in eligibility.

Approaches to Expanding Coverage

- Federal Law allows the following options for expanding Children's Health Insurance Coverage:
  - Expansion of Medicaid
  - Creating a separate, state subsidy program
  - Combination of Medicaid and a separate state program

Expansion of State Medicaid Programs

- States are subject to federal Medicaid rules relating to entitlement, benefits, cost sharing, and delivery for all additional children covered under expansion.
- States must submit a Medicaid plan amendment in addition to their plan for using the children's health insurance funding.
- SCHIP funding is used to provide the federal match for a SCHIP Medicaid expansion.
- Provides for existing federal Medicaid match once allotment under expanded program is used.

Creating a Separate State Program

- Separate State insurance programs can limit eligibility by:
  - geographic area;
  - income and resources;
  - residency;
  - disability status; and
  - access to other health insurance.
- States can set limitations on enrollment and develop waiting lists.
- States have full responsibility over administration of the program.

Creating a Separate Program (Continued)

- Separate state insurance programs need to determine the following:
  - provider network and delivery systems
  - methods to monitor quality of care
  - enrollment systems coordinated with Medicaid in order to enroll Medicaid eligible children into state Medicaid programs

Key Issues for Designing N.C.'s Children's Health Program

- North Carolina will need to consider the following key issues in designing a children's health insurance program:
  - Benefit packages
  - Cost-sharing
  - Administrative issues
  - Welfare stigma
  - Children with special health care needs
  - Limiting substitution
  - Immigrant children
  - Evaluation
  - Cost

Benefit Package Requirements

- Federal Law defines these four options for a minimum benefit package:
  - coverage of benefits equivalent to those provided in a benchmark benefit package
  - coverage of benefits actuarially equivalent to one of the benchmark benefit packages
  - coverage of comprehensive benefits provided by an existing children's health program
  - other health plans that the Secretary of HHS deems as adequate for a low-income population

Benefit Package Requirements (Continued)

- If the actuarially equivalence option is taken, States must provide the following:
  - four basic services (impatient/outpatient hospital services, surgical and medical services, laboratory and x-ray, and well-baby/well-child care)
  - aggregate value must be actuarially equivalent to the benchmark plan
  - mental health, vision, hearing and prescription benefits must have at least 75% the value of these services in the benchmark plan

Benefit Package Requirements (Continued)

- A benchmark benefit package may consist of one of the following:
  - Standard BC/BS preferred provider option offered by FEHBP
  - Health coverage generally offered to state employees
  - Health coverage by the HMO with the largest commercial, non-Medicaid enrollment in the state

Cost-Sharing Requirements

- State plans are required to include a description of the amount of premiums, deductibles, or other cost-sharing arrangements instituted by the program.
- Cost-sharing is limited based on total family income:
  - Families below 150% of poverty; cost-sharing must be consistent with Medicaid and premiums cannot exceed amounts imposed on Medicaid beneficiaries
  - Families above 150% of poverty: premiums, deductibles, and other cost-sharing must be based on a sliding fee schedule and is not to exceed 5% of the family income
- Cost-sharing cannot **favor** children from families with higher incomes.

Administrative Issues

- Use of an existing or separate administrative vehicle
- Adequacy of payment rates to providers
- Ease of application and enrollment
- Marketing and outreach strategies
- Use of managed care
- Coordination with other programs serving children and families
- Incentives for certain providers to be included in network
- Interaction with welfare reform initiatives
- Plan to ensure ongoing public involvement
- Consumer protections and oversight

Welfare Stigma

- There is a stigma associated with public insurance programs that may hinder enrollment of families in need.
- Methods for deterring welfare stigma:
  - designing benefit packages and cost-sharing arrangements comparable to private insurance
  - providing coverage through a state program rather than Medicaid
  - issuing insurance cards that mimic those provided by employer-sponsored coverage
  - carefully considering the name for the new program
  - carefully choosing the sites and methods for eligibility and enrollment

Children With Special Health Needs

- How can states best serve families with children with special health care needs (CSHCN)?
  - Families with CSHCN require access to specialty services and are most impacted by service limits and the inclusion of home and community-based care.
  - Families with CSHCN are concerned about the arrangement of care and provider network included in a state program.
  - These families are very concerned about continuity of care.
  - Limiting the scope of the benefit package could discourage families with CSHCN from participating.

Substitution or Crowd-Out

- There are two types of substitution:
  - Employee-based substitution or "opt-out" is when individuals choose a government-subsidized program instead of selecting employer-sponsored coverage.
  - Employer-based substitution or "push-out" is when employers reduce or eliminate health insurance coverage to workers and their families or increase employee and or individual costs.
- The impact of substitution is difficult to measure due to limited data, but most believe that "opt-out" is the greater concern.
- States that have already implemented children's health insurance programs have limited substitutions by focusing on "opt-out".

Substitution (Continued)

- Mechanisms limiting "opt-out" include:
  - Increasing premiums
  - Redefining copayments
  - Periods of uninsurance
  - Providing subsidies
  - limiting the scope of the benefit package
- Mechanisms limiting "push-out" include:
  - Purchasing cooperatives
  - Buy-ins
  - Reimbursements

Substitution (Continued)

- Other substitution issues:
  - What are the tradeoffs between administrative simplicity and barriers to substitutions and eligibility?
  - Is some substitution unavoidable and desirable?

Immigrant Children

- Medicaid for immigrant children:
  - States may cover "qualified aliens" who entered the country prior to August 22, 1996.
  - Among qualified alien children who entered the country post August 22, 1996, all but certain categories of children are barred from Medicaid for a five-year period.
  - Children who are not qualified aliens are not eligible for Medicaid.
- CHIP for immigrant children:
  - HCFA says CHIP is subject to the same restrictions on covering immigrants as Medicaid since it is a "means-tested" program.

Evaluation

- Federal law requires states to submit an annual report assessing the operation of the state's SCHIP plan - including the progress made in reducing the number of uninsured low-income children.
- State evaluations of their Child Health Plan are required by March 31, 2000.
- North Carolina will need to decide how it wants to evaluate the success of its program including what data needs to be collected.

Cost Issues

- Source of funding for the required state match
- Availability of existing state and local funding for health programs for children which can be used as state match
- Cost impact on the current state Medicaid program of enrolling more eligibles identified under the SCHIP program
- Cost impact of implementing presumptive eligibility and continuous eligibility on the current Medicaid Program
- The impact of federal changes to Medicaid in future years
- The availability of SCHIP funding after the first five years

Designing N.C.'s Children's Health Program

- SCHIP gives states the flexibility to design a children's health insurance program which will best meet the needs of a state's uninsured children.
- When designing a program, it is important for N.C. to decide the goals it wants to achieve. Examples of potential goals are as follows:
  - Improving health outcomes for children
  - Providing health insurance to as many children as possible
  - Providing a comprehensive benefit package
  - Insuring the parents of eligible children
  - Focusing on providing coverage for a specific population of uninsured children
  - Improving access to services
  - Delivering services cost effectively
  - Eliminating the welfare stigma associated with public programs
  - Utilizing existing state programs
  - Creating public/private partnerships

Health and Human Servic elated Reporting Requirements (Senate Bill 352)

October 1997

Section (SB 352)	Report Title	Reporting To?	Due Date
11.2	Reorganization Plan	Appropriations Subcommittee	Ongoing
11.10	Medicaid Growth Reduction Plan (For 1998-99)	Chairs, App'ns Subcommittee	9/1/97
11.21	Adult Care Homes Report	Joint Gov. Ops./FRD	10/1/97
11.28	Quarterly Review of ACTS	Chairs, App'ns Subcommittee/ FRD	9/30/97
11.51	Annual Reports on Wilderness Camp, Coach Mentor Training, and Gov.'s 1-on-1 Programs	Joint Gov. Ops.	10/1/97
11.55	Smart Start Progress Report	Joint Gov. Ops.	10/1/97
11.60	ABC's Plan for DHHS Schools (Interim Report)	Joint Legislative Ed. Oversight Committee	10/1/97
15.22	Report on Expenditures and Effectiveness of Communicable Disease Control Aid to Counties	Joint Gov. Ops.	10/1/97

November 1997 – None

December 1997

Section (SB 352)	Report Title	Reporting To?	Due Date
11.37	Thomas S. Cost Containment Measures (Status Report)	Appropriations Subcommittee/ FRD	12/1/97
11A.129	Progress Report on Integrating Health-Related Functions	Joint Gov. Ops.	12/31/97

January 1998

Section (SB 352)	Report Title	Reporting To?	Due Date
11.55	Smart Start Progress Report	Joint Gov. Ops.	1/1/98
11.61	Performance Audit on Div. Of Services for the Blind	Chairs, App'ns Subcommittee	1/1/98
Part V. Block Grants	Reports on 1) Use of TANF Funds for Reducing Out-of-Wedlock Births and 2) Use of SSBG Funds to Provide Substance Abuse Services for Juveniles	Appropriations Subcommittee	1/1/98
15.28	Report on Adolescent Pregnancy Prevention Coalition of NC	Joint Gov. Ops./FRD	1/15/98
15.29	Report on North Carolina Healthy Start Foundation	Joint Gov. Ops./FRD	1/15/98
15.33	Report on Prevent Blindness, Inc.	Joint Gov. Ops./FRD	1/15/98

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Health and Human Services Related Reporting Requirements (Senate Bill 352) (Cont'd)

February 1998

Section (SB 352)	Report Title	Reporting To?	Due Date
11.7	Provider Reimbursement Rate Study (Status Report)	Appropriations Subcommittee/ FRD	2/1/98
11.69	Study of Adult Care Home Bed Vacancy Rates	Chairs, App'ns Subcommittee	2/1/98
15.31	Report on Allocation and Use of Cancer Control Funds	Joint Gov. Ops./FRD	2/1/98

March 1998

Section (SB 352)	Report Title	Reporting To?	Due Date
11.40	Report on Special Alzheimer's Units	Appropriations Subcommittee/ FRD	3/1/98
11.49	Impact of Downsizing on Mental Retardation Centers	Appropriations Subcommittee/ FRD	3/2/98
11.71	Comparison of Medicaid Eligibility Requirements for In-Home and Institutional Services	Appropriations Subcommittee/ Commission on Aging	3/1/98

April 1998

Section (SB 352)	Report Title	Reporting To?	Due Date
11.5	Proposed Health Care Standards	General Assembly	4/1/98
11.10	Medicaid Growth Reduction Plan (Through 2001)	Chairs, App'ns Subcommittee	4/1/98
11.36	Thomas S. Progress Report	General Assembly	4/1/98
11.44	Efficiency Study of State Psychiatric Hospitals	Chairs, App'ns Subcommittee/ FRD	4/1/98
11.55	Smart Start Progress Report	Joint Gov. Ops.	4/1/98
11.60	ABC's Plan for DHHS Residential Schools (Final Report)	Joint Legislative Ed. Oversight Committee	4/1/98
15.32	Osteoporosis Task Force Progress Report	Joint Gov. Ops./Governor/FRD	4/1/98

Health and Human Services-Related Reporting Requirements (Senate Bill 352) (Cont'd)

May 1998

Section (SB 352)	Report Title	Reporting To?	Due Date
11.4	Title IVA-Emergency Assistance Funding	Chairs, App'ns Subcommittee	5/11/98
11.5	State Children's Health Insurance Program	General Assembly	5/11/98
11.27	Caring Program for Children Annual Report	Joint Gov. Ops./FRD	5/1/98
11.34	Carolina Alternatives Progress Report	General Assembly/FRD	5/1/98
11.37	Thomas S. Cost Containment Measures (Status Report)	Appropriations Subcommittee/ FRD	5/1/98
11.47	Whitaker School Replacement Facility Status Report	Appropriations Subcommittee/ FRD/Human Rights Committee	5/1/98
11.57	State Child Fatality Review Team - Final Report	Appropriations Subcommittee	5/18/98
11.71	Progress Report on Providing Adult Day Health Care Services Through Medicaid	Chairs, App'ns Subcommittee	5/1/98
11.73	Study of Alternate Living Arrangements	Appropriations Subcommittee/ Commission on Aging/FRD	5/1/98
Part V. Block Grants	Report on Special Children Adoption Fund	Chairs, App'ns Subcommittee	5/1/98
15.25	Heart Disease and Stroke Prevention Task Force Interim Report	General Assembly/Governor	5/18/98
11A.128	Environmental Review Commission (ERC) Study of Environmental Health-Related Functions	General Assembly	5/98
11A.129	DHHS Report on Additional Changes Required to Effectuate Integration of Health Functions, Including Results of ERC Study	General Assembly	5/1/98

Additional Reports (No Specified Due Date or Deadline After May 1998)

11.6	Award of Human Services Grants	Joint Gov. Ops.
11.35	Report on Willie M. Expenditures and Program Effectiveness	FRD
11.42	Study of Substance Abuse Treatment Programs	Joint Gov. Ops
11.57	State Child Fatality Review Team Quarterly Activity Reports	Chairs, App'ns Subcommittee/FRD
15.24	Report on State Training Program for Environmental Health Specialists	Joint Gov. Ops./FRD (7/1/98)

12/15/97

MINUTES

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

DECEMBER 17, 1999

The Joint Appropriations Subcommittee on Health and Human Resources met on Wednesday, December 17, 1997, at 9:00 a.m., in Room 414 in the Legislative Office Building.

Representative Cansler chaired the meeting with four Senators present and the following Representatives were present: Representatives Adams, Aldridge, Alexander, Berry, Clary, Earle, Esposito, Gardner, Howard, Hurley, Nye and Watson.

Ashley Thrift, NC Partnership for Children Board of Directors, began his presentation on Smart Start (see handout: "First Quarter Report and Achieving Accountable Programs and Services").

David Walker, Executive Director of NC Partnership for Children, Inc., gave his presentation regarding where the partnership is relative to follow-up by Coopers & Librands Consultants. The following issues were addressed:

-Reviewed administration of local partnerships – Study being conducted to assess capacity to comply with accountability/ feasibility requirements and cost benefit analysis.

