



Children's Social-Emotional Health Data Workgroup

Meeting #2, October 21, 2019

9:00am-3:00pm, The Hill Center



Welcome



Agenda

- Welcome and introduction
- Racial Equity Workshop
- Lunch
- Review/Discuss Potential Measures
- Tools Commonly Used in NC
- Small Group Work
- Evaluation and Next Steps



Meeting Objectives

- Develop a shared framework for understanding structural racism and connect the equity frame explicitly to our work
- Build relationships and commitments for continued learning and work on racial equity
- Continue reviewing and discussing potential tools/measures
- Begin prioritizing measures using shared knowledge and characteristics for strong measures
- Identify additional needs and resources for Meeting #3

Goals for Children's SEH Data Workgroup

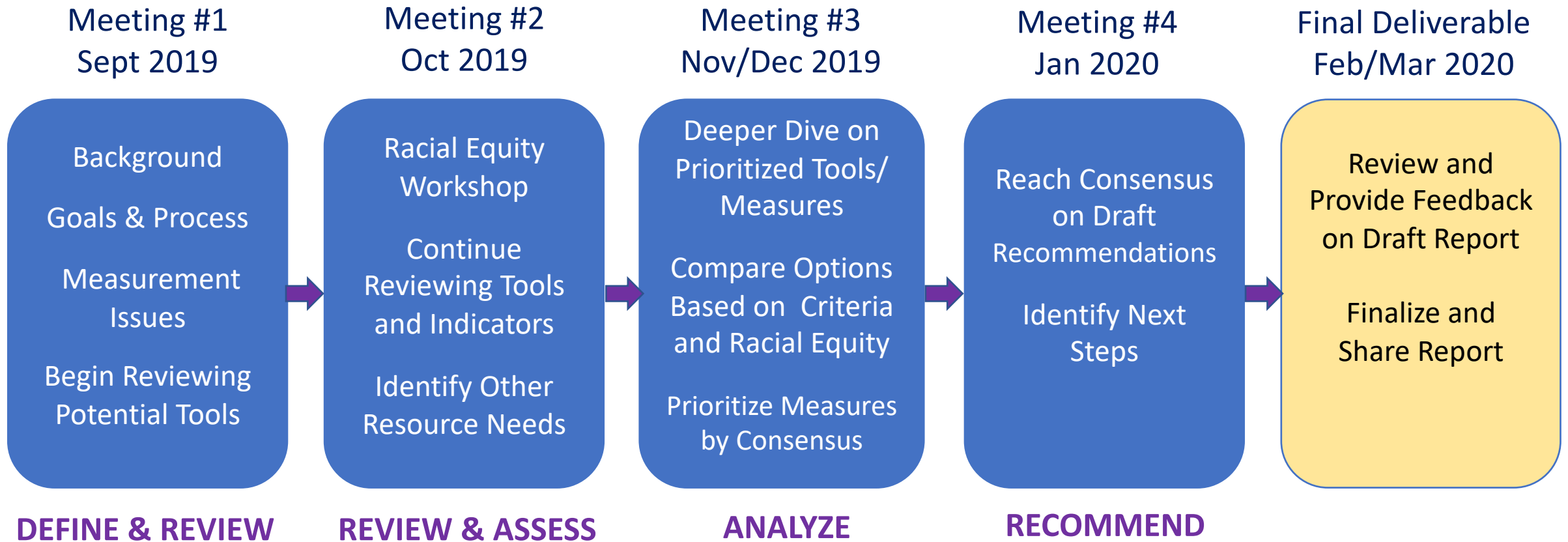
1. Recommend a population-level measure or portfolio of measures for young children's (0-8) social-emotional health (SEH) in NC
2. Advocate for tools that limit racial bias and measure SEH strengths, not just deficiencies
3. Propose next steps for the state in planning, communicating and implementing our recommended measures.

Desired Outcome

- ✓ To improve NC's early childhood system and child outcomes by having accurate and accessible data that describes children's SEH in North Carolina, and informs equitable and data-based decisions about policy, practice and resource allocation.



Process and Timeline



NCECF leads and facilitates; **Data Workgroup** reviews, advises and makes decisions; **Advisory Group** responds

Group Agreements

- Listen with an open mind and value all ideas
- Ask questions about what isn't clear to you
- Speak plainly -- i.e., use full names instead of acronyms unless defined
- Encourage and support participation of all group members
- Work towards consensus. We define consensus as "Even though the decision might not be exactly what we want, I can live with it and publicly support it."
- Approach the work with an equity lens by creating space for diverse opinions and backgrounds, and by supporting access for everyone to resources, opportunities, power, and responsibility.



RACIAL EQUITY A Path to Community Impact

Presented by CounterPart Consulting, LLC
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Grounding definitions

Building the Container



What is Equity?

Equity is doing the same things you've always done, the same way you've always done them, and just saying "EQUITY" more often.

~ paraphrased (sarcasm) from
Vu Le, Nonprofit AF blog

Building Equity Capacity means...CHANGE!

Infusing equity principles, practices, decisions, and actions into strategy, programs, advocacy, communications, relationships, internal operations and culture – for improved and sustainable mission impact.



LENS



FOCUS



CHANGE

EQUITY LENS

Focus on Outcomes & Root Structures



"How is power operating?"



Ownership

EQUITY & EQUALITY

Equity is a proactive, strategic approach to improving outcomes that accounts for structural differences in power, opportunities, burdens, and needs in order to design targeted solutions and make systems work equally well for all people.



RACE

A social and political construct, created by Europeans during the time of worldwide colonial expansion, to assign human worth and social status – using themselves as the model of humanity – for the purpose of legitimizing and concentrating their power.

~Adapted from Dr. Maulana Karenga

Focus explicitly, not exclusively, on race to...



- **Get results that matter & last.** Equity doesn't trickle down... by prioritizing the needs and outcomes of people of color, we can close gaps and improve outcomes for everyone.
- **Build power.** Race has been used as an effective “wedge” tactic throughout history... develop skill and confidence to build solidarity and win.
- **Solve problems.** By design, race is the most durable predictor of outcomes... and facilitates injustice of all kinds.

Race Equity

racial equity is something that has not existed or been considered important in this country...using policy and incentive to guarantee that all persons start from an equitable beginning

simply put: racial equity is about distributing resources to match need. RE requires shifts in resource allocation, access to opportunities, and policies in order to counterbalance disproportionate outcomes for people of color--caused by generations of systemic racism and bias.

racial equity seeks to remove policies and practices that perpetuate harm to minority communities and builds a new construct that is based on establishing fairness and justice.


Why is this an important lens?

racial equity is important because racism has great affects on children's health status and development.

race cannot be overlooked when assessing SEH because race is pervasive and equity is needed to build strong communities.

because surface data can make it challenging to see underlying root causes of differences when data is disaggregated.

because our measures should not advance thinking and policies rooted in individual and systemic racism. This would happen is we approach measuring SEH as solely within a person/within family phenomenon. Instead our work should help redefine SEH as a function of environmental and social conditions.



*"A racially equitable society would be one in which the distribution of resources, opportunities, and burdens is **not determined, predictable, or disproportionate by race.**"*

*~ Philanthropic Initiative for
Racial Equity*



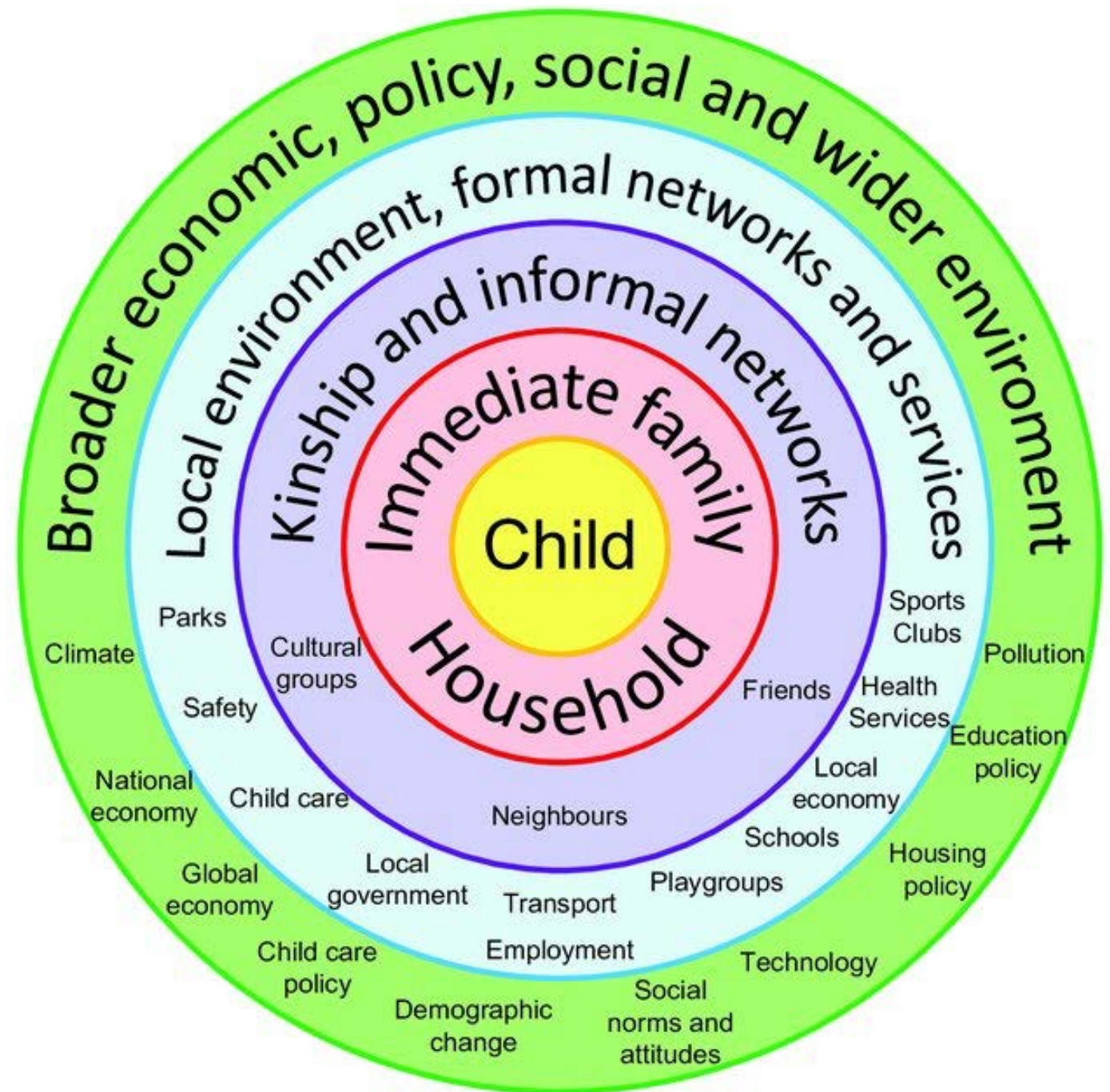
HISTORY OF AND BIAS IN ASSESSMENT: CONSIDERATIONS



History of Assessment

- Historically, there have been concerns in the field that many assessment tools were not sensitive to the unique needs of young children
 - Assessments authored in the '40s and '50s were used to make diagnostic decisions and many felt that outcomes were inaccurate, resulting in mislabeling, misdiagnosis, and inappropriate placement of young children

- Bronfenbrenner's model offered consideration of natural environments
- What have you seen as problems with assessment?
- How have you seen assessment models take these early childhood systems into consideration?
- What do you think were and are some of the issues?