-Engaged in strategic planning process.

-Reviewed plan for dispersing funds

-Reviewed process of monitoring local board activities.

Karen Ponder, Program Director for NC Partnership for Children, Inc., discussed the program and its initial purpose of infrastructure development for the benefit of children within communities. She discussed existing services in 43 counties and indicated 45 counties are in the process of planning for services (see handout - Achieving Accountable Programs and Services"). Ms. Ponder also cited four core services which Smart Start has begun, and they are:

- Improving the quality of child care.
-Accessibility
-Delivering family support services
-Comprehensive Health Care and Education

There was some discussion among the committee about what Smart Start is doing that other programs are not. Ms. Ponder responded by stating that Smart Start was filling the gaps and reaching children who otherwise would not be reached. She also discussed the fact that the program has also been successful with at-risk children through expanding their exposure to books.

The question of how Smart Start would track those books which are helping a child and Ms. Ponder replied that one way in which to do so would be through the use of a bookmobile, which could reach families who would not ordinarily get to a library due to a need to focus upon the basic needs of day to day living as a result of poverty.

Representative Shubert suggested that the structure of the Board of Directors for Smart Start lends itself to conflict of interests, based upon the fact that most board members expect their organizations to be recipients of Smart Start funding. She challenged the committee to address the issue. She also cited accounting as a serious problem, however, she did not assess the problem as being a result of the State Auditor's office, particularly in light of the fact that he primarily had to create a process by which to audit the program, due to the condition of the records.

Representative Cansler suggested the possibility that the General Assembly had not done a good enough job with directives to Smart Start and inquired about possible ways in which greater clarity could be brought to the process.

The question of whether or not some funding could be considered as in-kind contributions was raised. Ms. Ponder replied that certain guidelines/ standards which the State Auditor in the audit process would not permit a great deal of funding to be considered as in-kind contributions, however, if the programs had been able to use the standard that is applicable to tax exempt non-profit entities, they could have declared a great deal of funding as in-kind. Since the General Assembly clarified some issues and standards, much is being resolved.

Representative Steve Wood, asked if Smart Start was a state program and what the current funding level by the General Assembly was. Ashley Thrift replied that it is not a state program and that the funding level by the General Assembly is just under $92 million.

Representative Wood asked if there is a mandate for accreditation. Mr. Thrift replied that there is no such mandate, further explaining that a program can choose when and if it wants accreditation. He explained that Smart Start is a local agency.

Representative Shubert expressed concern regarding the possibility of the General Assembly mandating the placement of state employees on the board if it is supposed to be a private agency. The reason for her concern was relative to the kind of message it would be sending. She further stated that she would like to see the committee address the issue of conflict of interest, in that appointees are placed in a position to vote for funds they would be receiving.

Donna Bryant, PhD, Director of Family and Child Care Research Program, gave her presentation on early childhood research. She cited two portions of her research that are undergirthing Smart Start, (see handout: "Highlights of Smart Start Evaluation") to include the following

-Early Intervention Works for At-Rick Children

-Abcerderian Project- 0-15 years study (half received early intervention, half did not).

The drawback to the study was that they did not have randomized studies, rather on a much larger scale.

The study revealed that high quality does make a difference, particularly for at-risk children. The question is how we secure it. It was determined that one way in which to improve upon the quality of day care, particularly the at-home centers, was by improving upon the environment, which supports Smart Start's reason for its existence, also, to increase the quality and amount of training for teachers and increase quality and amount of training for directors.

The Committee adjourned for lunch at 12:45 p.m. and reconvened at 1:50 p.m..

Sue Russell, Executive Director of Day Care Services Association, gave her presentation on "Child Care Subsidy: An Investment of NC". (Handout attached).

Peter Leousis, Assistant Secretary, Human Services and Educational Policy, discussed child care and Work First. Mr. Leousis stressed the need to

implement a program which is designed to help families come off of welfare, remain off and never even need to get on it initially.

Jim Edgerton, Asst. Secretary, Health and Human Services, cited a provision that would permit the department to transfer TANF funds from cash assistance for child care, without the approval of the committee, however, Dr. Bruton assured the committee that the department had no intentions of taking advantage of such a provision and jeopardize the relationship that they are attempting to establish with the committee.

Senator Martin requested that the department compile the counties' priorities relative to utilizing child care subsidies.

Representative Adams suggested that if the state does not provide a livable wage, we will have a child care issue to resolve.

Representative Gardner suggested that she would like to see a projection of figures relative to the need to address transportation relative to child care.

Senator Martin asked whether any counties are developing plans to address the need for job training that would go beyond the twelve months under Work First. Kevin Fitzgerald replied that there were not, however, some have suggested using the Work First portion as a supplement.

After Peter Leousis concluded his presentation, Stephanie Fanjul, Director of Child Development made her presentation (see handout: "Improving Child Care in NC Revisions to the Child Care Law"). Ms. Fanjul gave an overview of the major points of the new child care law, SB929, passed by the General Assembly in 1997 session. The issues summarized in that law included the following:

- Intent of child care law
- New definitions
- Licensing changes
- Family child care home changes
- Child care center changes

Representative Gardner, asked Ms. Fanjul to address the issue of playground equipment safety and rules and revocation of license, bringing the committee up to date with regard to what was finally agreed upon by the Child Day Care Commission. Ms. Fanjul said that they did make temporary rules relative to playground equipment. That was the only area that was changed, because the section of the existing rules was

was repealed. They did feel there was a reason for having something on the books. They added four temporary rules. Those rules are now going through the same process to become permanent rules so there is still time for folks to talk to the Commission about how they would like them to be changed.

Ms. Fanjul explained that in questioning licenses being revoked, it is in the rules package that is going to be published that the Commission addressed revocations and what they did for the first time is to offer some limit to how long you have to wait after your licenses has been revoked or they have done what they call a summary suspension which is usually children are at grave risk. Ms. Fanjul said she has done three in the five years she has been with the state. They have addressed that in part in their rules.

Representative Cansler said the agenda for the meeting today has been covered.

The meeting was adjourned at 3:45 p.m.

Representative Lanier Cansler, Chairman
Joint Appropriations Subcommittee on Health and Human Services

Sarah J. Murphy, Acting Committee Clerk (From Tapes)
Joint Appropriations Subcommittee on Health and Human Services

VISITOR REGISTRATION SHEET

JOINT APPROP - HHS — 12/17/97

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR AGENCY AND ADDRESS
David Walker	N.C. Partnership for Children
Roslyn Savitt	NC Child Care Coalition
Gerry Cobb	NC Partnership for Children
MONICA HARRIS	NC Partnership for Children
Karyn Ponder	"
Rita Freeman	DCHHS
Stephanie Daniel	DHHS - DCD
Tommy Worth	Carolina Health Care Systems
John Rustin	NCFPC
NELS ROSECAND	OSBM
Connie Schardt	Dept. of Commerce
Lucy Kitchen	DHHS
Jim Edgerton	DHHS
DAN GERLACH	BUDGET & TAX CENTER

12/17/97 Am

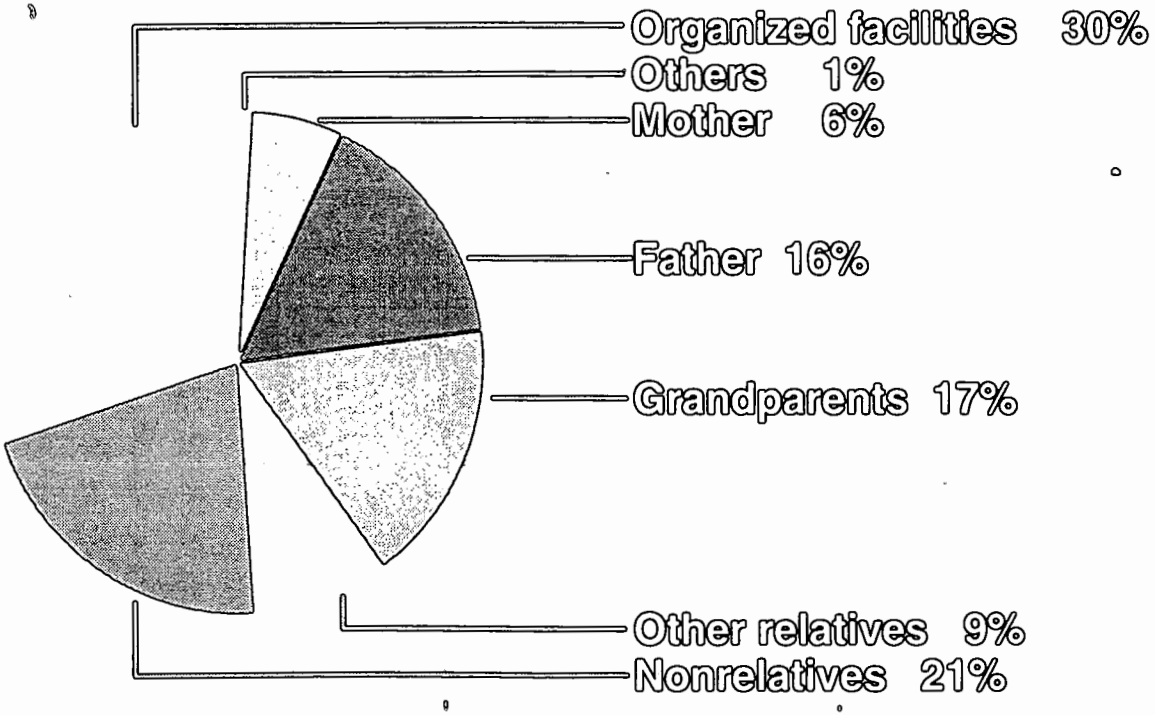
Highlights of the Smart Start Evaluation

December 17, 1997

Presented by:

Donna Bryant, Ph.D.
Frank Porter Graham Child Development Center
University of North Carolina at Chapel Hill
Chapel Hill NC 27599-8180
(919) 966-4523
bryant@unc.edu

Primary Child Care Arrangements Used by Families with Employed Mothers for Preschoolers: 1993



Source: Current Population Reports, 1996

From Cost, Quality, and Outcomes Study, 1995

Figure 4.1
Process Quality in Child Care Centers

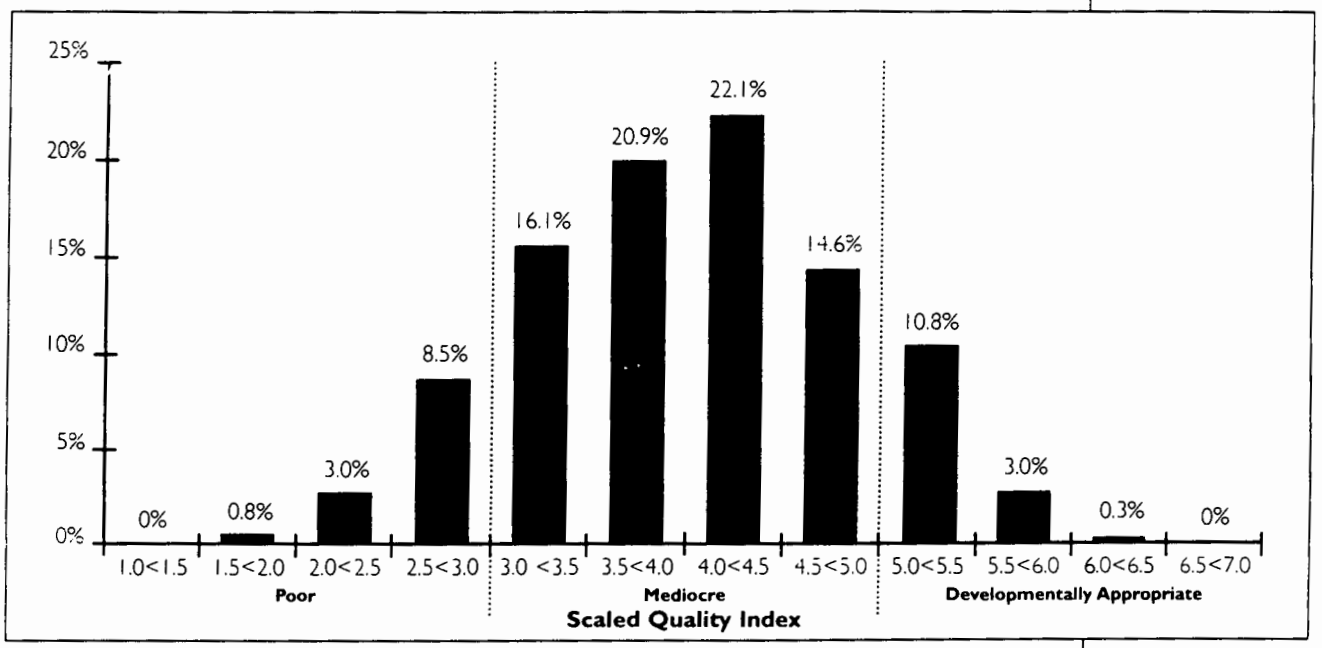
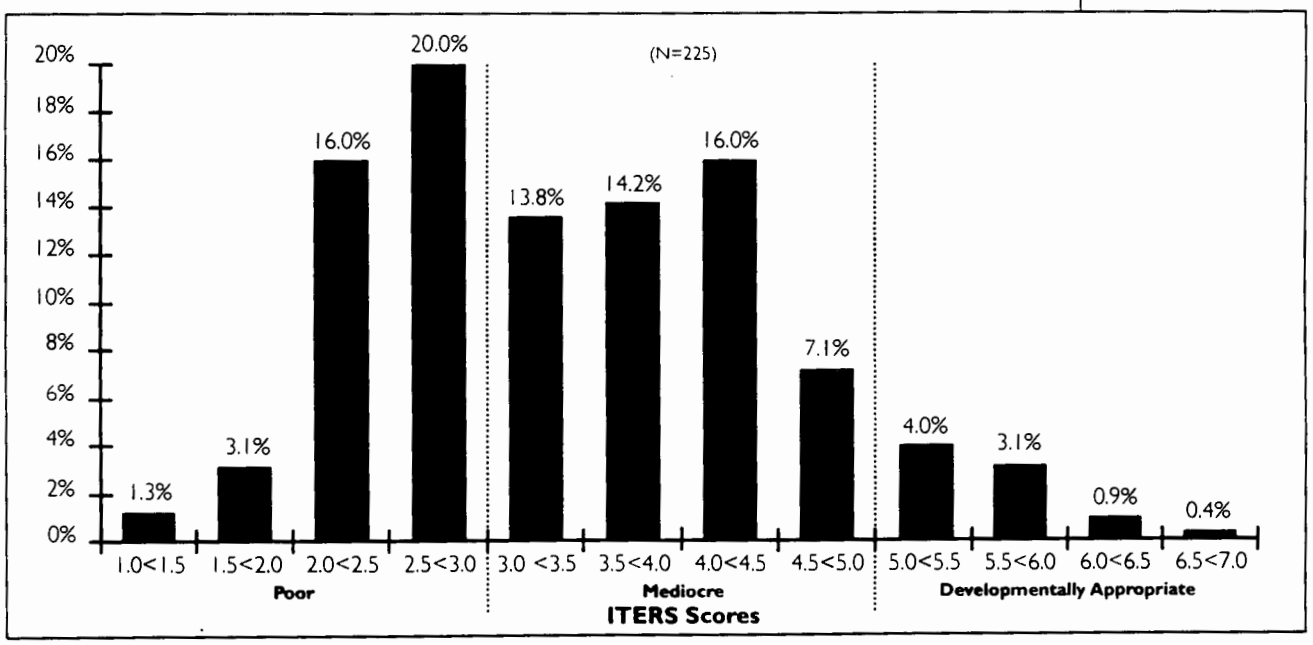


Figure 4.2
Process Quality in Child Care Centers: Infant/Toddler Classrooms

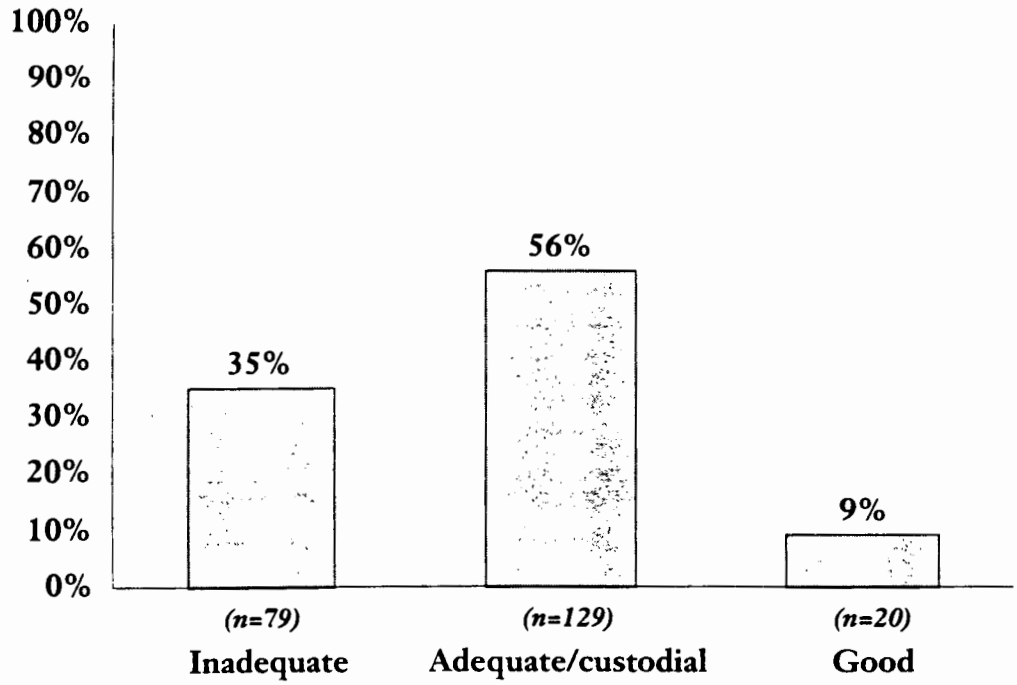


Another cause for concern is that few homes in this study are rated as "good quality."

As previously reported, the Harms and Clifford measure of global quality is correlated with the other measures of quality in this study. Providers who have higher global quality scores are rated as higher in sensitivity, and lower in restrictiveness and detachment. They are also observed to be more responsive. (See Table B5, Appendix 2, page 127.)

- As shown in Figure 7, thirty-five percent of the providers in this study received scores in the inadequate range (scores of 1 to 2), 56 percent in the adequate/custodial range (scores of 3 to 4), and 9 percent in the good range (scores of 5 to 7). This is another cause for concern.

FIGURE 7: GLOBAL QUALITY RATINGS FOR PROVIDERS



Source: Families and Work Institute, 1994

- The average provider in this study received a global quality score of 3.39. This is just slightly less than the average global quality score of 3.98 received by classrooms in the National Child Care Staffing Study (Whitebook, Howes, and Phillips, 1990).

Children's Language Experiences
(from Hart & Risley, 1995)

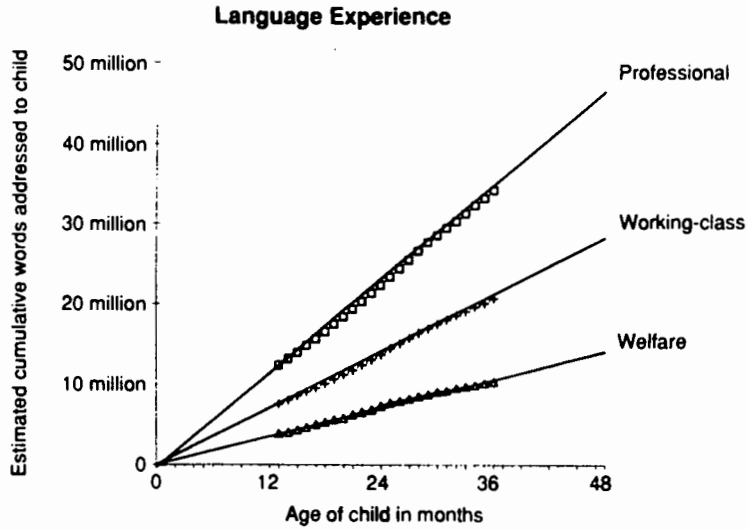


Figure 19. Cumulative number of words addressed to the child in 13 professional (squares), 23 working-class (plus signs), and 6 welfare families (triangles) extrapolated from birth to 12 months of age and from 37 to 48 months of child age. The linear regression line was fit to the actual average cumulative number of words addressed to the children per hour when they were 12–36 months old.

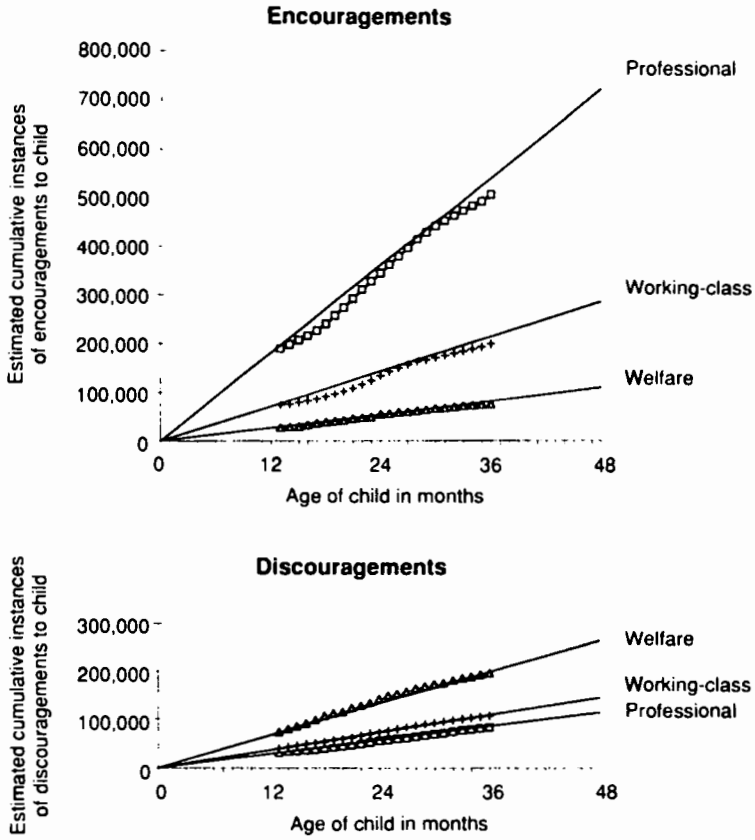


Figure 20. Cumulative instances of feedback containing encouragements (top graph) and discouragements (bottom graph) addressed to the child in 13 professional (squares), 23 working-class (plus signs), and 6 welfare (triangles) families extrapolated from birth to 12 months of age and from 37 to 48 months of child age. Encouragements were affirmations that repeated, extended, or expanded the child's utterances and expressions of approval of the child's behavior as "right" or "good." Discouragements were prohibitions directing the child "Don't," "Stop," "Quit," or "Shut up" and expressions of disapproval of the child's behavior as "bad" or "wrong." Note the reversal of the lines in the bottom graph, reflecting the prevailing negative Feedback Tone in the welfare homes. The linear regression lines were fit to the actual average cumulative numbers of affirmations and prohibitions addressed to the children per hour when they were 12–36 months old.

Smart Start Evaluation Timeline

1993–1995

1993	1994	1995
Pioneer Partnerships selected & began planning	Pioneer Partnerships began 1st year of implementing Smart Start	Pioneer Partnerships in their 2nd year of implementation
Observed process	Child care visits	Kindergarten Teacher Checklists
Designed evaluation plan	Collaboration study	Kindergarten Health Assessments
	Family interviews	Focus groups
	Key participant interviews	

Smart Start Evaluation Timeline (cont.)

1996–1997

1996

Year 3 of implementation

Child care visits

Collaboration study

Parent-business involvement interviews

Quarterly report

Feasibility study of tracking systems

Smaller, intensive studies of specific Smart Start efforts

1997

Year 4 of implementation

Kindergarten Teacher Checklists

Kindergarten Health Assessments

Qualitative study

Quarterly report

Smaller, intensive studies of specific Smart Start efforts

Evaluation is driven by the theories of change underlying Smart Start

Smart Start Services	*Short Term Change*	*Long Term Change*
Quality child care efforts	Better child care	More "ready" children at age 5
Family programs	Better functioning families	More "ready" children at age 5
Health programs	More children taking advantage of greater no. of health services	Children more healthy at school entry

Goal: All children are healthy when they enter school

Who? 9,412 kindergartners in 1995 in rounds 1, 2, and 3
Data abstracted from their Kindergarten Health Assessment forms

Purpose: To determine health status of entering kindergartners

Findings: Almost 100% rates of immunization, but prior K entry only 53% on time
2% failed hearing, 7% failed vision, 25% at least one health problem
Speech problems are the most likely to have been treated (40% referred)
But, difficult to interpret because large amounts of missing data

Goal: Families are supported in their role as primary teacher of their children

Who? 356 randomly selected families from first 12 partnerships
Smart Start Family Interview given to parent

Purpose: To describe the "typical" Smart Start family

Findings: Wide variety participating, but majority are poor or working poor
Median income = $20,000/year
63% of the low-income and 90% of middle-income families work
Mothers work an average of 37.5 hours/week

Family findings, continued

80% of the families had a child in care > 20 hours/week
Parents select care based on values and goals of program and characteristics of provider
Parents rate their own child care as good and CCR&Rs as very helpful
Child care subsidies for low-income families keep their annual costs at $1,281
30% of low-income families spend > 10% of income on child care and 16% spend > 20%

Family findings, continued

High expectations for their children's learning
Wide variety of activities reported, similar to national sample of parents
75% involved in at least one community group, most often (60%) a religious group
79% report high family strengths
Most use an informal network for help with problems
High level of satisfaction with community services

Goal: High quality and affordable child care are available for all families who need it

Who?	185 preschool classrooms, 1995 and 1997 Used Early Childhood Environment Rating Scale (ECERS)
Purpose:	To document change over time and whether related to Smart Start
Findings:	Significant increase in ECERS quality (14% to 25% rated good) Related to: percentage full-funding allocation received proportion of funds spent on child care the number of enhancement activities A to AA increased from 38% to 52%

Goal: All children are prepared to succeed when they enter school

Who?	3900 kindergartners in first 3 rounds Teacher ratings on the Kindergarten Teacher Checklist
Purpose:	Document skill level of kindergartners in 1995 and establish a baseline
Findings:	Mean score was fairly high, but 18% judged "not ready" Children with child care rated significantly higher than those without Poor children rated significantly lower than non-poor children No differences across partnership rounds

Goal: To bring parents and business into the Smart Start process

Who?
66 interviews in 24 partnerships and 57 interviews in 4 case study partnerships

Findings:
A range of involvement strategies are needed, but only a few are implemented
Choice of a wide range of roles results in more involvement
Parents and business people both required logistical support, but their needs differed and conflicted
The promise of local control had great appeal to business
Expanding the number and diversity of parent representatives gave voice to parents
Sustaining the partnership requires coordination and resources