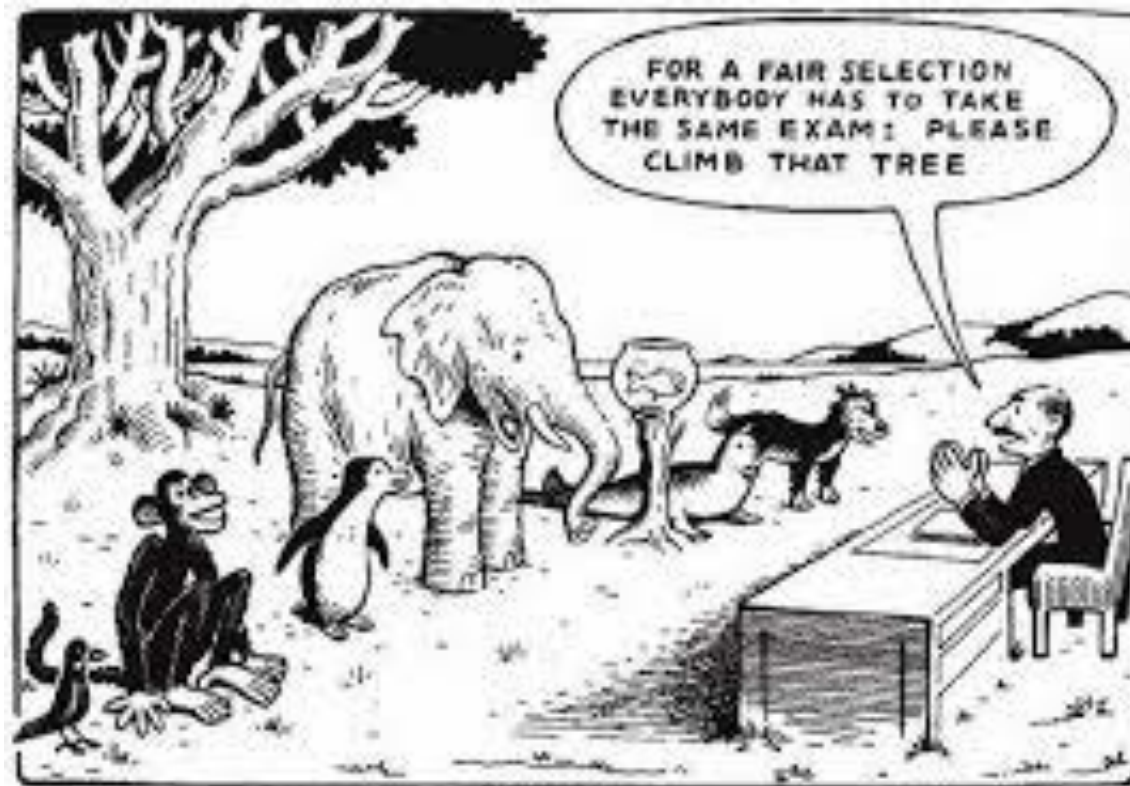


What is Culture:

- The way we live
- Values, mores, customs
- Behavioral expectations
- Belief Systems
- Communication styles
- Traditions that are shared and passed between generations
- Does assessment typically take culture into consideration?

Common Uses and Challenges Norms and Testing

- Educators and others use [standard scores to make comparisons](#) in the determination of student performance levels based on normed data
- [The normal curve with standard deviations is utilized to examine various content areas](#)
- Norms along the normal curve allow evaluators to compare test performance
- Different cutoff levels are used for different content areas when dealing with standard deviation
- Normative sample - means for various age and grade levels of the normative sample are established [for comparative purposes](#)
- [Lack of representativeness of specific population groups in the sample poses sample bias](#)
- In order to use age levels, it is important to determine chronological age
- Grade and age level scores are deemphasized in assessment reports because they could be misleading

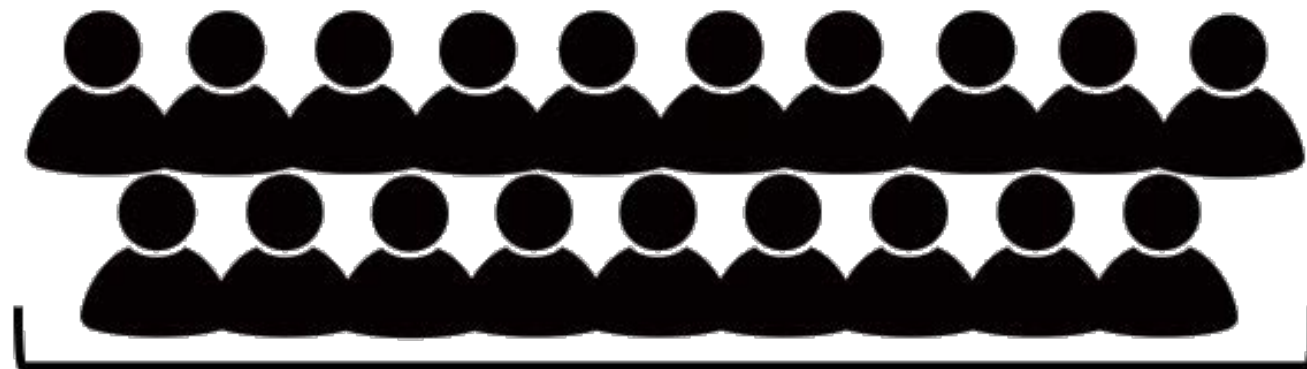


Cultural Bias in Assessment

- Measures developed for one culture or ethnic group may not be valid or reliable for another.
 - » Not simply a matter of language translation
 - Meaning may be lost
- Cultural bias can lead to minimizing or exaggerating psychological problems

Social Emotional Health





Universal Screening



Intervention

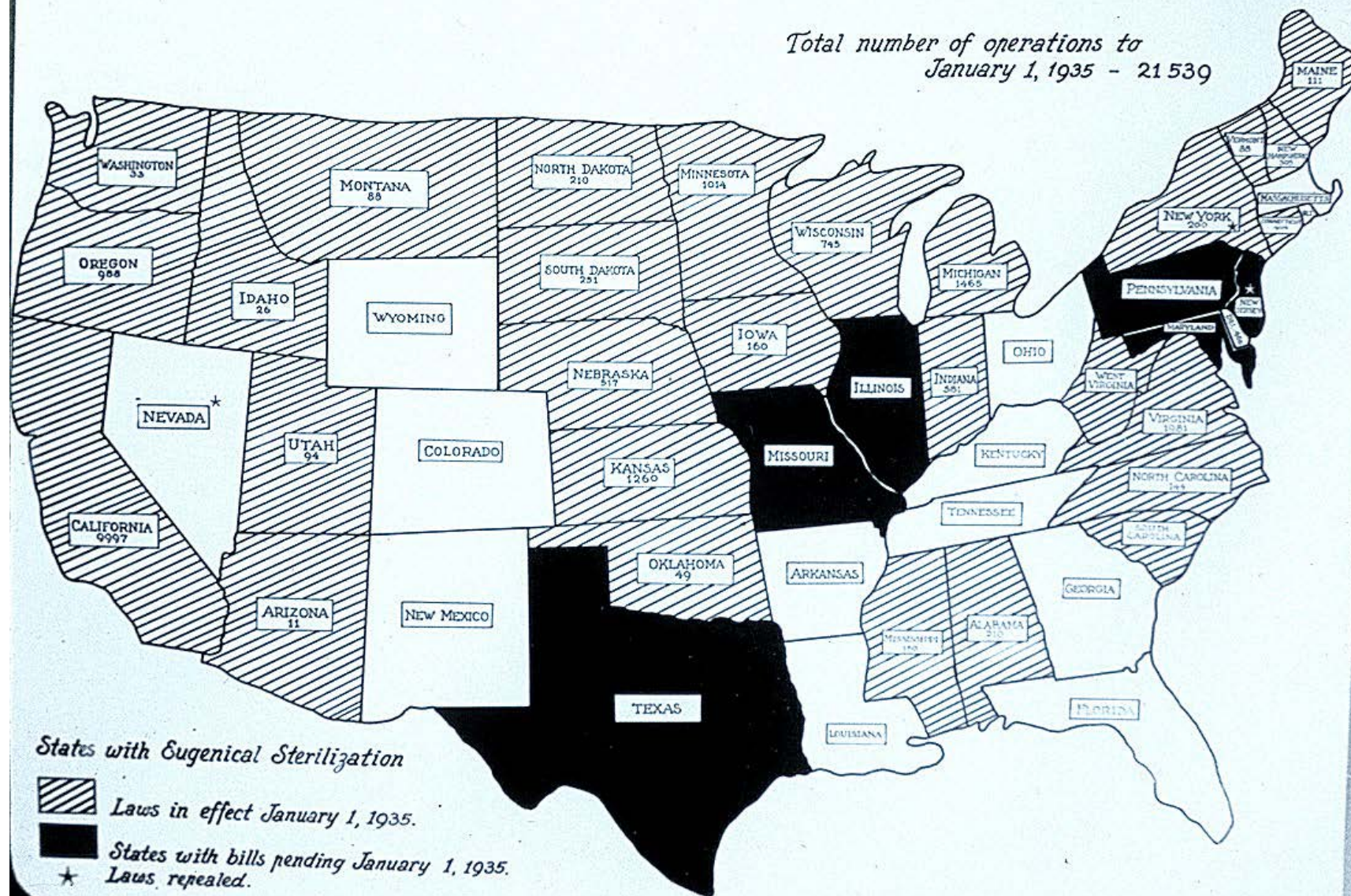
Eugenics

- the science of improving a human population by controlled breeding to increase the occurrence of desirable heritable characteristics.

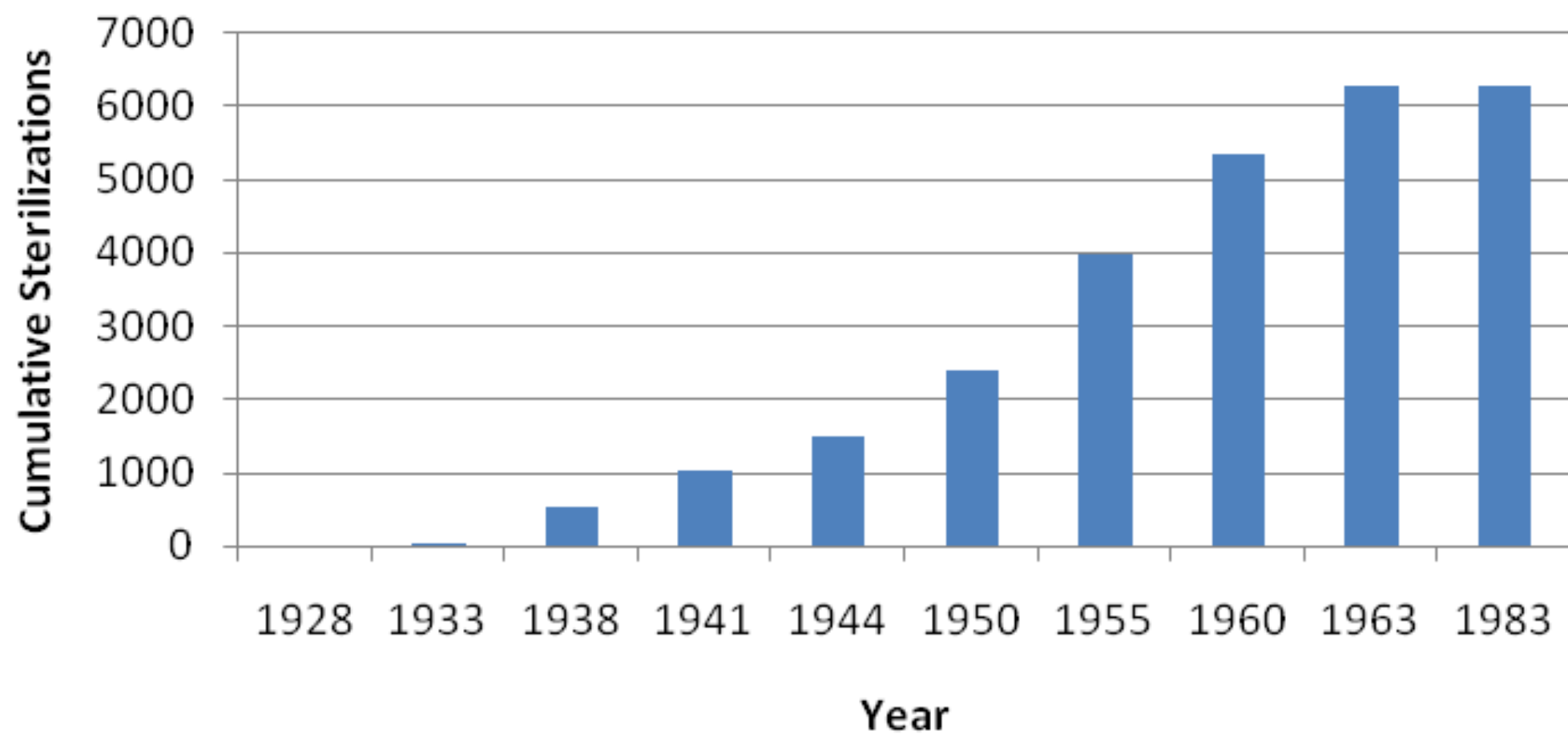
LEGISLATIVE STATUS OF EUGENICAL STERILIZATION IN THE UNITED STATES

AND THE TOTAL NUMBER OF OPERATIONS BY EACH STATE TO JANUARY 1, 1935.

*Total number of operations to
January 1, 1935 - 21 539*

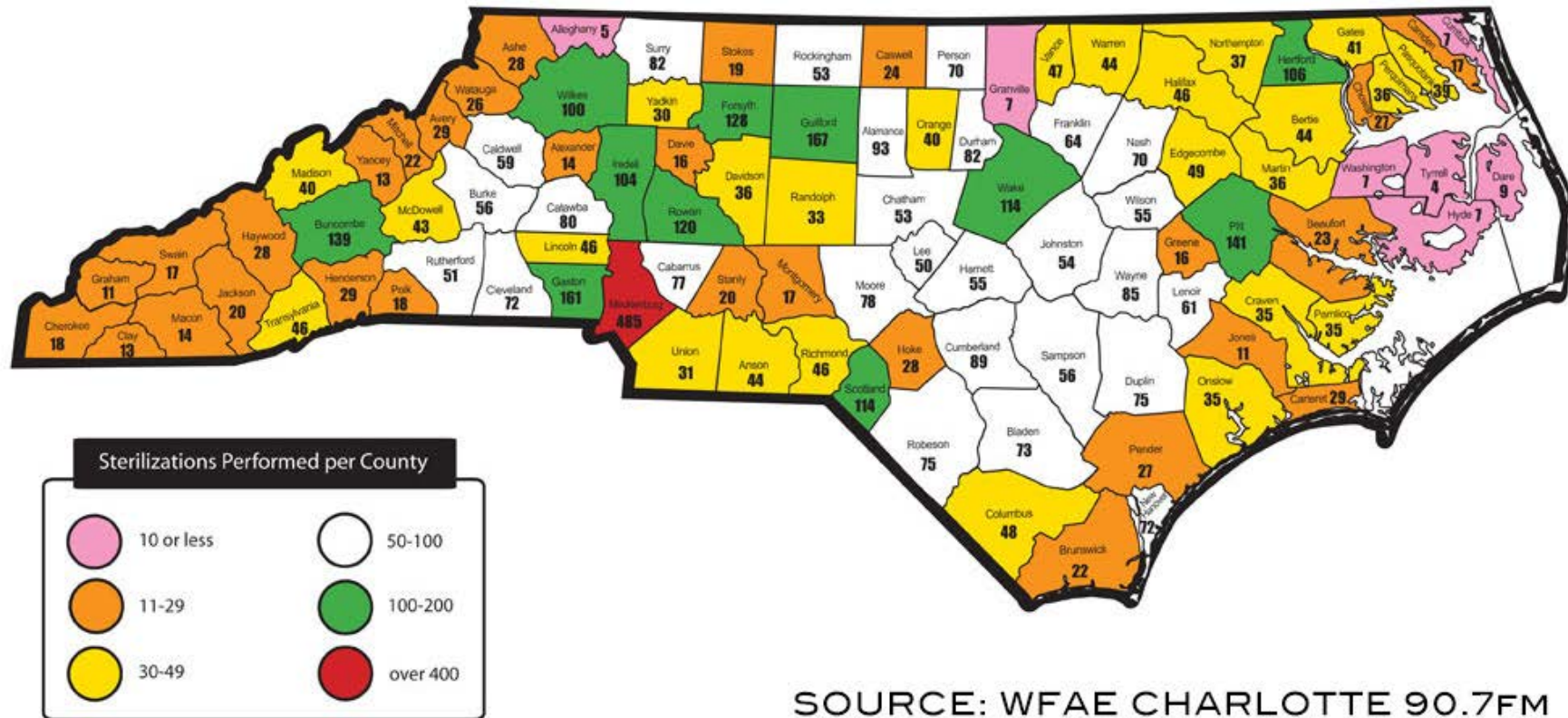


North Carolina Sterilizations



NC Eugenics

PEAK OF EUGENICS PROGRAM IN NORTH CAROLINA
JULY 1946 - JUNE 1968



SOURCE: WFAE CHARLOTTE 90.7FM

NC Eugenics

- North Carolina's experience is unique because most states stopped performing involuntary sterilizations after World War II.
- North Carolina expanded its effort. Seventy-nine percent (79%) of sterilizations performed in North Carolina occurred after 1945.²²
- At the beginning, sterilization numbers were racially balanced, but during the 1950s the program became more racially oriented.
- By the late 1960s, sixty percent (60%) of those sterilized were black, even though they only made up a quarter of the population.²³
- Around this time, the Human Betterment League, formed in 1947, launched a large media campaign promoting sterilization as a way to save taxpayers' dollars.²⁴
- The case was made that sterilization would reduce the amount of welfare the State would provide. No matter what the reasons for North Carolina expanding sterilizations after WWII, it was an anomaly.

What Are Our Responsibilities

- How can we acknowledge the historical aspects of assessment?
- What can we learn from the historical misuse of assessment results?
- How can recognize the limitations and promise of state-wide social emotional health measurement?
- Other thoughts or concerns?

Storytelling

Building the Container



Stories from the Field

What is your racial identity? When did you become your racial identity? How is that different from your ethnicity?

Sharing Your Story

How does your racial identity, and race in general, inform and relate to your work?

Stories from the Field

Given your own experience, what do you know about race and social-emotional health assessment?

Stories from the Field

What have you heard about race and assessment of social-emotional health from teachers/administrators/parents?

History

The Construction of Race



Race and Whiteness are Both Unscientific Concepts

“Scientific studies conclude that race has no biological meaning or significance. The gene for skin color is linked with no other human trait. The genes that count for intelligence, athletic ability, personality type, and even hair and eye color are independent of the gene for skin color.”

Aspen Institute Roundtable on Community Change, Structural Racism and Community Building (Washington, D.C.: The Aspen Institute, 2004), p.15.

How was whiteness created?

In the mid 1500s, Britain defines Irish as non-white to justify their subjugation of Irish people.

British brought their views of whiteness and their dominance as a structural feature of the "New World."

Poor white indentured servants were building alliances with enslaved Africans due to similar state of oppression.

Whiteness was created as a political construct and an organizing tool used by owning class to unite Europeans and to maintain control over Native Americans and enslaved Africans.

Racial Designations have Changed Based on the Labor Needs, Biases and Fears of the Dominant Culture

The U.S. has often reclassified immigrants who identify themselves as white.

White-identified South Americans moved to the U.S. and were labeled Latinos.

People in power were threatened by increased immigration.