Evaluation Assistance Team

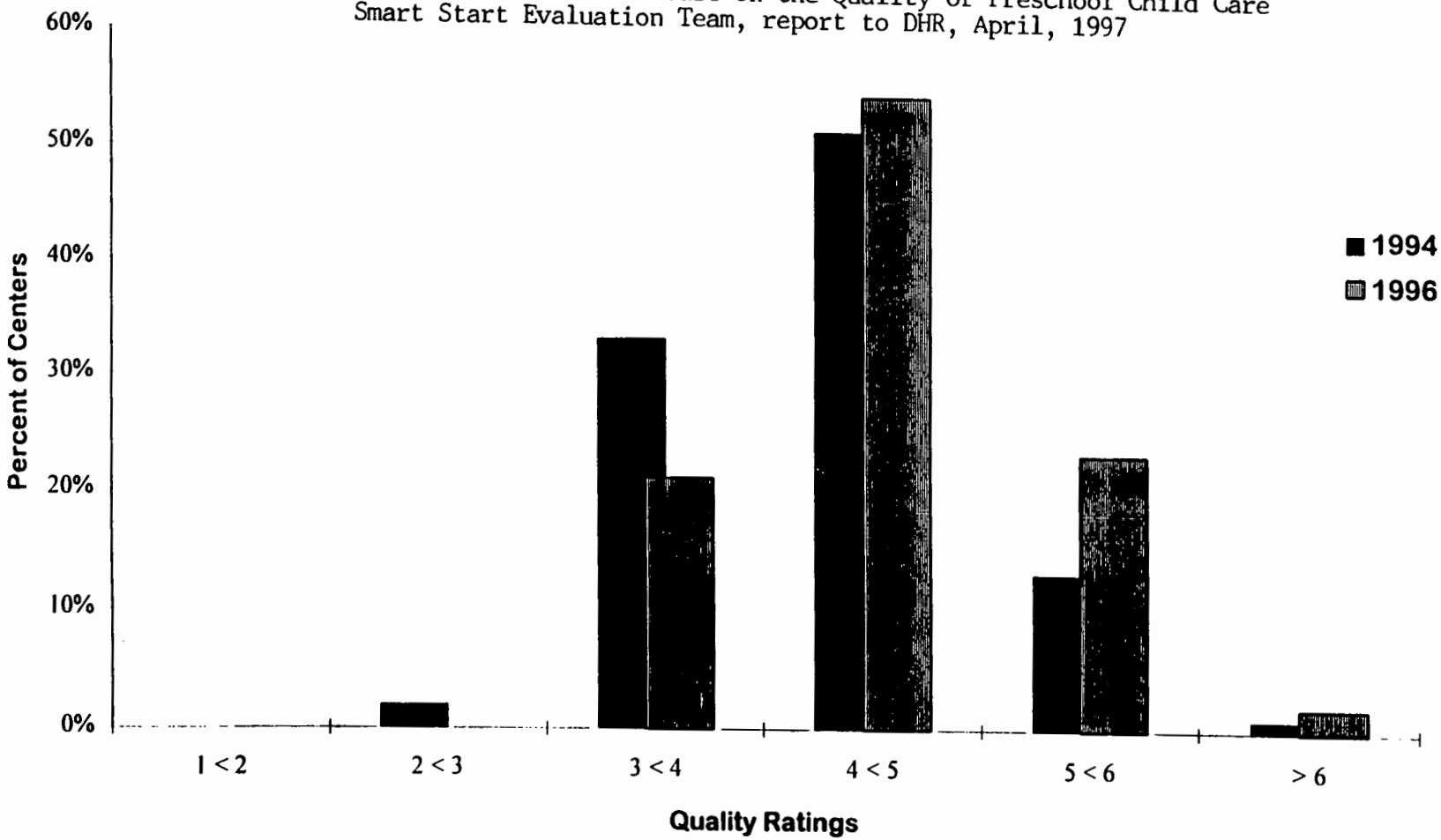
What? A subgroup within the Smart Start evaluation team assigned to help local partnerships plan and conduct local evaluations

Will help:
- decide local evaluation strategies
- design local studies
- summarize existing information

Through:
- on-site consultation
- sharing of information, instruments, strategies
- presentation of workshops
- training on quarterly reporting
- question and answer forum on our web site

Figure 3: Quality of Preschool Classrooms in 1994 and 1996

From The Effects of Smart Start on the Quality of Preschool Child Care
Smart Start Evaluation Team, report to DHR, April, 1997



Future Reports by the Smart Start Evaluation Team

January - June, 1997

1. Child care summary combining 1994 and 1996 observational and director report data, also individualized for each partnership

2. Parents as Teachers report--summary of about 400 parent responses to brief questionnaire about their involvement in PAT

3. Unique ID study--summary of the problems and solutions of 4 partnerships as they tried to gather data using unique identifiers

4. Subsidy study--interviews with parents coming into the subsidy program about their child care situation, before and current

5. Compliance data--matching the compliance data from DCD to data we have collected to determine suitability of the compliance dataset for future use.

6. Playground study--comparison of child care center playgrounds in a partnership that has directed funds towards playground improvement and in a county which is not involved in Smart Start

7. Health report--summary of the kinds of information we have obtained or tried to obtain from numerous health databases with recommendations of how to improve them

8. Collaboration report--results of 200+ phone interviews with key agency participants in Smart Start partnership counties to assess types of interagency contacts, awareness, connectedness, parent involvement, human services planning, and other indices of collaboration

9. Kindergarten Teacher Checklist--summary of the results of KTC data obtained in fall '97, analyzed by year ('95-'97), round (early v. late), SES of county, and other key variables (possibly by proportion of partnership funds spent on child care?)

12/17/97 AM

Smart START

Accountability

Achieving Accountable Programs and Services

With the start of fiscal year 1997, the NC Partnership for Children assumed new oversight responsibilities of local partnerships and the overall accountability of Smart Start programs and services. As a result, the NCPC adopted new accounting policies and procedures and implemented a team approach to ensure the fiscal integrity of programs and services. The partnership also developed core services to guide partnerships in planning and ensure funds are spent appropriately to achieve Smart Start's goal that children arrive to school prepared to be successful. The following outlines Smart Start accountability.

Uniform Standardized Accounting System

A uniform standardized accounting system is in place and used by all partnerships. The NCPC is moving quickly toward a system that will capture data and connect it to services provided to children and families.

The Team Approach

The NCPC recognizes that contract monitoring, programmatic monitoring, and fiscal accountability are not separate and distinct from each other. In the team approach, a program coordinator, contracts coordinator and accounting coordinator are designated to each local partnership.

This structure ensures sound accountability and timely resolution of local issues and needs. The team recognizes capacity levels are different for each county and provides the technical assistance necessary to meet individual issues and needs.

Accountability Plan

Some of the tools that were implemented as part of the NCPC's Accountability Plan adopted by the NCPC board include:

- Require bonding of all board members, executive directors and other employees who receive or handle Smart Start funds.
- Outsource payroll for the NCPC and local partnerships
- Ensure local partnerships adhere to established Accounting Policies and Procedures.
- Integration of Fiscal Contracting and Reporting Systems.

Accounting Policies and Procedures

In order to receive funding for programs and services at the local level, sound accounting policies and procedures must be in place.
Planning counties (Year 5) are putting checks and balances in place to lay the groundwork for future program and services funding.

Resource Development

A plan to disburse private sector funds has been implemented by the NCPC. In 1997, requirements for Smart Start's private sector match requirement were broadened in legislation to count certain contributions made to Smart Start funded projects.

Programs and Services

The NCPC requires any approved local partnership activity to include sound research which proves the activity prepares children for school.

Measurable Outcomes

The NCPC Strategic Planning Committee requires, in order to approve plans, that each activity must have measurable outcomes included as a part of the plan.

Local Board Monitoring

Local partnership boards are required to monitor each of the partnership's activities. This also helps in the decision-making process to fund future activities.

Core Services

Every partnership is required to develop an early childhood system based on Smart Start core services.

Smart START Programs and Services

Results that Ensure Success for Children and Families

Research shows that high quality child care does make a difference, resulting in improved outcomes for children, including cognitive and language improvements. Comprehensive health services result in the best possible health outcomes for children and reduce the excessive costs of more expensive emergency care.

Overall Goal of Smart Start:

Children will arrive at school healthy and prepared for success

- The success of Smart Start's goal and its overall impact is being evaluated by Frank Porter Graham/UNC.
- Baseline data on the health and readiness of children was collected in 1995. A follow-up comparative data collection is taking place in fall of '97.
- An initial report from FPG showed significant improvements to the quality of child care in the first counties which implemented Smart Start.

Smart Start is assuring successful long-term outcomes in the following ways:

Improving the **quality of child care** programs

- Teachers are improving their knowledge and education through T.E.A.C.H. scholarships
- Teachers are remaining in classrooms for a longer periof of time because of compensation projects such as W.A.G.E.$ and salary supplements, resulting in more consistent care-giving for children
- Child care programs are upgrading the quality of child care environments through assessments, better learning materials, and training programs

Making child care **available** for every child who needs it

- Families who can't afford to pay the full cost of care are receiving subsidies (recent data indicate more than 42% of all Smart Start money is spent for child care subsidies)

Making child care and services **accessible** for every child who needs them

- The number of child care spaces is increasing
- The number of inclusive spaces for children with special needs is increasing
- Transportation services are being coordinated and are therefore available for children who need them

Delivering **family support** services

- Families are finding good child care through child care resource and referral services
- Parents are learning to read and are reading to their children because of literacy programs
- Parents are improving their parenting skills through parent education classes
- Families are better able to access existing community resources through family resource centers that serve as neighborhood hubs for programs and services and links to services outside neighborhoods

Comprehensive **health care** and **education**

- Health services are being integrated with other services in communities to assure the best possible health outcomes for children
- Children are being screened at an earlier age for health and developmental problems such as vision, hearing, dental, and appropriate development and are receiving appropriate immunizations because of Smart Start needs assessment and coordination of services
- Children are receiving earlier treatment for health and developmental problems because of health consulation to child care programs

Additional **Overall Impact** of Smart Start

- An infrastructure of services for children and families is being created
- Services to children and families are beeing coordinated and gaps in services and resources are now being addressed
- Fragmented services are being reduced
- Local community agencies and organizations are becoming more accountable to the community for the services they provide because of Smart Start planning. Emergency situations for children are being handled more quickly and in a more coordinated way

NCPC 12/97

Smart START Local Partnerships

Performance Standards

Organizational Development and Management of Local Smart Start Partnerships

ORGANIZATIONAL DEVELOPMENT

- Vision statement
- Annual strategic plan
- Active board of directors
- Annual review of mission/goals
- On-going collaboration
- Effective communication system

PROGRAM DEVELOPMENT

- Core Services
  - Child care & education- availability
  - Child care & education- affordability
  - Child care & education- accessibility
  - Family support services
  - Health care and education
- Activities have measurable outcomes
- Grant process in place
- Unduplicated services
- Research-based activities

ADMINISTRATION

- Organizational chart & responsibilities
- Active supervision & management of staff
- Staff development & review process
- Allocation process for funding
- Bidding process
- Personnel policy & procedures manual
- Technology plan

FISCAL

- Fiscal policies & procedures
- Audit & accounting policies & procedures
- Prior year's audit findings addressed
- Contracts management system
- Contracts monitoring system

LEGISLATIVE COMPLIANCE

- 501(c)3 agency, established after 7/1/93
- Required board members
- Submission or annual plan
- 10% cap on capital expenditures(biennial)
- 30% subsidy mandate
- Open Meetings Law
- Public Records Law
- Conflict of interest policy
- Mandated reporting of abuse & neglect
- No supplantion of existing funds
- Consent form for home visits

Performance Standards for Smart Start Programs

Critical Success Variables

Every child has access to a high quality child care program

- **Teacher education**
  All teachers working in early childhood programs have an associates or bachelors degree in early childhood education or child development or they are enrolled in a degree program leading towards the attainment of such a degree.

- **Program standards**
  Every early childhood program has a AA license and/or is nationally accredited or is progressing toward the attainment of AA and/or national accreditation.

- **Compensation of early childhood work force**
  Teachers working directly with children in early childhood programs are compensated at a rate that is comparable to teaching staff with comparable education in public schools (measured at the county median.)

Child care and education are available

- **Sufficient supply of child care that is appropriate and accessible.**
  Families are able to find and access needed and appropriate child care.

Child care and education are affordable

- At least 75% of young children (0-5) living in families earning less than 75% of the county median income will receive subsidized early care and education services.

- No family will pay more than 10% of their income for child care

Health predictors for school success

- All young children will have a source of primary medical and dental care, with access to comprehensive, integrated, specialized care (including mental health services) as necessary. All care, including preventive screenings, will be coordinated with the child's primary care provider.

- Child care environments are safe and healthy for all children in care.

Family support

- Families are able to find needed and appropriate services.

- Opportunities are available to all families to learn appropriate, responsible parenting.

12/17/97 pm

IMPROVING CHILD CARE IN NORTH CAROLINA
REVISIONS TO THE CHILD CARE LAW

Senate Bill 929 was passed by the NC General Assembly in the 1997 session and revises the Child Care Law. The major points of the new law are summarized below. A Legislative Study Commission will examine how the new law is implemented.

Intent of Child Care Law

- ☆ Ensure that child care providers have education and training in child development.
  - ➧ By using the existing community college system and making child care education more accessible through scholarships, teachers will be better qualified to care for children.
- ☆ Streamline regulations so that child care consultants from the Division of Child Development may focus on helping child care providers improve the quality of their programs.
- ☆ Help parents make more informed choices about child care programs through a rated license.
- ☆ Improve child care licensing standards to lead to better outcomes for children.

New Definitions

- ☆ Five categories of child care are reduced to two: child care centers and family child care homes. The term "facilities" refers to both child care centers and family child care homes.
- ☆ Child care providers operating more than one type of program at the same site, serving different children, for four hours or less are not required to be licensed; however, they may volunteer to be licensed. (In order to receive subsidized child care funds, facilities must be licensed.)
- ☆ Definitions for "lead teacher" and "child care administrator" in child care centers were added. A lead teacher must be at least 18 years of age and have at least a North Carolina Early Childhood Credential or its equivalent. A child care center administrator must be at least 21 years of age and have at least a North Carolina Early Childhood Administration Credential or its equivalent. Child care teachers and administrators may be hired before completing the Credential requirements.

Licensing Changes

- ☆ A permanent rated ("evergreen") license will be developed to reflect program standards, staff education levels and how the program has complied with state laws/rules.
  - ➧ An "evergreen" license will eliminate the need for annual license renewal, allowing division consultants to concentrate on providing technical assistance to facilities.
  - ➧ Annual compliance visits will still be made to centers.
- ☆ The NC Child Care Commission may adopt enhanced voluntary program standards which reflect higher quality child care than required by the law. These enhanced program standards will expire on July 1, 1999.
- ☆ Drop-in and short term child care arrangements are required to display a notice that they are not licensed.
- ☆ Family child care homes are required to be licensed, but have different licensing requirements than centers.