Southern and Eastern Europeans, Jews, Asian and Pacific Islanders and Mexicans were considered white and non-white at different times.

Christian Arabs were deemed non-Asian while Muslims were categorized as Asians.

Some Ways Racial Categorization has been Enforced

After slavery ended, Jim Crow laws were created, then the Civil Rights Movement started, and then retrenchment again.

African Americans experienced an increased removal of children from homes via the child welfare system and increased incarceration of children.

The U.S. government routinely violated negotiated treaties with Native American sovereign nations.

19th and 20th Century: Native American children were removed from their families to attend "Indian Schools" to assimilate to European cultural norms.

Racial designations of Asian American and Pacific Islanders changed 4 times in the 19th century.

19th and 20th century whites passed 600+ pieces of legislation limiting or excluding Asians from citizenship.

TWP - 2016 – CAPD, MP Associates and World Trust

The Construction of Race

The **1790 Naturalization Act** permitted only "free white persons" to become naturalized citizens, thus opening the doors to some European immigrants, but not others. Only citizens could vote, serve on juries, hold office, and in some cases, even hold property. Immigration restrictions further limited opportunities for people of color. Racial barriers to naturalized U.S. citizenship weren't removed until the McCarran-Walter Act in 1952, and white racial preferences in immigration remained explicit until 1965.

From *Race: Power of an Illusion*, PBS

TWP - 2016 – CAPD, MP Associates and World Trust

The Construction of Race

The **1830 Indian Removal Act**, forcibly relocated Cherokee, Creeks, and other eastern Indians to west of the Mississippi River to make room for white settlers. As white U.S. citizens also moved into former Mexican territories, the rights and privileges of Mexicans eroded. Once territories had a significant white majority (instead of Indian or Mexican majorities), the territories became states. Most of the former Mexicans lost their treaty-guaranteed rights of citizenship, land, and resources in these new states.

Congress authorizes the establishment of the **Carlisle Indian Industrial School in 1879** in Pennsylvania. Native children are forcibly removed from their families and placed in boarding schools. They are punished for expressing their traditional language, spirituality, or cultural traditions. Many suffered physical, emotional, and sexual abuse.

The Construction of Race

Jim Crow laws in the South (and customs in the North) included a highly evolved system of leasing [enslaved people] that regenerated itself around convict leasing. By 1900, the South's judicial system had been wholly reconfigured into laws specifically written to intimidate Black people — criminalizing them for changing employers without permission, vagrancy, riding freight cars without a ticket, and engaging in sexual activity (or loud talk) with white women.

From *Slavery By Another Name* – Douglas Blackmon.
TWP - 2016 – CAPD, MP Associates and World Trust

The Construction of Race

With the Great Depression intensifying competition for jobs, the Bureau of Immigration launches an **intensive deportation campaign in 1930** to repatriate immigrant and U.S. citizen Mexicans in. More than 400,000 Mexican immigrants and naturalized citizens and their U.S. born children were removed from Arizona, California, and Texas.

From *Slavery By Another Name* – Douglas Blackmon.
TWP - 2016 – CAPD, MP Associates and World Trust

The Construction of Race

The landmark **Social Security Act of 1935** provided a safety net for millions of workers, guaranteeing them an income after retirement. But the Act specifically excluded two occupations: agricultural workers and domestic servants, who were predominately African American, Mexican, and Asian. As low-income workers, they also had the least opportunity to save for their retirement. They couldn't pass wealth on to their children. Just the opposite. Their children had to support them.

From *Race: Power of an Illusion* – PBS
TWP - 2016 – CAPD, MP Associates and World Trust

The Construction of Race

The Servicemen's Readjustment Act, or **G.I. Bill of 1944**, was a series of programs that poured \$95 billion into expanding opportunity for soldiers returning from World War II. Most African Americans were channeled toward traditional, low-paying jobs and small Black colleges, which were pitifully underfinanced and ill equipped to meet the needs of a surging enrollment of returning soldiers; 92 percent of the unskilled jobs were filled by Black people. By 1946, only one fifth of the 100,000 Black people who had applied for educational benefits had been registered in college. At the same time, white universities were doubling their enrollments and prospering with the infusion of public and private funds, and of students with their G.I. benefits.

The Construction of Race

President Ronald Reagan signs **The Anti-Drug Abuse Act in 1986**. In addition to the \$1.7 billion allocated for the “war on drugs,” the bill also created mandatory minimum penalties for drug offenses. Over the next 30 years, the US saw a 500% increase in the number of incarcerated individuals with more than 60% being racial and ethnic minorities despite higher levels of drug use within white communities.

TWP - 2016 – CAPD, MP Associates and World Trust

The Construction of Race

The Trump administration **family separation policy** is an aspect of his immigration policy enacted in **2018**. Under the policy, federal authorities separated children from parents or guardians with whom they had entered the US illegally. The adults were prosecuted and held in federal jails, and the children placed under the supervision of DHHS. By early June 2018, it emerged that the policy did not include measures to reunite the families that it had separated. Since 2018, despite the official end of the separation policy, hundreds of additional children have been separated from their parents.

https://en.wikipedia.org/wiki/Trump_administration_family_separation_policy

Race is not biological; it has been constructed over time through the allocation of advantages and disadvantages

- Colonization... removal... enslavement... genocide...
- 1790 Naturalization Act and other shapers of citizenship...
- 1830 Indian Removal Act and other shapers of land and property...
- 1900s Jim Crow laws and customs that shaped justice and safety and cross-racial interaction...
- Federal Housing Administration and other shapers of housing and neighborhoods...
- 1935 Social Security Act and other shapers of economic security...
- 1935 Wagner Act and other shapers of labor and work...
- 1944 GI Bill and other shapers of opportunity...
- 1956 Interstate Highway Act and other shapers of mobility and connectivity...
- Current-day policies, practices, and conversations about immigration, health care, education, criminal justice, and others continue to construct race...

Structural Racism

The cumulative impact of racialized disparities in power over time.



A race-explicit framework for Equity

Trying on a New Lens



Applying a Racial Equity Lens

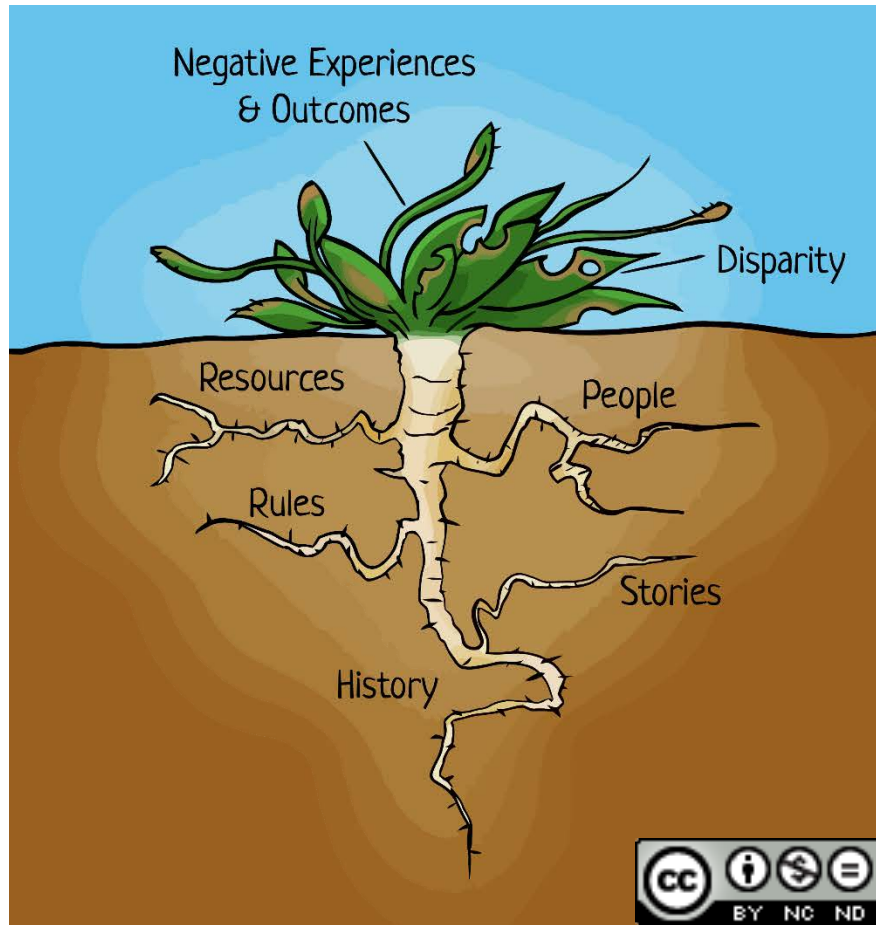
1. **Acknowledge** how life options and outcomes are shaped by interacting structures and power relationships that benefit some and burden others based on racial identity and other social determinants.
2. **Analyze** the cumulative impact of structures and power relationships on a specific issue, condition, or population.
3. **Strategize** structural interruptions and innovations to close gaps and improve outcomes and opportunities for all.
4. **Repeat...**



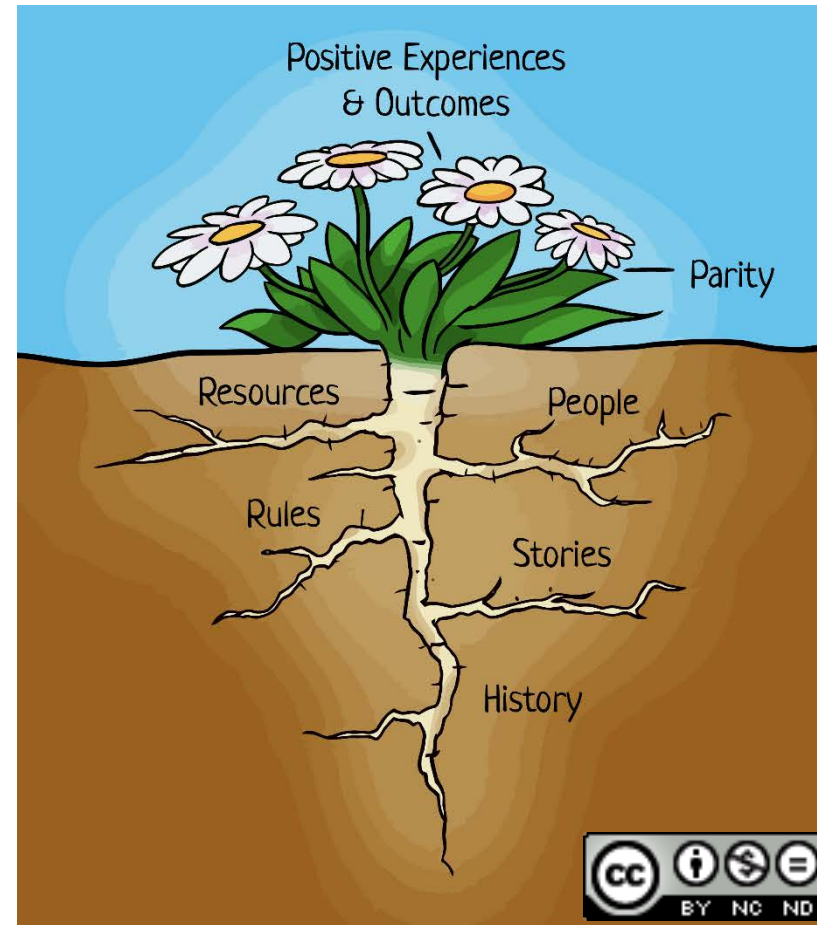


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Structural racism is like a persistent weed...