☆ Centers licensed for 6-12 children (previously called large family day care homes) may be allowed to care for additional school-age children in some situations, as allowed in family child care homes.

Family Child Care Home Changes

☆ Verification of children's immunization and health status is required.

☆ Effective January 1, 1998 the minimum age of a family child care provider raises from 18 to 21. Providers already licensed on that date are exempt from this requirement.

☆ Effective January 1, 1998 family child care providers are required to have a high school diploma or its equivalent. Providers already licensed on that date are exempt from this requirement.
- ➧ Over 80% of providers already meet this requirement.

☆ Providers are required to complete annual on-going training in child development, in addition to the already required first aid and CPR training. The number of hours will be determined by the Child Care Commission.

☆ Effective March 1, 1998, criminal record checks will be required for all household members over age 15 who are present when children are in care. This will apply to new family child care homes and nonlicensed homes approved to receive subsidy.

Child Care Center Changes

☆ Directors of centers must have at least a North Carolina Early Childhood Administration Credential or its equivalent by September 1, 2000. Directors hired after September 1, 1998 must be in an approved credentialing program within six months of assuming administrative duties and finish coursework within two years.
- ➧ Nearly 50% of current center directors have an Associate degree or higher which would be equivalent to a credential. Directors can enroll in courses now at community colleges and the complete Administration Credential will be available in 1998.
- ➧ Scholarships are available through the T.E.A.C.H. Scholarship program.

☆ Lead teachers in centers must have at least a North Carolina Early Childhood Credential or its equivalent. They must be enrolled in an approved credentialing program within six months of employment (or within six months of the new law taking effect, whichever is later) and complete the Credential within 18 months of enrolling in coursework.
- ➧ Approximately 50% of the teachers currently working already meet these requirements.
- ➧ Scholarships are available through the T.E.A.C.H. Scholarship program for the two community college courses needed.

☆ The Department of Health and Human Services will establish categories to recognize levels of staff education in order to develop appropriate staffing requirements for centers licensed for 200 or more children.

☆ Topics for on-going staff training are limited to nine areas of early care and education.

☆ All teachers in child care centers are required to receive child development training annually. Teachers may carry over some excess training hours earned to the next year.

☆ Child care centers are allowed to use domestic kitchen equipment, provided appropriate temperature levels for heating, cooling, and storing are maintained.

☆ The playground rules adopted by the Child Care Commission requiring conformance to U.S. Consumer Product Safety Commission guidelines for playground safety are repealed. The Commission has adopted temporary rules to make sure outdoor play areas are free from hazards that could injure children.

Number of Children Served in Subsidized Child Care*
July, 1996 - September, 1997

Month, Year	Children in Families Receiving Work First Cash Assistance	Children in Families At Risk for Welfare, But Not Rec. Cash Assistance	Total Non-Smart Start	Smart Start Child Care	Total Children Served	Increase/ (Decrease)	Children on the Subsidized Child Care Waiting List
July, 1996	26,646	28,529	**55,175**	5,813	60,988		
August, 1996	26,262	29,234	**55,496**	5,471	60,967	**(21)**	
September, 1996	23,679	26,541	**50,220**	5,050	55,270	**(5,697)**	
October, 1996	20,626	27,099	**47,725**	4,963	52,688	**(2,582)**	
November, 1996	19,419	31,538	**50,957**	5,025	55,982	**3,294**	
December, 1996	17,278	34,265	**51,543**	5,230	56,773	**791**	
January, 1997	16,523	37,618	**54,141**	5,620	59,761	**2,988**	
February, 1997	15,985	39,973	**55,958**	6,252	62,210	**2,449**	
March, 1997	16,065	43,163	**59,228**	7,776	67,004	**4,794**	
April, 1997	16,514	47,362	**63,876**	8,684	72,560	**5,556**	
May, 1997	16,881	50,099	**66,980**	8,471	75,451	**2,891**	
June, 1997	18,483	57,336	**75,819**	7,524	83,343	**7,892**	
July, 1997	17,693	57,008	**74,701**	7,759	82,460	**(883)**	**3,945**
August, 1997	18,104	60,700	**78,804**	7,747	86,551	**4,091**	**5,289**
September, 1997	16,001	54,811	**70,812**	7,910	78,722	**(7,829)**	**7,805**

* Includes children subsidized through the DCD reimbursement and EIS direct payment systems.

12/16/97

12/17/97 am

MINUTES

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

DECEMBER 18, 1997

The Joint Appropriations Subcommittee on Health and Human Services met on Thursday, December 18, 1997, in Room 544, in the Legislative Office Building at 9:00 a.m.

Senator William Martin, CoChairman presided. Senator Martin announced at some point during the meeting today he would like to get very brief comments from the Committee members relative to their feelings regarding the TANIF transfer for child care so that the Secretary will have some information with which to go to Governmental Operations.

Senator Martin introduced Mr. Dick Peruzzi, Director of the Division of Medical Assistance to give his presentation on Medicaid Growth Reduction Plan Update. (Handout attached to minutes). He spoke about the cost reduction plan and the progress they are making to achieve the appropriations limits of 9% in 1998-1999,8.5% in 1999-2000 and 8% in the fiscal year 2000-2001. He said Medicaid growth is driven by the number of eligibles in the program, the cost per unit of service, the units of service; that is how many times a person visits a physician or the number of days a person might be in the hospital, and long - term care bed growth. When new nursing home beds are appropriated they impact the Medicaid program.

Mr. Peruzzi continued to explain the Medicaid Cost Sharing and the control the department has. He gave an idea of what they are able to do to impact the actual Medicaid expenditures. Payment rates can take its toll to reduce the rate of growth in the Medicaid program and when this happens they basically take short, medium and long term actions. Mr. Peruzzi explained the CAP/MR Expenditures (handout attached to minutes).

Mr. Peruzzi said the Health Care Delivery system that Medicaid uses is really where they have their work cut out for them in order to achieve the budget reductions. A change needs to be made in the structure of the way Medicaid services are being delivered to place more responsibility and hopefully more risk on the providers. The first thing they are doing is expanding Carolina Access state-wide. Carolina Access is showing they can reduce emergency room services significantly. They feel by working closer with the physicians and providing more feed back information they can get a lot more cost reduction out of the physicians by giving them the authority to manage this care.

Mr. Peruzzi continued explaining the long term plan. He thinks more money will be spent on additional administration to do all the things they are trying to do. He said they are now operating their program in North Carolina at 24% below the national average of administrative cost on Medicaid Programs. To do all the things that they are trying to do they are going to need to spend a little more money on systems and on personnel.

For clarification Senator Martin asked if the CPT Modifier is inclusive of what they would be doing on the crossover detailed processing? Mr. Pruzzi said this is correct.

Representative Nye asked the reason for allowing nursing 2% and hospitals 0%? Mr. Peruzzi said one of the reasons was that Medicare took action to not give hospitals an inflationary increase and they felt that since they did that it would be appropriate for Medicaid to do the same thing. Another reason is that they are also providing hospitals with other payments that are in addition to the regular payments that they get. This is an appropriate reduction for them.

Mr Peruzzi said in answer to Mr. Nye's question about CAP slots that the action they took is an action that is in concert with the Division of Mental Health, Advocates, area programs, providers and provider associations, in recognition that the community inclusion rate they were paying which is $28.00 per hour, is too high based on pioneer rates. They had received comments from a number of providers as well as Mental Health saying they did not understand why we are providing this service to an area program that costs from $9.00 an hour up to $21.00-$22.00 and it is being billed at $28.00. They took a look and found it was true. They put together a task force including the Division of Health, the Division of Medical Assistance, Area program Sandhills, Piedmont, Mecklinburg and Gaston. the Client Advocates, Arch and DD Council are on this task force also providers; including Life Incorporated, ARHA and others. This committee said these rates are too high. The rate reduction will go into affect January I, 1998, allowing for a 2-month lag time for this system so that the impact is on in the last 4 months of this state fiscal year. They can serve 264 more people for the same amount of money. Next year 1,000 more people can be served for the same amount of money.

Representative Nye asked how they plan to serve additional people when you have a freeze on it?

Mr. Peruzzi said that they are trying to work with the area programs. If they establish a budget and everyone agrees to that budget and speaks to what is a reasonable budget in the context of the total Medicaid program then what they really want to do is say, can we be able to stick with that budget? Their philosophy is to make sure that all of the in-home service programs are run appropriately and cost effectively and that is what the most recent action was. They took an additional $3 million back to the area programs to help them better administer this program.

Representative Cansler asked a question about recent federal changes, about what Medicare pays for and what Medicaid pays for? Have we factored in where we are going and what potential cost we are going to incur in dealing with this both from a direct home health of what the implications may be from a larger cost?

Mr. Peruzzi said this is a very big concern they have. He said there is a bill that is being offered in Congress to reverse this. In the state of North Carolina unless other Medicaid programs have said we will cover home health services exactly with Medicare policy which we do not. Theirs are a little more liberal than Medicare. They expect the bill to come out February 5th and they have not taken any action on this. They would probably have to pick up the personal care part of that if the aid went away.

Representative Cansler asked Mr. Peruzzi asked how are you going to know when you get to the point that the reimbursement is not adequate to maintain staff, facility and do the other things that need to be done so the folks can anticipate quality care?

Mr. Peruzzi said that we need to be extremely careful not to use rates as a sole mechanism of meeting budget targets. He feels there are places they can look for appropriate reductions when they see cost information that supports those. He said their emphasis has to be on access and access to changing the way services are delivered. The doctor controls services and if the doctor cannot control the rate of the services then there have to be other options. Mr. Peruzzi said it will be better if they can get integrated service networks made up of non profit providers, give them as close as they can to the total amount of the money, and hope they can achieve some of the same savings as HMO's are able to do by reducing in patient hospital and ER and some other things. Take that money that otherwise would go into someone's pocket and use that to go back into the community to provide population based services to attack the problems that the acute care system has to deal with.

Senator Forrester asked about the cost of the in home blood testing. The cost is probably the nurse going into the home of the patient to get the test. Has the state looked at using DRG's in the Medicaid situation in home health care?

Mr. Peruzzi said yes, Medicaid is working on the system to prospectively reimburse home health because in the Medicare program home health has been growing at an enormous rate, like 30% per year.

Representative Clary was concerned with the local Public Health Departments and Medicaid resources in the poorer counties. She wasn't sure about having enough private providers to take care of the patients.

Mr. Peruzzi said the private provider is given a $3.00 management fee to help managed care and this is per person enrolled in their practice. Mr. Peruzzi said the only thing state health has done has said that the primary care physician must approve a health check screen if it is provided by the Health Department. They are not impacting any of the other services that the Health Department is providing to Medicaid.

Senator Dannelly asked why the drug-dispensing fee is one of the highest in the country?

Mr. Peruzzi said one of the problems in the whole drug area is that the pharmacist is kind of like at the whole sale food chain. The manufacturer set the prices and can increase prices almost at their whim. The doctor does the prescribing and the pharmacist fills the prescription.

Representative Hurley asked Mr. Peruzzi what other states are doing on this medical situation?

Mr. Peruzzi said some states are going big time into HMO's. The State of Arkansas is doing pretty much like North Carolina. Mr. Peruzzi said what his Department is planning to do is kind of a hybrid. They want to have Carolina Access out there and they want to be able to convert over as they can to these integrated service networks. Also they have said to HMO's, when they are ready to do those kinds of conversions or when they have Carolina Access in a community, on a selective basis they will allow HMO's to come in and compete. They are trying to keep as much money contained in the system and in the community as they can.

Representative Gardner said her County Commissioners has just voted to denounce the state, the new Medicaid plan, the new Carolina Access. Their County Health Director, Mr. Shaw indicated that they would have a $700,000 hole to eat as a result of the new Carolina Access program. Unless they become a primary care provider they are going to loose these Medicaid dollars. Mr. Shaw told his county that even if they do in fact become a primary care provider they would still loose money in the range of $50,000 to $250,000.

Representative Clary said in Cleveland County her Health Department Director is contracting through CLECO, which is non-profit and has coordinated efforts basically through the entire medical community. CLECO has clinics that are open 24 hours a day to be able to still insure them of the 24-hour delivery system. Is that acceptable?

Mr. Peruzzi said he did not see why not. Physicians are not available 24 hours a day so they have to make arrangements to cover for themselves during that period. The requirement is that the client be able to access 24 hours a day.

Secretary Bruton said CLECO is an excellent, just about perfect, model of what they are trying to do with Medicaid reform. He said they are trying to move the system from paying for incidences of service; office visits, emergency room visits and hospital visits that address or take care of a crisis and move all of the money they possibly can to prevention, to health promotion, and to long term improving the health of the people. A fundamental change is being made in their Medicaid money from a paying mechanism for taking care of problems to a mechanism improving the health of the low-income people in the state. Secretary Bruton said the Public Health Departments in the state could make money instead of loose money.

In answer to Senator Phillips question. Secretary Bruton said all of the Public Health Directors have been made aware of this program and talked with about it and encouraged implementing the program. The implementation date has been put off until July I.

Senator Martin asked Mr. Dick Peruzzi, Division of Medical Assistance to give his presentation on the Medicaid Dental Program. He said Dental is an optional program for Medicaid programs with one exception. They are required to provide dental services to children whom as a result of dental screening or health checks are determined to need dental services. In North Carolina they have chosen to broaden the program to include adults. Mr. Peruzze called

attention to the handout on Dental Expenditures and the growth rate. (Attached to minutes). He discussed the expenditures as compared to other states.

Mr. Peruzzi said, in explaining the price of services as being priced in terms of their value to the consumer. He said they have a task force that is working on various options on what they might be able to do in this program.