Racial equity can be an enduring flower...



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Applying a Racial Equity Lens

How is structural racism operating?

- How are **resources** designed, distributed, and controlled? Whose needs and wants do they meet and privilege?
- What **rules** are in place? Who do they benefit and who do they burden?
- What **stories** are being told or assumed? Who determines them? Who do they elevate and who do they degrade?
- What **people** are directly impacted and what is their voice? Who has authority or influence, and what actions are they taking?

How could racial equity take root?

- How could **resources** be available, accessible, and relevant to the needs of the people who need them the most?
- What **rules** could be fair to everyone and right past wrongs?
- What **stories** would more accurately convey and support the full humanity of all people?
- How could **people** with authority and influence be more reflective of and accountable to those who are directly impacted?

Applying a Racial Equity Lens

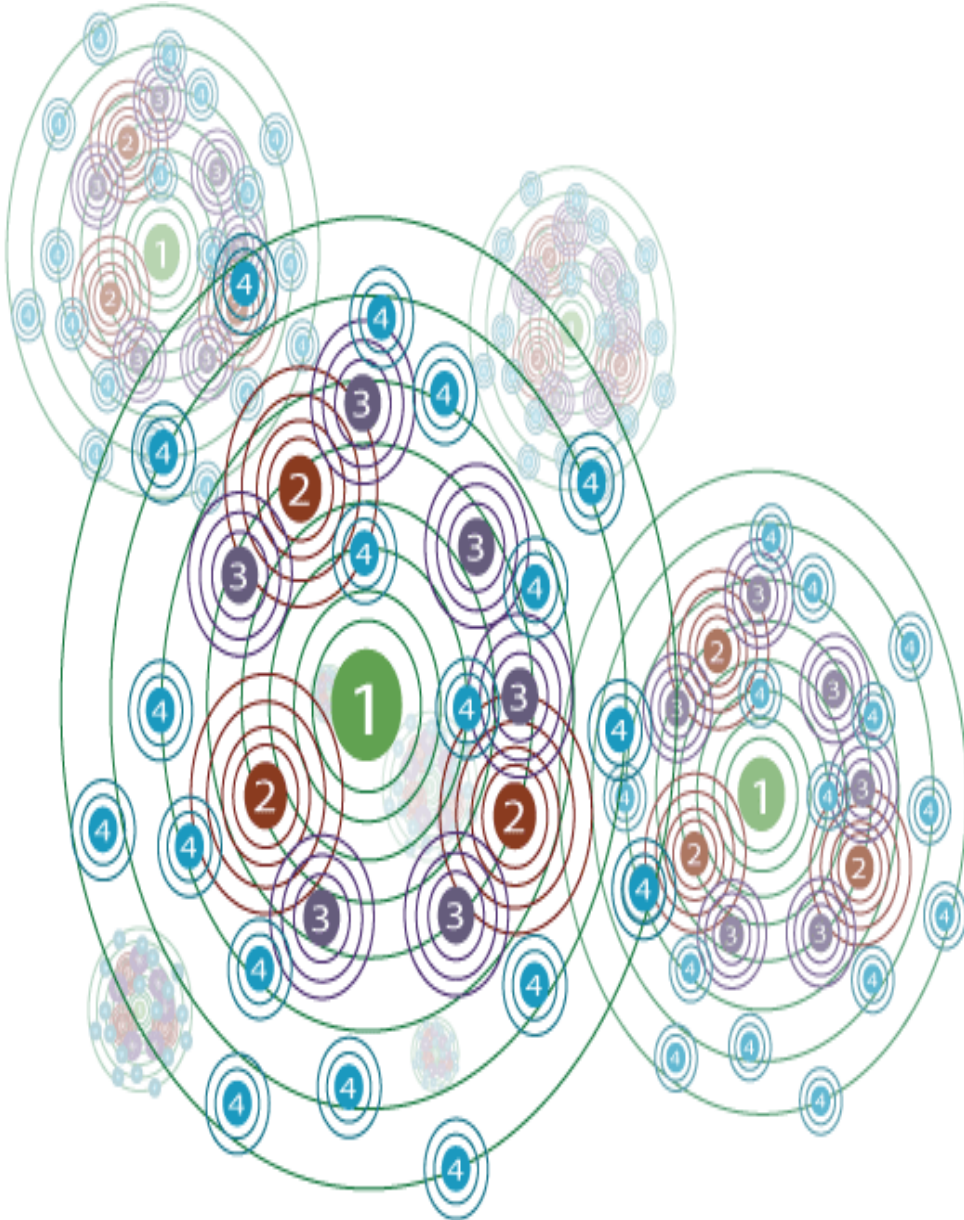
Black children make up 18% of preschool population enrollment but 48% of preschool children suspensions. Boys receive three out of four of preschool suspensions overall. (2011-2012)

Pathways uses an **Equity Lens**

Leading with racial equity means prioritizing strategies that specifically work to improve outcomes for children of color and giving special consideration to the wisdom and innovation of people of color to develop responses that are lasting and reach all children.



Interrupting Structural Racism



"To say that it is not our fault does not relieve us of responsibility. We may not have polluted the air, but we need to take responsibility, along with others, for cleaning it up... The task for each of us... is to identify what our own sphere of influence is (however large or small) and to consider how it might be used to interrupt the cycle...."

From Beverly Daniel Tatum, Ph.D., "Why Are All the Black Kids Sitting Together in the Cafeteria?"



Lunch!

Meeting #1 Recap

- Intro to workgroup, goals, racial equity frame and timeline
- Reviewed key issues related to measurement of SEH in EC
- Discussed three commonly used screens
 1. Survey for Well-Being of Young Children (SWYC)
 2. Ages & Stages Questionnaire (ASQ-3)
 3. ASQ-Social Emotional (ASQ:SE-2)

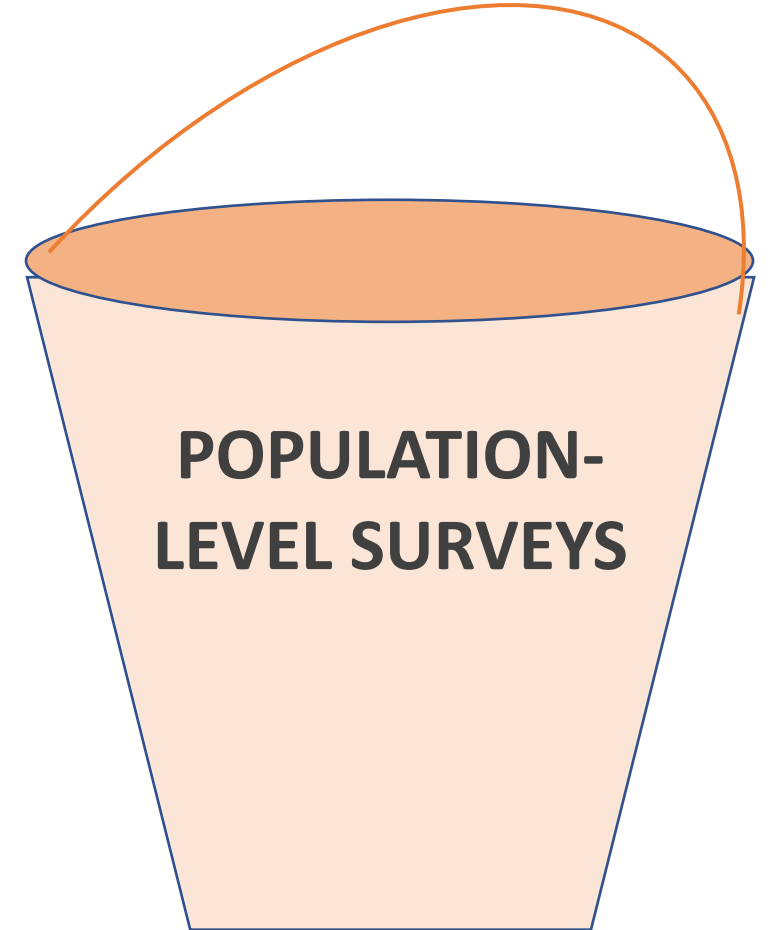
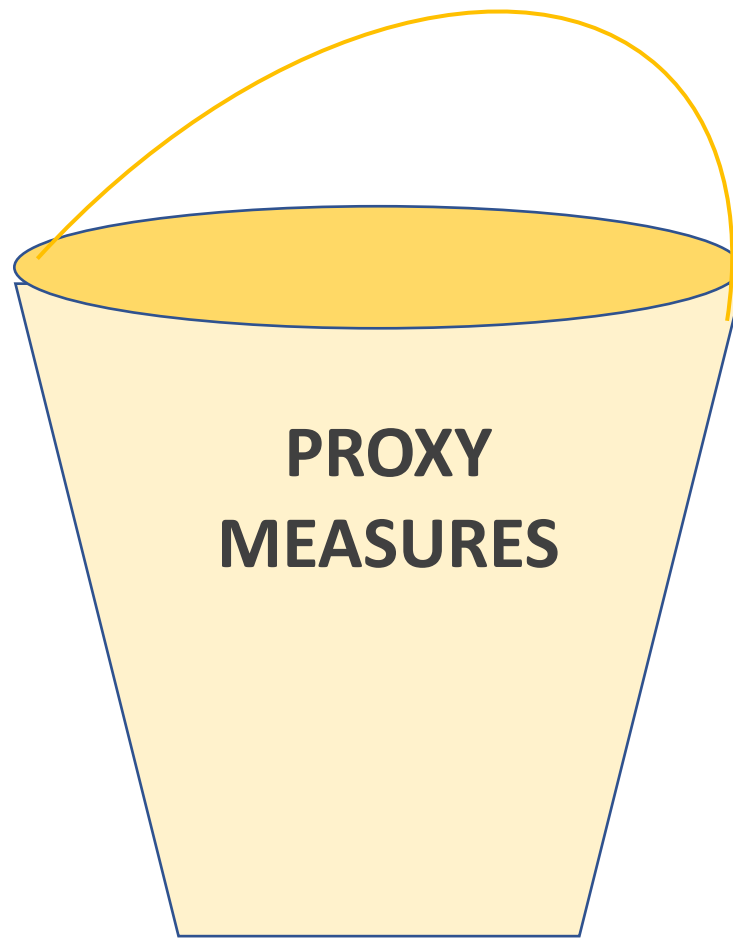
Child Trends Memo

- Identified various state early learning standards, indicators & frameworks related to SEH, but no reported population-level data outside of some early intervention data
- States are primarily relying on child-level screens, surveys, and program-level data (e.g., Healthy Steps, home-visiting)
- Other strategies include use of Quality Rating Improvement System (QRIS), incentives, identifying a developmental screener for statewide adoption, focusing on competencies and two-generation approach

Child Trends Memo

- Challenges: Few shared data platforms, difficulty capturing kids who aren't in system, limited culturally appropriate assessments and standardized SEH measures, reporter bias
- Recommendations:
 - Examine potential to collect screening and referral data
 - Explore Medicaid partnerships tying reimbursement to collection of SEH data
 - Use National Survey of Children's Health items

Three Buckets of Potential Measures



North Carolina Preschool Exceptional Children Data

Early Childhood Outcomes

<https://nceln.fpg.unc.edu/state-data>

NC Early Learning Network

- Home
- Initiatives
- Resources
- EC Preschool Coordinators
- Training Modules
- State/Local Data
- Events


Home » State Data

State Data


North Carolina Early Childhood Data Profile


Welcome to the NC Early Childhood Data Profile! These pages contain data related to the Exceptional Children Preschool Program from a variety of sources and reports, including the preschool grant, Child Count table, State Performance Plan (SPP) and other required data sets. Data from the preschool grant are reported at the close of the school year reflecting information from the previous year. SPP data are collected at various times during the year, generally representing data for the previous year. The December child count (618 data), collected in December, are reported the following spring. Please use the links below to visit each page.

[Child Find](#) | [Least Restrictive Environments](#) | [Transition](#) | [Child Outcomes](#)



This project is a program of

 PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction :: Office of Early Learning (Pre-K – Grade 3)

 **UNC** | FRANK PORTER GRAHAM
CHILD DEVELOPMENT INSTITUTE

[Accessibility](#) | [Web Login](#)

<https://nceln.fpg.unc.edu/childoutcomesresources>



Early Childhood Outcomes System (COS)

INTRODUCTION

All early intervention and early childhood special education programs across the country have developed early childhood outcomes measurement systems in response to the U.S. Department of Education's requirement to measure young children's progress. While Individual Family Service Plan (IFSP) outcomes and Individualized Education Program (IEP) goals are written specifically for individual children, **the three child outcomes measured for federal reporting purposes are the same for everyone and measure the change in a child's overall functional development over the time a child received early intervention or early childhood special education services.**

Child outcomes ratings must be completed upon entry to the early intervention and early childhood special education program, and upon exit from these programs. Interim ratings can also be completed as a means of tracking a child's developmental progress. A comparison of the entry and exit ratings will then determine which type of developmental trajectory describes the child's progress over time. Programs are then evaluated based upon the percentage of children who maintained progress within the same **developmental trajectory** improved functioning and changed developmental trajectories, or who changed developmental trajectories to reach age level functioning (see, Understanding the Developmental Trajectories brochure).

The entry level ratings should be completed by the assessment team members conducting the entry level evaluations for program eligibility. This has proven to be the most reliable entry level rating process. Exit level ratings should be completed by service providers and teachers based on data from parent interviews, child observations, or other assessment data.

CHILD OUTCOMES RATINGS: AGE-EXPECTED, IMMEDIATE FOUNDATIONAL OR FOUNDATIONAL LEVELS OF FUNCTIONING

Determining how a child's functioning compares to what is expected for his or her same age peers requires knowledge of the **child outcomes, child development**, and what the **child's functioning** looks like across settings. It also takes a **team** to conduct the ratings! Gaining parent input about how the child functions at home and in the community is important as is collaboration between regular and early intervention and special education providers. Critical resources for providers and teachers include the NC Foundations for Early Learning and Development and age referencing guides. Critical skills required to conduct reliable and valid ratings include the documentation of child observations and application of age referencing information to those observations.

The decision tree process (see last page of this brochure) helps teams determine COS rating. Using information from child observation, parent interview, and other assessment data, a team compares the child's functioning to that of a same aged peer who is developing according to age expectations. If a child's functional skills fall within age-level then he or she is considered to demonstrate "Age-Expected" functioning. The term "Immediate Foundational Skills" refers to observed child behavior that is close to, but does not reach age expectation. These are the skills that occur just before those which are age expected. The term "Foundational Skills" refers to observed child behavior that is not at age expected levels and depicts the skills of a **much younger** child.

PUBLIC SCHOOLS OF NORTH CAROLINA | State Board of Education | Department of Public Instruction
Exceptional Children Division :: Office of Early Learning (Pre-K - Grade 3)

A Family Guide to Understanding the Early Childhood Outcomes Measurement Process

NC DEPARTMENT OF PUBLIC INSTRUCTION

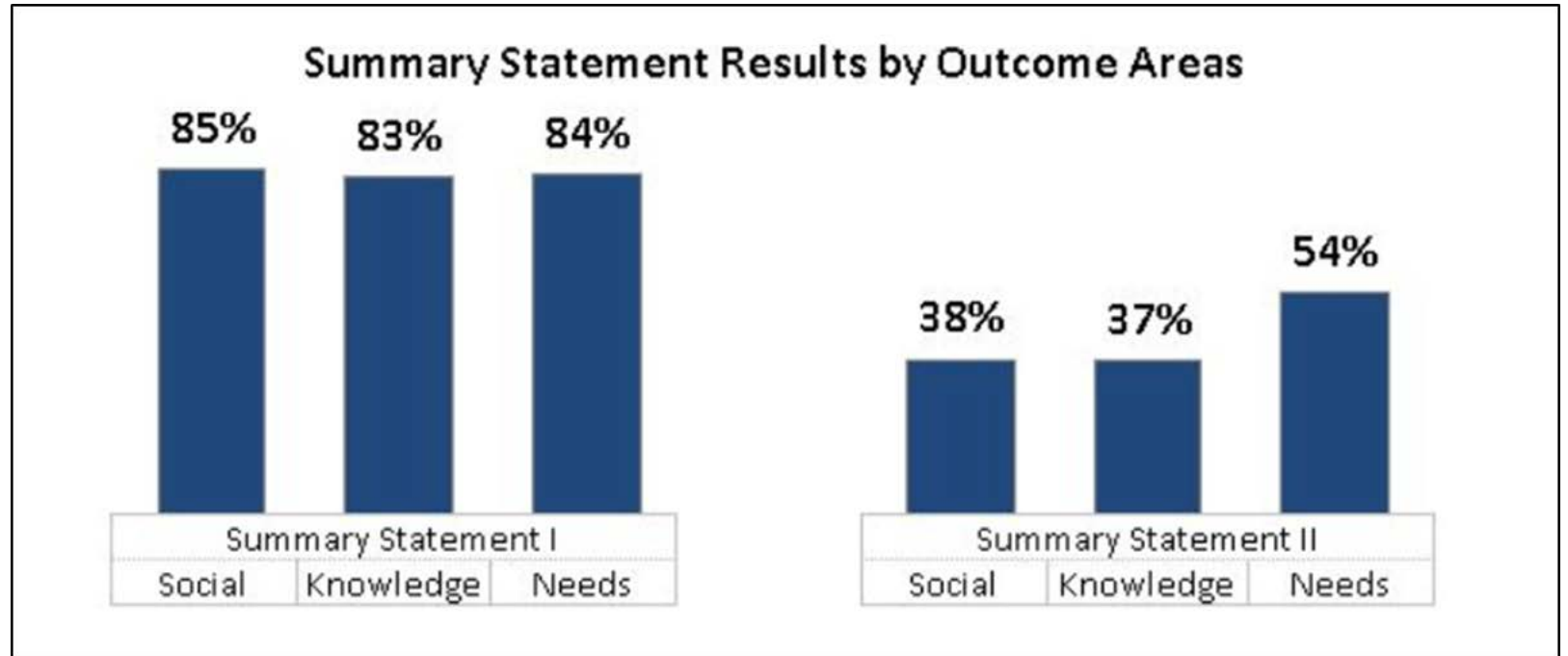
INTRODUCTION

As a parent of a young child who is participating in the NC Infant-Toddler or Exceptional Children Preschool Program, you want to be sure these services are helping your child develop and learn. Services are designed to make the most of each child's potential, as well as to strengthen the family's ability to support their children. But how can you know if your child's early intervention or special education program is meeting his or her needs?

One way to learn more about your young child's progress is through three "child outcomes" that are measured for every child in the United States who participates in an early intervention or early childhood special education program. These outcomes will help you know how well your child is developing and participating in activities at home, at school, or in the community. In addition to helping measure your child's individual progress, these outcomes are also used to measure how well your child's early intervention or early childhood special education program is serving all children who are enrolled. As the parent, you are a critical part of your child's development and education. This handout will help you understand and meaningfully participate in the outcomes measurement process for your child's program.

NC State
Data

2017-18



Summary Statement 1:

_____ % of children made greater than expected growth and changed their developmental trajectory by the time they exited the program

Summary Statement 2:

_____ % of children exited the program on age-level

Current Resources

• Early Learning & Development Progressions

<https://nceln.fpg.unc.edu/node/2772>

NC Early Learning Network									
Home	Initiatives	Resources	EC Preschool Coordinators		Training Modules		State/Local Data		Events
Assessment	Child Find	Transition	Pyramid Model	Foundations	Outcomes	Inclusion	ECPC	Learning Progressions	

[Home](#) » [Resources](#) » North Carolina Early Learning and Development Progressions: Birth to Five

North Carolina Early Learning and Development Progressions: Birth to Five

The North Carolina Early Learning and Development Progressions: Birth to Five are an expansion of the North Carolina Foundations for Early Learning and Development (2013). The Learning Progressions break down the sequence in which children learn skills for emotional and social, health and physical, language and communication, and cognitive development. Skill descriptions at two-, three-, or six-month intervals allow teachers and families to observe and document a child's current level of development and to track incremental changes over time. Observation guidelines provide situations for observation of skills, strategies for eliciting the skill, if needed, what observed behavior indicates achievement of the skill, and routines-based intervention or embedded instruction.