Representative Gardner spoke of having so many children in the rural counties especially who do not have excess to a dentist and are having to go to other states to get care for their teeth. She told of some instances that a dentist set up a clinic just for these children with an educational program of how to care for teeth as well as repair. She feels the preventive educational program is needed as well as treatment.

In answer to Representative Hurley's question about what kind of service is covered by the Dental Program, Mr. Peruzzi said they provide a full array of dental services. They provide the service that is needed. He said the program is pretty comprehensive.

In defense of the Dentists, Representative Aldridge spoke of the overhead expenses the dentist has and why he cannot take Medicaid patients.

Secretary Bruton said it is almost impossible to get the low income children cared for under the current system and the dentists who care for them do it for the love of children. The dentist pays out of his or her pocket to take care of those children. We have a group together trying to figure out ways that they can get the rate up. They have not been able to get the rate up high enough to pay for what it currently costs in the modern practice of dentistry. There will not be enough Medicaid money. Secretary Bruton said in some areas there are some alternatives. He said in Moore, Hoke and Montgomery Counties the hospitals are purchasing dental equipment and are hiring a dentist to work in that office just to take care of Medicaid patients. They have a big education prevention and outreach into the schools component for this dental care proposition. The Dental Society is very supportive of this kind of activity.

Senator Martin referred to a discussion the afternoon before about the situation that exists about childcare. One of the recommendations made by the department was that we cannot act on it as a committee, that we voice our approval, sort of a sense of the committee's thinking with reference to the department being able to transfer $10.8 million of tentative dollars to child day care subsidy.

The issue was do we want to address the waiting list that is out there or to let it languish for the time being. If we do want to address it several things must be considered. There is a need apparently for the day care services if we are to meet the participation rates and the other goals relative to Work First among other issues. We do apparently from all of the information presented have a significant and growing waiting list. That waiting list is not going to be reduced without some form of funding on a continuance basis to enable this to be done. Based upon that, the issue becomes if we decide this is a valid thing to address options for providing that funding. The transfer could be accomplished apparently according to the Executive Budget Act by Governmental Operations. The Secretary expressed the view that he wants to approach Governmental Operations to exercise this option but he wanted to do so only if there was some sense from this committee that there was a significant level for agreement with doing so. If we do not proceed with exercising that option then the only other thing that I am aware of that could be done would be waiting until the short session and seeing if there is some other source of fund where it could be done on a continuance basis and that did not sound very promising with the discussion yesterday. Senator Martin asked for comments from individual members in terms of whether or not you think this is an option that we want to express our opinion that the Department should proceed with trying to get the transfer.

Representative Nye said he thought the evidence yesterday was that the TANIF Fund had adequate money in it. The proposal was to transfer some $10 million to address the day care slots with the availability money. I really do not see what harm that is doing. You are using the money to serve the people.

Senator Forester asked if the TANIF transfer money is a one-time transfer or will it be picked up in the continuation budget in the short session.

Jim Edgerton said what they would propose to do would be transfer it this year administratively and then when we come back to short session ask that it continue.

Representative Adams said that in view of the fact that is one of the major deterrents along with transportation and problem areas for people going to work. I would be in support of it. I don't think it is going to do a lot of harm to the program.

Representative Gardner said she just wanted to be sure that the money is there for the people the money was intended for.

Senator Martin added he would hope that whatever is decided upon that the Department would work towards trying to come up with some clear projections that can be pretty well justified that whatever revenues would be transferred from TANIF for this purpose in the future would clearly be tied in to recipients of TANIF.

Representative Cansler said his position at this point and time would be to let things settle. See if there are other opportunities for dollars to use rather than the block grant. Give us enough time to see exactly what our needs are going to be before we start using the block grant. He feels caution should be exercised and not be played up like a major catastrophe. He is not so sure that it is much different than what has existed. The department has not had the information to know it was there and that we need to move real cautiously in what we are going to do.

Senator Dannelly said he agrees with using TANIF Funds as a one-time deal. He does not want anyone to get the idea they can continue drawing from the fund.

Representative Alexander also agrees with using the TANIF Fund one time.

Representative Hurley agrees with the Department and their recommendations on this. He feels they are in best position to direct the flow of funds and they can serve the needs and he would follow their recommendations on this.

Senator Martin asked Jim Edgerton what protection can be given the TANIF Funds to assure other non-TANIF uses in the future? Senator Martin asked that this be answered after the rest of the committee has a chance to express feelings on the TANIF Fund decision.

Senator Forrester asked how the Governor could come back during the short session of the General Assembly and ask for additional money for the children's health insurance program since the plan has to be in by June 1, 1998?

Carol Shaw said when they submit their State plan they don't necessarily have to have the money in hand to match that money. The money does not have to be approved at the same time as the plan.

Secretary Bruton said we do not and must not wait for approval of the child health insurance plan for working out the financing. They have to get the plan in well before the regular scheduled session or they will run the risk of missing the clock. Because of the special provision the committee has to approve the plan before it can be submitted. Secretary Bruton said approval of the plan must not wait on the completion of the budget in the short session.

Representative Clary asked Secretary Bruton if it is true that less than 10 of the children that are on the waiting list are TANIF recipients?

Secretary Bruton said he had heard this percentage passed about and suspected this is about right.

Representative Clary said she feels the question before the committee today in discussing this is not whether or not to move this money to help this waiting list for day care. The question is, do you want to reserve the integrity of the TANIF money? She said TANIF money is sent to us for a purpose, this is federal dollars to move people from welfare to work. Do you want to reserve it for that, or are we truly interested in picking up the neighbor's problem that has found out someone else is getting day care and they want it too?

Senator Martin explained that Secretary Bruton said 10% of the people relative to the waiting list is actual TANIF eligible at this point. Another larger percentage would be those who are at great risk of being TANIF and then the smallest portion of all would be the woodwork situation. Senator Martin asked Peter Leousis to please elaborate on this a little bit more.

Mr. Leousis said that Secretary Bruton is right that about 10% of the waiting list for child day care are families who are currently on Work First. The other 90% would be people who have already left Work First and are therefore not counted as being a Work First family anymore or who may have been on welfare before. Mr. Leousis said they are working with the Jordan Institute at the University of North Carolina at Chapel Hill to help them to do a better job of finding out just exactly who these families are. He said the questions the committee members are asking today are exactly the same questions he ask both the Division of Social Services and the Division of Child Development over a month ago. Who are the families and what are they making? There is not

enough money to go around to serve everybody to eliminate the waiting list for everybody who might be eligible under the higher eligibility criteria for childcare Mr. Leousis said they have a new family eligibility schedule and a new sliding fee schedule for families. The percentage or the amount that a family pays of their Income for childcare is based on how much they make and the state pays the difference between within 7%, 8% or 9% of their gross monthly income. The difference between what they are paying for families that are on Work First and for families that are not on Work First is only $20.00 a month. There is about $3,000 difference in annual income for those who are not on Work First and the families who are on Work First. There is not a big difference in the annual salaries.

Representative Clary said she still opposes removing this money. She said we need to reserve the integrity of the TANIF Fund for the purpose for which it is. If there is a 10% figure of children on the waiting list then it should correspond with the amount of dollars that you would like to move out of the TANIF Fund. She said if we looked at the amount that would take care of the 10% of the children that are TANIF recipients she would accept that.

Mr. Leousis said 10% of about 7,800 is about 800 children. He said they spend about $I,500 a year for childcare. This is the state part of the subsidy. He said the state does not set the priorities for counties but they will be working very closely with counties as they develop and implement their plans to target the families. He said they man date that they serve Work First families first but they will strongly encourage that.

Senator Martin ask Mr. Leousis if there could be some assurance that in usage of TANIF dollars, anything that is requested as far as a transfer you could come up with some mechanism that correlated it to TANIF directly, will you be able to do that?

Mr. Leousis said that is the work they are doing with Jordan Institute.

Senator Miller said that it seemed to him to deny the transfer if cash assistance has come in by high projections and the need for child subsidy would come ahead of projections it would be imposing a great deal of virginity on state government. He said he would happily allow them this flexibility. Senator Miller said if the working poor are finding out that there is more that they can do to help their children, welcome aboard.

Senator Martin said this committee cannot approve or disapprove all they can do is offer a sense of the Committee. Secretary Bruton said he has a sense of the committee's thinking on this matter.

The next agenda item was Pharmaceutical Assistance Programs for the Low-Income Elderly and Senator Martin introduced Mr. Stuart Bratesman, Jr., Policy Analyst with Duke Long Term Care Resources Program. (Handout attached to minutes). Mr. Bratesman said about a year and half ago the Kate B. Reynolds Charitable Trust ask if they could give them advise on this issue. He said they did a literature review of the research findings in the academic and scholarly literature in this field and he presented a review of Findings. He talked about the state of research in this area, the problem the Pharmaceutical Assistance is meant to address, what benefits these kinds of programs provide, the 12 states that are providing Pharmaceutical Assistance Programs in the United States and what they do. He talked about the primary issue that the managers of these programs say is the most important issue in pharmaceutical Assistance and that is the cost of these programs and how the cost can be controlled. He pointed out the different types of cost controls, the unintended consequences of these cost controls that have been used. Also pointed out the utilization review of the medications being used by the recipients of these programs and also talked about the key lesson they learned from the findings in the literature.

Mr. Bratesman said not much has been written about this subject. All the studies that have been done so far have been based on administrative data. They are not done on randomized trials that scientific researchers prefer to produce a more reliable findings. Mr. Bratesman said what they could learn from what has been studied and written is that many low-income elderly are very sensitivity to medication costs. Many low-income elderly take their prescriptions less often than their doctor tells them to in attempt to stretch them out or they may take them only when they feel pain or when they are feeling particularly sick or ill and many times they just won't purchase the prescription at all because they cannot afford the price. This leads to greater instances of illness or hospitalization. The benefits that exist around the country are an increased use in prescription medication. A reduced consumption of Medicare reimbursement for health services. There is a study that says that over all there is a cost saving to the medical system. There is a reduced number of emergency room visits and reduced rate of admission to nursing homes. Mr. Bratesman explained the program in Durham as being a program that is well designed and has a very beneficial impact for the patient and the medical system as a whole.

Mr. Bratesman said the key lesson they have learned from the review of the literature in the field is that the planners need to pay very close attention to examine each program option from the prospective of each of the participants who are engaged: patients; doctors; pharmacists and administrators and think through the full consequences of how each of the players in the system is likely to react to different program components.

Representative Cansler asked most of time when formularies have been used do they specify specific medications, or is it broader than that?

Mr. Bratesman answered in some cases they specify specific medications and other cases they specify categories in medications that are permitted in the system and other cases it is based on categories of diagnosis.

Senator Moore asked what is the funding source for the Durham County trial program and how long has it been in effect?

Mr. Bratesman said it has been in effect for roughly 2 or 3 years. There are a variety of foundations. The Duke Foundation and the Kate B. Reynolds have provided funds for them. They have received funds from a number of other sources also. They are requesting funds from the county department of social services.

Representative Aldridge asked for an explanation of the wide difference in cost per enrollee in Vermont and New Jersey.

Mr. Bratesman said the programs are very different. The prescriptions are more affordable to a New Jersey patient than a Vermont patient and makes the New Jersey patient much more likely to purchase prescriptions through the program. They are learning and making adjustments to their programs.

Senator Phillips asked if the Durham program is a fee-based program?

Mr. Bratesman did not remember whether they charge a fee or not.

Senator Phillips said the program in Davidson County is Duke Endowed partially funded and it is free. They have medical, dental and a pharmacy program. They are going to fill l4,000 prescriptions this year. This is up l,000 more than last year. They have seen over 5,000 patients and hundreds of dental patients. Their hospital is supportive because it does alleviate the use of the emergency room and hospitalization simply because of the program.

Senator Phillips asked for a contact in Durham to be able to talk with about the funding of their program.

Mr. Brateman said the Director of the program in Durham is Gena Upchurch and the name of the program is Senior Pharmacist. He will call Senator Phillips' office and give him the phone number.

Senator Martin introduced Lynn Kern and Bonne Cramer to present options for making prescriptions more affordable for older adults. Lynn Kern spoke first and said she serves on the Study Commission on Aging and from forums she has attended over the last four years one of the major problems she has heard about from older adults is the lack of ability to get access to and afford prescription drugs. With that concern of the elderly throughout the state the issue was raised by the North Carolina Coalition on Aging, The Senior Tar Heel Legislature and the Governor's Advisory Council on Aging, the Department of Health and Human Services did put together a small prescription drug work group. They put together some recommendations that the department could work on. The work group was charged with coming up with recommendations to improve the access and the affordability of prescription drugs and particularly for low-income older adults. This did not include persons with disabilities. Medicare except in very extreme cases does not pay for prescription drugs. Ms. Kern said this group was very sensitive to the Medicaid budget limitations and the limitations on the rate of growth so they did not put forth any recommendations that would require any on-going expansion of programs.

Ms. Bonne Crammer guided the work of the task force and did a lot of the over-sight of the information gathering and research and explained the deliberations of the work force and shared some of the recommendations that came out of the work group. A handout was given with statistics Ms. Cramer referred to throughout her presentation. (Handout not attached to minutes. We could not find a copy.) Ms. Crammer said that older adults rely on prescription drugs more than other age groups. Unofficial estimates by the Health Care Financing Agency in Washington indicate that about 89% of older adults take one or more prescription drugs. HCFA also indicates that older people spend an average about $742.00 per person per year on prescription drugs and they believe that also holds true in North Carolina. Older adults generally rely on Medicare for their health care benefits but Medicare has very limited coverage for outpatient prescription drugs. Older adults also purchase Medicare supplement policies in the state but what they are finding is that those policies that have a prescription drug benefit by and large are fairly expensive. The premiums range from about $130.00 to $160.00 per month and they are out of

range for a lot of older adults. Ms. Crammer said they project that only about 14% of those that have Medicare supplement policies are able to purchase ones that have prescription drug coverage.