- [North Carolina Early Learning and Development Progressions: Birth to Five Online Tool](#)
- [North Carolina Early Learning and Development Progressions: Birth to Five Printable Version](#) – Expands the NC Foundations for Early Learning and Development goals into observable behaviors at two-, three-, and six-month intervals. (Please note that the printed version is more than 800 pages.)
- [NC Early Learning and Development Progressions at a Glance](#) – Printable listing of the developmental progressions without observation guidelines.
- Instructions for navigating the NC Early Learning and Development Progressions: Birth to Five can be found [here](#).

Assists teachers and families in identifying the age level of a child's current functioning to improve reliability of child outcome ratings

Current Resources

• Understanding Implicit Bias

<http://modules.nceIn.fpg.unc.edu/foundations/tier-ii-module-2>

Effective Teacher Practices Supporting the North Carolina Foundations for Early Learning and Development

Tier II Module 2

Module 2: Understanding Implicit Bias

This module will help the learner (1) understand the meaning of implicit bias, (2) understand how implicit biases affect the early childhood classroom, and (3) receive strategies to help increase awareness of implicit biases.

Videos: You may want to download the videos to your laptop or a flash drive to use for training presentations. The videos for this module can be found [here](#). You will need the password in order to view the videos. To get the password, click [here](#).

Pre-learning Assignment & Review

 [Module 2 Pre-Learning Assignment](#)

Face-to-Face Session

 [Module 2 PowerPoint](#)

 [Module 2 At a Glance](#)

 [Module 2 Script](#)

Handouts

 [Understanding Implicit Bias](#)

 [Preschool Implicit Bias Research Brief](#)

 [CRD and Yale Study Infographic](#)

 [Implicit Bias Is](#)

 [Racial Inequities in School Discipline](#)

 [Helping Early Educators Unlearn Biases](#)

Post-learning Activity

 [Module 2 Post-Learning Assignment](#)

Introduction to Implicit Bias- Train the trainer module

Current Resources

- **Early Childhood
Mental Health
Modules**

<http://modules.nceln.fpg.unc.edu/early-childhood-mental-health-modules>

Early Childhood Mental Health Modules

Welcome to this set of modules that address early childhood mental health (ECMH) competencies adopted by the North Carolina Infant Mental Health Association (NCIMHA), developed by the Alamance Alliance for Children and Families. The competencies describe the knowledge and skills personnel who work with young children and families need in order to provide excellent care. This set of modules addresses the first 4 competencies: 1) parenting, caregiving, family functioning and parent-child relationships, 2) child development: infant, toddler and preschool age children 3) biological and psychosocial factors impacting outcomes, and 4) risk and resiliency.

The modules introduce core ECMH competencies to be used as in-service education for all people working with young children and their families. This includes early care and education providers as well as early childhood professionals in other fields such as early intervention, health departments, child protective services, and home visitation. **Successful completion of each module (70% passing score) will provide a certificate of completion for one (1) contact hour.**



To access these modules through the Division of Child Development and Early Education (DCDEE) Moodle site, follow this link: <http://www.dcdde.moodle.nc.gov/>. Directions to access Moodle trainings can be found at the bottom of their page.

Introduction

Module 1: Early Brain Development and Self-Regulation

Module 2: Toxic Stress and Early Brain Development

Module 3: Building Resilience through Early Relationships

NC Early Childhood Action Plan Data Dashboards

2025 Goals

To track progress toward the targets and sub-targets of the 2025 goals in the [North Carolina Early Childhood Action Plan](#), each of the 10 goals of the plan has its own page of data and information. The page for each goal is listed below.

The dashboards are intended to promote collective insight and awareness around the data outlined in the plan. All data will be reevaluated and updated on a regular basis.

For more details about the data reported in the North Carolina Early Childhood Action Plan Data Dashboards, please view the [data appendix](#).



[Goal 1: Healthy Babies](#)

Babies across North Carolina from all backgrounds will have a healthy start in their first year of life.



[Goal 2: Preventive Health Services](#)

Babies, toddlers, young children and their families will have regular, ongoing access to high-quality health services.



[Goal 3: Food Security](#)

Babies, toddlers, young children and their families across North Carolina will have access to enough healthy food every day.



[Goal 4: Safe and Secure Housing](#)

Babies, toddlers, young children and their families across North Carolina will have access to safe, secure and affordable housing.



[Goal 5: Safe and Nurturing Relationships](#)

Babies, toddlers and young children across North Carolina will grow up with safe and nurturing family and caregiver relationships.



[Goal 6: Permanent Families for Children in Foster Care](#)

Babies, toddlers and young children in foster care will grow up in stable, consistent and nurturing families, whether that is with the child's birth family or through an adoptive family.



[Goal 7: Social-Emotional Health and Resilience](#)

Babies, toddlers and young children across North Carolina will express, recognize and manage their emotions in a healthy way, especially under stress.



[Goal 8: High-Quality Early Learning](#)

Babies, toddlers and young children across North Carolina will have access to high-quality opportunities to engage in early learning.



[Goal 9: On Track for School Success](#)

Young children across North Carolina will enter kindergarten on track for reaching their developmental goals.



[Goal 10: Reading at Grade Level](#)

Young children across North Carolina will read on grade-level in elementary school, with a particular focus on African American, American Indian and Hispanic children who face the



Early Periodic, Screening, Diagnostic and Treatment (EPSDT)/Medicaid Data

Marian Earls, CCNC

Kern Eason, CCNC

Madhu Vulimiri, NC Medicaid



Health Measures Background

Major Measure Resources

- National Quality Forum (NQF) endorses measures. Not all NQF are HEDIS.
- The Healthcare Effectiveness Data and Information Set (HEDIS) is a product of National Committee for Quality Assurance (NCQA).
- The Centers for Medicare and Medicaid Service Core Quality Measures (CQM's)-Child Core Set; Behavioral Health Core Set—some NQF, some NCQA, some both.

Sources: Claims, e-measures, electronic health record (EHR)/chart

Existing Mental/Behavioral Health Measures

- National Behavioral Health Quality Framework
 - 510 measures – 53 endorsed by NQF
 - 68 for <18 yr olds – 17 endorsed by NQF
 - Most are claims–based, process, screening, depression
- Pediatric-pertinent measures–minimal
- Needed:
 - Outcome measures (well-being)
 - Functional measures (child or adolescent; family)

MEASURE DESCRIPTION	STEWARD	NQF	CHILD CORE SET	BH CORE SET	AGES
Initiation and Engagement of Alcohol and other Dependence Treatment **	NCQA	0004			≥ 13
Follow-up care for children prescribed ADHD Medication	NCQA	0108	X	X	
Screening for Clinical Depression and follow-up Plan **	CMS	0418	X	X	12 to 17
Follow-up after Hospitalization for Mental illness	NCQA	0576	X	X	6 to 17
Depression Remission at 12 months *	MN Community	0710			≥ 18
Pediatric Symptom Checklist	Mass General	0722			4 to adol
Child & Adolescent MDD: Suicide Risk Assessment *	AMA PCPI	1365			
Maternal Depression Screening	NCQA	1401			
Developmental Screening in the First 3 Years of Life	OHSU	(1448)	X		
Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	2801	X	X	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NCQA	NA	X	X	

*emeasure

** requires chart/EHR data

NC Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Profile

- Developed as part of Community Care Network of NC (CCNC) Quarterly Measures and Feedback during the CHIPRA Quality Demonstration Grant
- Uses existing NQF measure when one exists
- Many of the key EPSDT components do not have a national metric
- Data from claims (CPT and ICD-10 codes), **statewide** data
- Reported **quarterly** to regional CCNC Practice Support Staff and to practices
- Use of data to drive quality

*NC Medicaid reports HEDIS pediatric measures and some of the Child Core Set **annually** for the **previous** calendar year*



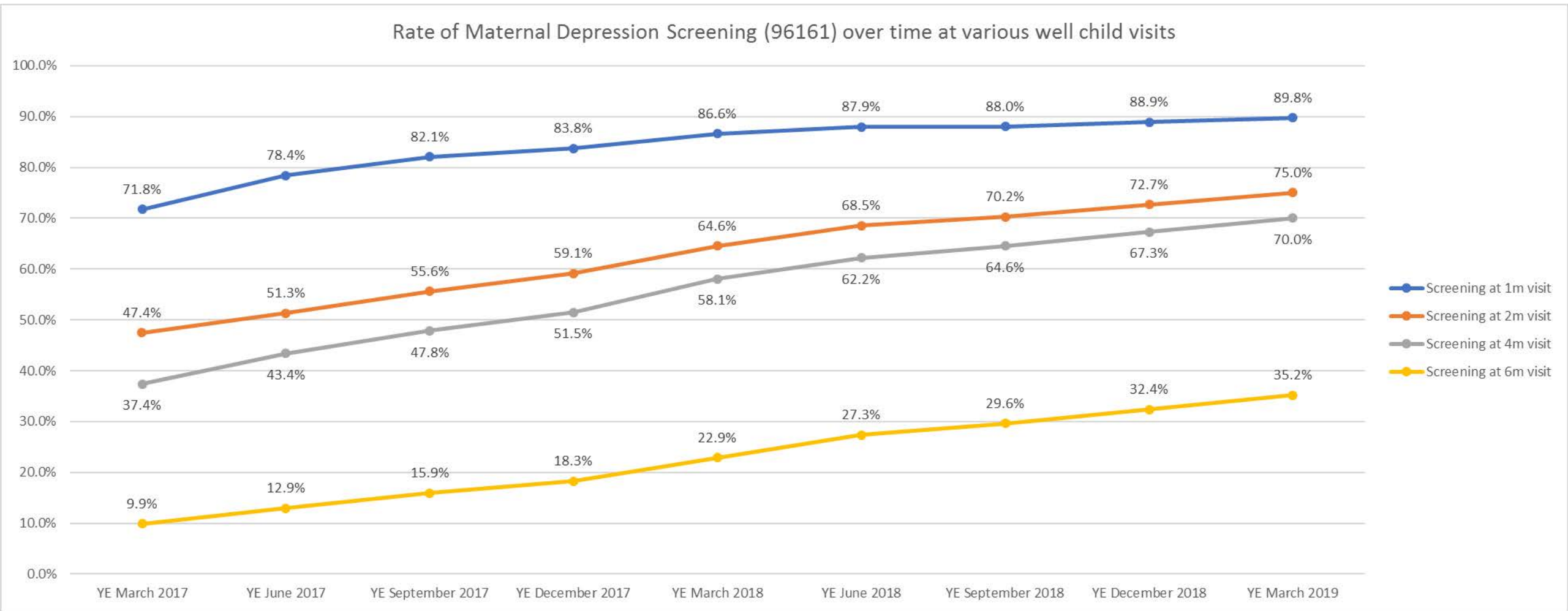
NC EPSDT Profile

- 0-15 Month Well Visits
- 3-6 Year Well Visits
- 7-11 Years Well Visits
- Adolescent Well Visits (12 to 21)
- BMI Percentile Screening
- Lead Screening (at age 1 and age 2)
- Early Childhood Developmental and Autism Screening Rate (0-5)
- Maternal Depression Screening Rate
- School Age (Developmental/Behavioral Health for 6-10) Screening Rate (using PSC)
- Adolescent Depression Screening Rate
- Adolescent Risks and Strengths Rate
- Vision
- Hearing
- Annual Dental Visit (age 2-3)
- Dental Varnishing (4 or more by age 42 mos.)
- Childhood Immunization Status-Combo 3
- Childhood Immunization Status–Combo 10
- Adolescent Immunization Status - Combo 1
- Adolescent Immunization Status - Combo 2