Ms. Crammer said about the time they began the study of the work group Dr. Jim Mitchell from East Carolina University Center on Aging was just completing a survey that he done of over 600 older adults in rural Eastern North Carolina to try to determine just the extent of the problem they were having in affording prescription drugs. From her statistics Ms. Crammer pointed out the kinds of strategies these folks were using when they were not able to afford the drugs that had been prescribed by the doctor. People bought less than the amount prescribed, they took less than the amount prescribed and only took the drug when they thought they needed it. 12% went without the needed drugs and people were making choices about which drugs to buy because they could not buy the whole packet. The remainder of the individuals interviewed one way or another borrowed money to purchase the drugs. All of this can have a negative impact on the health of North Carolinians.

Mr. Crammer said they estimate about 47% of North Carolina's population has no coverage for prescription drugs. As the income levels get lower that percentage gets higher. There are People with 200% of poverty or less income and 56% of those have no coverage for prescription drugs through Medicaid or through any other source. The largest coverage group of those who do have access to prescription drugs is with Medicaid and then lesser amounts are covered through an employer and a little over 19,000 are estimated to have other drug coverage through private insurance. Medicare supplements policies are included in that group.

Ms. Crammer said they believe the people more vulnerable in the groups talked about are those people who are referred to as qualified Medicare beneficiaries and specified low-income Medicare beneficiaries. These groups have incomes of 100% of poverty or less in the case of the qualified group and 120% or less in the case of the specified low-income group. Both of these groups also have low asset levels $4,000 for a family of one and $6,000 or less for a family of two. These are the groups that Medicaid pays the part B, Medicare premiums and deductibles and co pays for the qualified Medicare beneficiaries and pays the premium only for the specified low-income Medicare beneficiaries. The Division of Medical Assistance estimates there are currently in 1997 57,955 of these folks and this includes those who are 65 and older and those who are adults and are disabled. The work group felt very strongly that those almost 58,000 persons were the most vulnerable in the state in terms of

prescription drug coverage and they did not want to separate the age from the disabled. They are dealing with almost 58,000 persons.

Ms. Crammer said some of the things they are already doing here in North Carolina to assist with this issue have already been discussed in this meeting. She pointed out the increase in Medicaid services. There are 7 programs that are state funded in the state that are serving non-Medicaid eligible populations. Ms. Crammer said they now have the drug manufacturer assistance programs in North Carolina. She said one of the things they do know is that so many of the low-income people do not know about the different programs that exist, so this is a major barrier to these people for utilization. There are at least 10 community programs that exist in the state Ms. Crammer said. Senator Phillips talked about one and Stuart Brakesman talked about the Durham Pharmacy Assist program. Ms. Crammer said she looked at the Durham program report for the year before and they are serving people with incomes below the poverty level. The average age was 78 and they found they are serving a group that takes about 9 medications per month. The periodic review of sitting down with someone to review the medications they are taking and educating people to ask more questions is something that they heard from these programs and she feels that is very strong. She said most of the programs are supported by private foundation grants, money that is raised in the community and they are in a constant struggle to continue the funding.

Ms. Crammer discussed the prescription drug discount enrollment program. One of the ones they looked at is one being sponsored by AARP called the Member Choice Program where a discount is provided on prescription drugs that is averaging about $200.00 a year per person. Ms. Crammer said they have been working with AARP because a little over half of their membership are over 65 or older. They are currently serving only 18,000 people with the Members Choice Program. Ms. Crammer said the task force feels with better marketing AARP could serve more of their members. This program will not get to the very low-income groups.

Ms. Crammer said the task force looked, based on a very limited benefit of $300.00 per year, per person, what it would cost to establish a state funded program for the 58,000 folks, the qualified Medicare beneficiaries and the specified low-income beneficiaries and determined that it would cost $17.4 million in 1998, increasing to about $6 million in the year 2003. While this could potentially help a great many people it would require a significant and on going investment of state funds. The work group has not recommended that option.

The group was very interested in what might be done by way of looking at a Medicare waiver. To state of Vermont is the only state to get such a waiver. The work group has not been able to come up with anything that was cost neutral which is a main category that Health Care Financing Administration would require. Ms. Crammer said the group thoroughly explored the possibilities of looking at Medicaid waiver. Minnesota is one of 29 states that participates in a drug purchasing alliance. This alliance is intended to reduce administrative duplication for contracting as well as to get the best price on volume buying and is used for people who are the state's responsibility, such inmates. Minnesota has been urging the state to extend the discounts that you can obtain through that alliance to private citizens. The Legislature has just authorized the state under the Department of Administration to set up a separate state funded and state administered alliance to negotiate drug discounts for the general public consumers. The work group feel this is something North Carolina should continue to watch.

Ms. Crammer suggested what the work group thinks is possible here in North Carolina as follows:

- In the current Medicaid program, Medicaid receives a rebate from manufacturers for drugs purchased for Medicaid enrollees and currently this rebate averages about 20% of the cost of each prescription. The work group wondered if it would be possible to establish a similar kind of arrangement for those 58,000 persons. This would be for qualified beneficiaries and the specified low-income Medicare beneficiaries and see if they could achieve those kinds of savings 20% per prescription on average for those groups. The Pharmacy Network Corporation which is the claims processing piece for the pharmacies and includes about 99% of the pharmacies in this state indicate that the Network is willing to consider such an arrangement. We believe it could help the persons needing this service. The work group felt that there would be a one time funding required to cover the six months of rebate during the lag time when the rebates are coming from the pharmacists. This would be one-time money and the Department will work actively with foundations, pharmaceutical companies and thinking of any other method that they might use to pursue this one-time start up of the rebates.

-The work group have thought about the local programs and they do survive on a shoe string budget. They are constantly trying to get money and keep alive. They fervently believe that the patient-education and periodic review of drugs is an extremely important function. The

Department of Health and Human Services believes that they need to work diligently thorough out the state to help these programs to continue to be funded.

Ms. Crammer said they do have many things underway and one of them is that they believe by streamlining the Manufacture Assistance Programs that they could make many more physicians aware of it. That they could market their availability to more low-income people and that there would be a greater use of those programs. They are working with the North Carolina Medical Society to do that.

The Department of Insurance who was a very active participant on this work group, is currently negotiating with the Health Care Financing Administration in Washington on a new Medicare supplement plan that would include a drug benefit. The Insurance Commissioner is very supportive in trying to establish a new plan that would buy at an additional $31.00 per month prescription drug coverage. A person in North Carolina could purchase a Medicare supplement policy with prescription drug coverage for about $78.00 a month as opposed to the current fee of about $135.00. This would benefit only new Medicare enrollees about 1,700 people in 1998.

Ms. Crammer said they believe there is a great deal that could be gained if the AARP Members Choice Program was much more widely used and while it would not help the low-income folks a great deal it certainly would be of great benefit to the more moderate income folks.

Ms. Crammer said the Department will continue to pursue any kind of opportunity that they might have available to get the one-time funds that could be used possibly to set up a similar kind of rebate advantage for the 58,000 qualified Medicare beneficiaries and the specified low-income beneficiaries.

Senator Martin asked Ms. Crammer in terms of estimated coverage through the employer how that correlates with employed persons who actually have insurance through the employee?

Ms. Crammer said this information is available and she will get it for Senator Martin.

Senator Martin extended to all present best wishes for a happy holiday season on behalf of Co-Chairs Representatives Gardner, Cansler, and Clary.

The meeting was adjourned.

Senator William Martin, CoChairman
Jt. Appropriation Subcommittee on Health and Human Services

Sarah J. Murphy, Acting Committee Clerk (From Tapes)
Jt. Appropriation Subcommittee on Health and Human Services

MEDICAID COST REDUCTION PLAN

Objective: Reduce the rate of growth of Medicaid state appropriations to 9% in SFY 98-99, 8.5% in SFY 99-00 and 8% in 00-01.

Medicaid growth is driven by:

- Eligibles
- Cost per unit of service
- Units of service
- LTC bed growth
- Medicare cost sharing

DMA has some control over cost per unit of service and units of service.

12/18/97 AM

Budget Targets (Provider Payments $000)

	Projected	Target	Reduction
SFY 98-99	**$4,617,743**	**$4,548,734**	**$ 69,009**
SFY 99-00	**$5,012,663**	**$4,864,416**	**$ 148,246**
SFY 00-01	**$5,444,684**	**$5,180,117**	**$ 264,567**

*Changing payment rates can take 30-60 days or longer to implement and 30-90 days to before any budget impact is felt.
*If it is necessary to reduce a payment rate July l, the impact on the budget may not be felt until December or later, depending on the service.
*Because of this lag time, if we need to cut $100 out of the budget and that decision is made on July l, because of the time it takes to do APA, State Plan change, Policy and system changes, consult with providers etc, the rate would have to be reduced by $171 to achieve a savings of $100 in that year.

To reduce the rate of growth of Medicaid we are taking short term, medium term and long term actions.

Short term actions are those things we can do that can have a reasonably short term impact on expenditures. Our plan was to begin reductions in the program in SFY 97-98 to be sure we did not come in over budget and to smooth out the $69 million reduction necessary for next year. If we had to make the entire $69 million reduction next year, we would have to cut program by $117 million because of the lag time previously described. Our target for this year was to cut about 1/2 of 1% of the budget. To accomplish this we took the following actions:

1. Limit the inflation factor for nursing facilities to 2%. Projected savings this year are $9.4 million. Full year savings $15 million. (NF budget $807 million).

2. Limit hospitals to Medicare's inflation rate-0%. Savings this year $13.3 million. Full year savings $25 million. (Inpatient budget $737 million).

3. Adjust physician fees down if they exceed Medicare rates. Annual savings $1 million. (Physician budget $380 million).

4. Limit home health aide and personal care service rates for inflation and adjusted to estimates of actual cost. Annual savings $1.5 million. (Home health and Personal Care budgets $141 million).

5. ICF/MR overhead reduced in accordance with plan. Annual savings $0.5 million. (Budget $193 million).

Total reductions for SFY 97-98 $25.6 million or a little over one half of one percent of the budget (0.6%) and on an annualized basis, 1%.

We do not plan any additional reductions in rates at this time. We need to see how these reductions flow throught the system and how our actual expenditures vs budget are tracking.
If we need to take further reductions, here are some of the options:

Hospital Outpatient and ER: Currently, these services are reimbursed at 80% of costs. Both DMA and Medicare are looking at methods to reimburse on a prospective basis. Interim actions could include reducing the percent of costs or changing the reimbursement to a prospective system or to rates more closely aligned with comparable services. (Budget $200 million)

Drugs: Currently, we reimburse at average wholesale price (AWP) minus 10% plus a $5.60 dispensing fee except for refills in the same month. NC's dispensing fee is one of the highest in the country. Fifteen states use an AWP discount greater than 10%, 18 use

10% and 8 use less than 10%. Options include reducing the dispensing fee (which is set by the legislature), increasing the AWP discount to higher than 10% , reimposing the requirement that phamacies bill Medicaid at the lower of the Medicaid rate or the lowest rate the pharmacy charges the general public. Each 1% reduction in AWP would save $2.3 million in requirements. Each 1% reduction in dispensing fee would save $470,000 in requirements. We are also working with a task force of pharmacists and physicians on other options including how we can make providers more cost conscious when prescribing drugs. (budget for drugs $449 million)

In-home Services: (Home Health and Personal Care) Tighten up medical necessity criteria, introduce controls such as assessment, reassessment and prior approval. Require Medicare billing before billing Medicaid. Reduce inflation factors.
We are working with the Association on these options.

Community Alternatives Services (CAP): Hold to reasonable budget limits. Effective January l, the CAP/MR Community Inclusion rate will be reduced from $28 to $21. This reduction was not taken as a budget reduction but to adjust an inflated payment rate closer to cost. We are continuing to review CAP/MR rates for reasonableness and are working with area program, DMH, private providers and advocates to insure the program is cost effective. (CAP/MR budget $120 million, CAP/DA budget $126 million).

Public Provider Services: These include public health, area program mental health, state hospitals, state ICFs/MR. Hold to reasonable budget targets and reimburse at reasonable costs.

Adult Care Facility-Personal Care: Hold inflation increases pending cost report data and RTI report that supports existing rate structure as per HCFA interim approval for this service. HCFA must approve any increase.

Physician Services: Limit payment to the lower of Medicaid or Medicare rates. Reduce inflation factor.

Durable Medical Equipment: Tighten up provider enrollment criteria. Reduce rates to Medicare rates or cost based on current cost data. Competitive bid.

Medium term actions are those that require longer periods of time before a budget impact is felt.

Some examples of medium term actions include new and more complex prospective reimbursement systems like prospective reimbursement of hospital outpatient.

They include system changes that affect the way claims are paid. For example, we have three MMIS system changes underway that will save costs:

Crossover Detail Processing: When claims crossover from Medicare the State pays coinsurance and deductible. By looking at each detail of the claim rather than the total of the claim, we can chect the details for and deny duplicate payments. Detail level crossovers also provides us the opportunity to change reimbursement policy at the detail level.

CPT Modifiers: This change will permit the claims processing system to read modifiers to CPT codes. The result of this is to permit more accurate claims processing, more accurate payment of crossover claims and the potential to develop more stringent payment based on a more explicit definition of what service is being performed.

Audit File Expansion: This will significantly speed up the installation of audits in the claims processing system. Audits are used to verify various policies for claims payments and act as a deterrent to fraud and errors on submitted claims. The current method of installing audits in the system is expensive and lengthy.

Another medium phase effort is the expansion of ACCESS statewide. This effort will place all Medicaid eligibles (with certain exceptions like some institutionalized and some disabled) under managed care. We are also working to provide better feedback information to ACCESS physicians so he or she has a better understanding of performance compared to a peer group.

Finally, our long term plan is to gradually develop local community based integrated service networks composed of traditional Medicaid providers including physicians, hospitals, public health, community clinics etc. that may be patterned after Medicare PSO (provider service organizations) which can take risk. Paying providers a capitation fee will offer the opportunity for these enterprises to generate savings and and reinvest those savings in their communities for preventive health services.
We are working on nine demonstration projects which are designed to make ACCESS more cost effective.

I do want you to know that to accomplish our budget targets we will need to spend additional money on administration. Currently, our admin costs are 24% below the national average of all Medicaid program.

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CAP/MR EXPENDITURES
($000's)

			Percent Increase
SFY 93-94	$ 19,884		
SFY 94-95	$ 26,085		31%
SFY 95-96	$ 56,652		117%
SFY 96-97	$ 105,656		87%
SFY 97-98	$ 119,760	(Budg.)	13.3%
SFY 98-99	$ 139,158	(Budg.)	16.2%

97-98 YTD November Actual	$ 53,457
Annualized	$123,287
Over Budget	$ 8,527

North Carolina
Medicaid Community Care Manual
October 1996 Revision

13.1.8 Community Inclusion

Community Inclusion is a habilitation service that provides direct instruction to the client to increase the independent living and social skills needed for basic interactions with others in both the home and the community. The service may involve instructing the individual in skills and behaviors that are appropriate to a specific setting or activity, such as eating a meal with others or working with others on completing assignments or chores; teaching the individual to complete activities or transactions that are a part of living in a non-institutional setting, such as accessing public transportation, using a vending machine or crossing the street; and developing cognitive skills, especially in the areas of reasoning, identifying options and making choices or decisions.

13.4.8 Community Inclusion

Your agency must be licensed, accredited and/or authorized, as applicable, according to DMH/DD/SAS policies and procedures. A Habilitation Technician provides this service under the supervision of a Qualified Developmental Disabilities Professional (QDDP). In addition, services developed and overseen by a QDDP may be implemented by a trained individual with at least a high school diploma or high school equivalency certificate who is privileged by the area program to provide this service and operates under the program supervision of a QDDP.

CAP-MR Committee Members

1. Government Agencies- Division of Mental Health, Division of Medical Assistance

2. Area Programs- Sandhills, Piedmont, Blue Ridge, Mecklenburg, Gaston

3. Client Advocates- ARC, DD Council

4. Providers- Life Inc., RHA, Omni Vision, Howell's, CNC, Therapeutic Alternatives, Educare, Financial One, Access, Skill Creations, Group Home for the Autistic, and others

5. Association- North Carolina Association of Rehabilitation Facilities, ICF-MR Facilities Association, North Carolina Community Support Providers Council

Proposed Community Inclusion Individual

		Individual
A. Direct Labor		$ 18,807.76
B. Health		$ 1,624.48
C. Retirement		$ 2,043.22
D. Workers Comp		$ 1,201.82
E. FUTA		$ 61.59
F. FICA		$ 1,438.79
G. Loaded Labor Subtotal		$ 25,177.66
H. Communication		$ 120.00
I. General Requirements		$ 1,346.00
J. Subtotal		$ 26,643.66
K. Overhead	*(20% of Loaded Labor)*	$ 5,035.53
L. Total		$ 31,679.19
M. Estimated Billable Hours Per DMA Original		1603
N. Additional Non-Billable Time for Training, Travel, Client Missed Appointments		108
O. Net Billable Hours		1495
P. Hourly Rate		$ 21.19

Schedule 25

CAP-MR Medicaid Paid Claims: sfy97 ytd - = = > July, 1996 - June, 1997			
COS-56 without adjustments			
July 28, 1997			
Dollars and unduplicated persons served by service.			
A) Total unadjusted dollars paid July, 1996 - June, 1997			$ 106,199,243
B) Total unduplicated persons served			3,726
C) Dollars and unduplicated persons by service: short list			
	(note: a client may receive more than one service)		
Service	Service	Dollars	unduplicated persons
W8101	SCREEN/ASSESSMNT	4,128	23
W8103	CASE MANAGEMENT	12,984,301	3,629
W8105	ADULT DAY HEALTH	28,232	12
W8111	MR PERSONAL CARE	6,802,258	945
W8118	RESPITE - INSTIT	48,913	12
W8119	RESPITE - NON-IN	5,589,872	1,525
W8128	PARNT/CAREGVR TR	81	2
W8129	COMMUN SKILLS TR	34,547	48
W8130	DEVELOPMENTL DAY	1,406,019	233
W8131	COUNSELING	167	3
W8133	ADAPTV BEHAVR TR	273,244	174
W8136	THERAPEUTIC RECR	149	1
W8144	IN-HOME AIDE L1	125,185	50
W8149	HOME MOBILITY AI	49,161	66
W8151	MR WAIVER SUPPLI	960,169	822
W8153	MEDICAID SUPPLIE	1,105,109	953
W8155	PREVOCATIONL IND	849,630	58
W8156	PREVOCATIONL GRP	105,535	31
W8157	SUPPRTD EMPL IND	357,030	31
W8158	SUPPRTD EMPL GRP	1,564	2
W8159	SUPPRTD LVG LOW	760	1
W8160	SUPPRTD LVG HGH	36,716	14
W8161	CRISIS STABILIZA	37,053	16
W8162	PRSNL EMRG RSP S	671	5
W8163	AUGM COMM DV PRC	153,908	92
W8164	AUGM COMM DV RNT	24,252	9
W8177	COMMUNITY INCLUS	72,157,034	3,033
W8178	FAMILY TRAINING	129,467	138
W8179	ADULT DAY CARE S	25,423	9
W8180	VEHICLE ADAPTATI	164,421	30
W8181	RESPITE CARE NRS	827,810	63
W8182	SUPPORTED LIVING	1,604,551	169
	subtotal	105,887,360	
	other services	311,883	
	TOTAL	106,199,243	3,726
D) Dollars and unduplicated persons by service: full list			
	(note: a client may receive more than one service)		
Service	Service	Dollars	unduplicated persons
A0320	A0320	55	1
A4244	A4244	3	1
A4338	A4338	291	2
A4363	A4363	26	1
A4402	A4402	2	1

68% of total

BENEFITS OF NEW RATES

Under Old Rate Plan
Total CAP/MR Expenditures SFY 96-97 $106.2 million
Number of clients served 3,726
Average cost per client $28,502

Under new rate plan
Total CAP/MR Expenditures SFY 96-97 $106.2 million
Number of clients served 4,590
Average cost per client $23,134

Additional clients who could have been served with the same expenditure, 864, an increase of 23%.

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DENTAL EXPENDITURES
($000'S)

SFY 93-94	$ 34,240
SFY 94-95	$ 37,814
SFY 95-96	$ 42,318
SFY 96-97	$ 42,476
SFY 97-98	$ 42,547 (Annualized through Nov.)

Medicaid Expendatures - Total and Dental
Selected States - Federal Fiscal Year 1996
Sorted by PerCent of Total Expendatures

State	Total Medicaid Expenditures	Dental Expenditures	Dental as a PerCent of Total Expenditures
Kentucky	$2,087,296,799	$34,208,778	1.64%
Texas	9,206,669,731	108,693,714	1.18%
North Carolina	**4,088,863,478**	**41,723,714**	**1.02%**
Georgia	3,560,561,472	32,901,644	0.92%
Florida	5,800,663,440	51,631,949	0.89%
South Carolina	2,013,832,070	14,502,799	0.72%
Virginia	2,119,400,769	11,197,705	0.53%
Alabama	2,036,656,611	10,058,913	0.49%
New York	24,325,409,241	106,680,446	0.44%
Mississippi	1,601,712,119	3,171,905	0.20%
Maryland	2,441,028,457	2,158,951	0.09%
Tennessee	3,137,642,182	41,266	0.00%

Medicaid Recipients and Dental Recipients

Selected States - Federal Fiscal Year 1995

Sorted by Percent of Total Recipients

State	Total Recip.	Dental Recip.	PerCent of Total
New York	3,035,477	865,102	28.50%
Kentucky	640,930	158,174	24.68%
Texas	2,043,099	486,381	23.81%
South Carolina	495,500	113,238	22.85%
Georgia	1,147,443	260,538	22.71%
North Carolina	**1,084,337**	**226,844**	**20.92%**
Florida	1,735,141	339,475	19.56%
Virginia	681,313	106,156	15.58%
Alabama	539,251	65,649	12.17%
Maryland	414,261	41,177	9.94%
Mississippi	519,697	29,907	5.75%
Tennessee	1,466,194	430	0.03%
Total	**36,281,586**	**6,382,937**	**17.59%**

Medicaid Recipients and Dental Recipients
Selected States - Federal Fiscal Year 1997
Dental Procedure Cost

Procedure Code	Dental Procedure	Texas	South Carolina	Georgia	North Carolina	Florida	Virginia	Alabama	Maryland
D0120	Periodic Oral Evaluation	10.00	13.00	-	**13.43**	14.00	11.00	29.00	5.00
D0140	Limited Oral Evaluation	15.25	12.00	15.20	**26.76**	7.00	-		
D0150	Comprehensive Eval.	15.25	14.00	17.40	**18.52**	14.00	-		
D0220	Intraoral Periapical 1st Film	5.50	5.00	5.80	**7.59**	4.00	5.50	4.50	3.00
D0272	Bitwings 2 Films	10.00	9.00	40.50	**12.51**	8.00	8.80	9.00	5.00
D1201	Floride Appl. - Child	25.00	-	-	**30.61**		-		17.00
D1351	Sealant per Tooth	16.25	11.00	15.40	**12.74**	12.00	-	14.00	3.00
D2140	Amalgam 1 Surface	25.00	24.00	22.80	**27.49**	25.00	17.60	26.00	23.80
D7110	Tooth Extraction	32.50	30.00	21.80	**30.61**	23.00	16.50	24.00	14.00
D7120	Each add'l Extrac.	27.50	-	20.80	**30.61**	20.00	16.50	24.00	8.00

North Carolina Medicaid Dental Procedure Analysis
State Fiscal Year 1997

Procedure Code	Dental Procedure	Procedure Cost	Average Billed	Medicaid % of Average Billed
D0120	Periodic Oral Evaluation	13.43	25.36	52.96%
D0140	Limited Oral Evaluation	26.76	34.18	78.29%
D0150	Comprehensive Eval.	18.52	33.63	55.96%
D0220	Intraoral Periapical 1st Film	7.59	12.29	61.76%
D0272	Bitwings 2 Films	12.51	18.52	67.55%
D1201	Floride Appl. - Child	30.61	36.16	84.65%
D1351	Sealant per Tooth	12.74	23.92	53.26%
D2140	Amalgam 1 Surface	27.49	46.08	59.66%
D7110	Tooth Extraction	30.61	52.49	58.32%
D7120	Each add'l Extrac.	30.61	49.08	62.37%

Pharmaceutical Assistance Programs for the Low-Income Elderly: A Review of Findings

Stuart Bratesman, Jr., MPP
Policy Analyst
Duke Long Term Care Resources Program

N.C. Appropriations Committee
December 17, 1997

Pharmaceutical Assistance

- State of the Research
- The Problem
- What Benefits?
- Twelve States
- Primary Issue: Costs
- Cost Controls
- Unintended Consequences
- Utilization Review
- The Key Lesson

State of Research

- Not Much Has Been Written
- Administrative Data - No Randomized Trials
- *Soumerai, et. al.: "Research in Need of Discipline"*

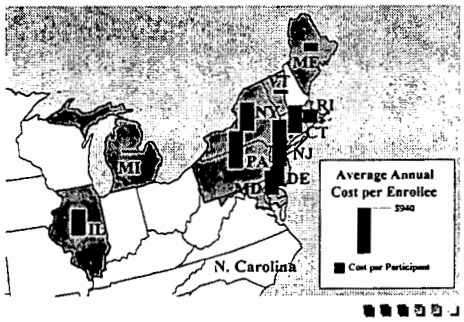
The Problem

- Many Low-Income Elderly are Very Price Sensitive to Medication Costs
- Can't Afford to Buy Prescriptions
- Prescription Stretching
- Health Problems that Could Have Been Treated or Controlled by Drugs Become More Serious and Expensive

What Observed Benefits?

- Increased Use of Prescription Medications
- Reduced Consumption of Medicare-Reimbursable Health Services
- Reduced Emergency Room Visits
- Reduced Rate of Nursing Home Admissions

Twelve States



Primary Issue: Costs

- Key Concern of Administrators
- Great Variation Between States
  - Vermont: $86 / year / enrollee (80% co-payment)
  - New Jersey: $935 / year / enrollee
- Aging Population
- Newer Drugs & Price Inflation
- Individual Consumption Rises Over First Three Years

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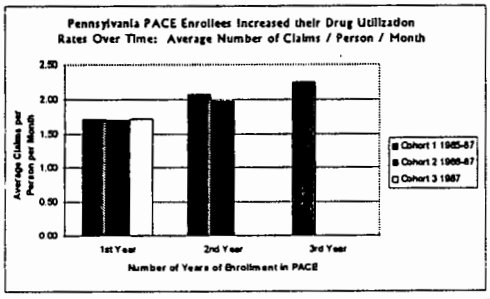
Consumption Rises



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Cost Controls

- Eligibility Limits
- Annual Enrollment Fees
- Co-payments
  - Fixed • Percentage • Sliding-Scale
- Deductibles
- Dollar Caps
- Quantity Caps
- Formularies

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Unintended Consequences

- Discourage Use of Effective Medications
- Formularies Prompt Substitutions
  - Major Tranquilizers for Minor
  - Irrational Substitutions
  - Answer: Education
- Cap = 100% Co-payment
  - N.H. Medicaid 3 Meds/Month Cap ⇨ 35% Decline in Cardiovascular Drugs

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Utilization Review

- Administrative or Health Oriented?
  - Duplicate Claims & Abnormal Patterns
  - Medical Appropriateness - Drug Interactions
- After-the-Fact or Intervening
- Type of Feedback

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Excellent Model Here in N.C.

- Durham County Senior PharmAssist
- Strong Client Education
- Prospective Utilization Review
  - Prevents Bad Interactions
- Reduces Hospitalization
- Emergency Room Visits Down 31%

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The Key Lesson

Planners need to examine each option from the perspective of each of the participants:

- patients;
- doctors;
- pharmacists; and
- administrators

and think through the full consequences of how each is likely to react.

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