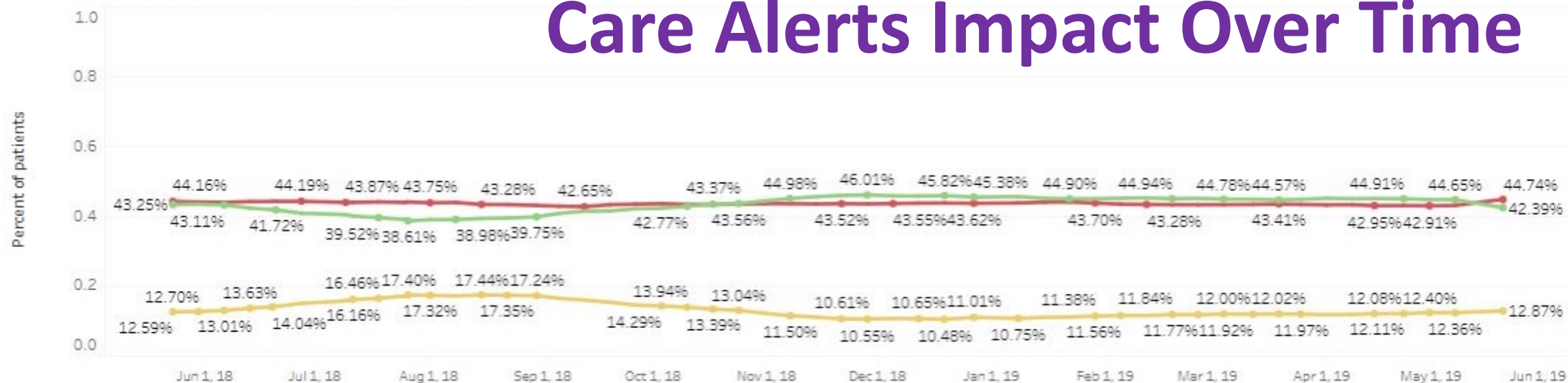
EPSDT Profile (most recent two quarters)

		HEDIS Benchmark	CCNC	CCNC	CCNC Trend
Measure/Topic			2019, Q1	2018, Q4	
Early Periodic Screening Diagnosis and Treatment (EPSDT)					
0-15 Month Well Visits	64.10%		76.1%	76.0%	0.1%
3-6 Year Well Visits	73.00%		70.1%	70.5%	-0.4%
7-11 Years Well Visits	N/A		52.6%	52.1%	0.5%
Adolescent Well Visits (12 to 21)	53.00%		47.3%	46.2%	1.1%
BMI Percentile Screening Recorded	N/A		37.8%	36.6%	1.2%
Lead Screening (by second birthday)	N/A		66.5%	66.0%	0.5%
Developmental and Behavioral/Social-Emotional/Mental Health Screenings					
Early Childhood Developmental and Autism Screening (ABCD)	N/A		93.6%	93.8%	-0.2%
Maternal Depression Screening Rate	N/A		43.4%	37.9%	5.5%
School Age (Develop/BH) Screening Rate	N/A		33.3%	33.3%	0.0%
Adolescent Depression Screening Rate	N/A		57.6%	56.1%	1.5%
Adolescent Risks and Strengths Rate	N/A		17.6%	17.1%	0.5%
Oral Health					
Annual Dental Visit (age 2-3) ²	N/A		44.7%	44.5%	0.2%
Dental Varnishing (up to 3.5 years)	N/A		46.8%	47.1%	-0.3%
Immunizations					
Childhood Immunization Status - Combo 3	69.40%		69.4%	69.5%	-0.1%
Childhood Immunization Status - Combo10	35.40%		34.5%	34.5%	0.0%
Adolescent Immunization Status - Combo 1	77.60%		79.9%	79.1%	0.8%
Adolescent Immunization Status - Combo 2	32.70%		28.7%	27.9%	0.8%
Vision and Hearing					
Vision	N/A		67.9%	62.3%	5.6%
Hearing	N/A		88.3%	88.5%	-0.2%
Behavioral Health					
Metabolic Monitoring for Children/Adolescents	34.6%		34.4%	34.5%	-0.1%

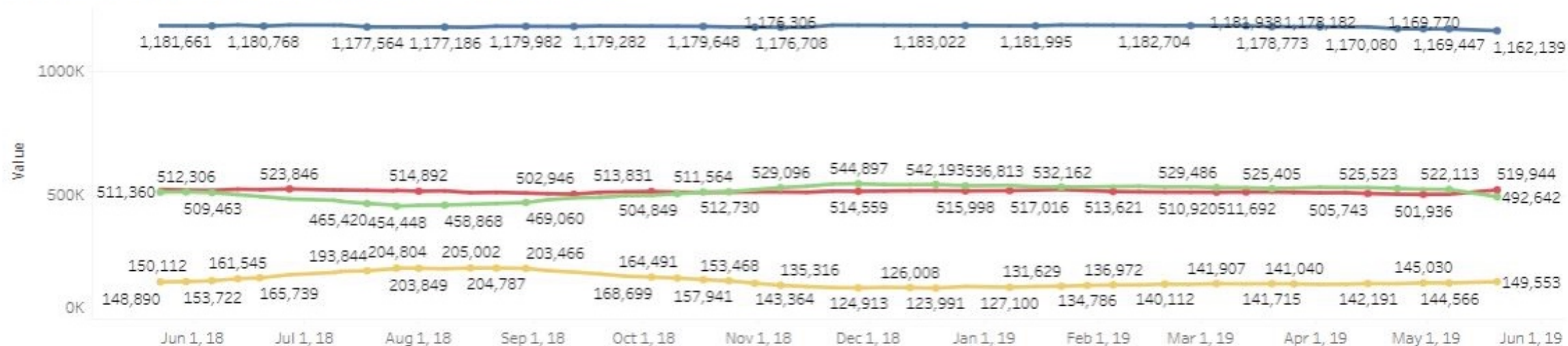
Maternal Depression Screening Rates by Infant Visit



WCV status rates over time



WCV status total numbers over time



Additional Possible Data Sources

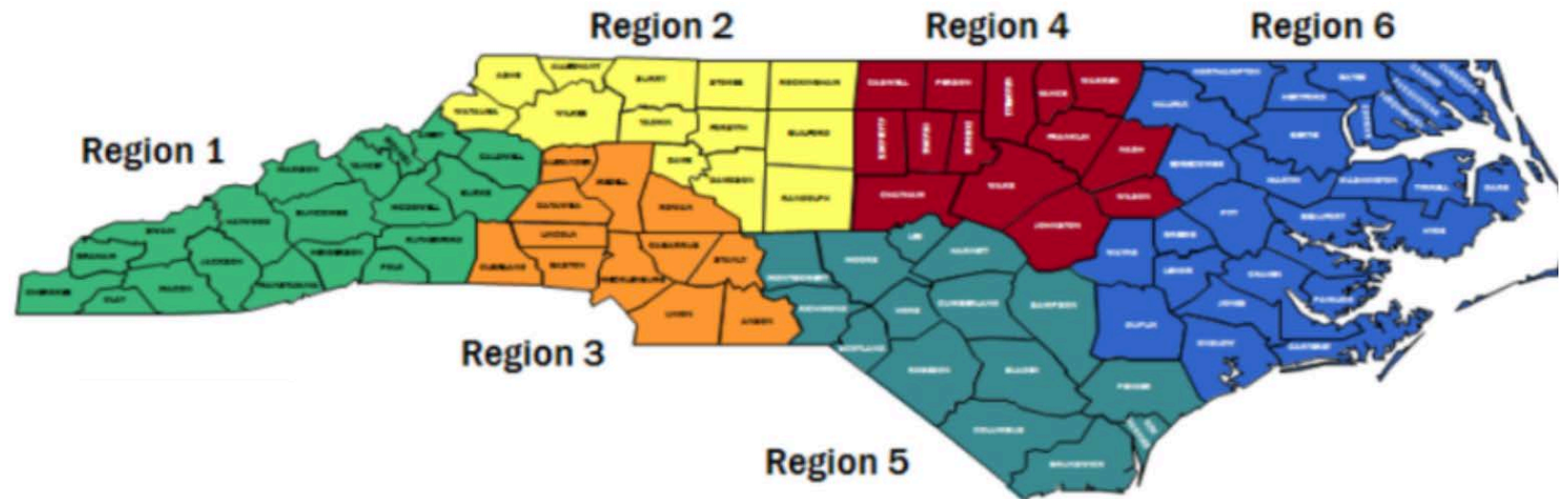
- Care Coordination for Children (CMARC) – Ages 0 to 5
 - Virtual Health (HELIOS)
 - Life Skills Progression (LSP) – Pre-and Post-Intervention
 - The Survey for Well-Being for Young Children (SWYC)
 - Children identified as at risk for Toxic Stress
- Children's Health and Development Information System (CHADIS)



NC Medicaid Transformation: EPSDT Requirements in Managed Care



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**



Oregon's Medicaid Process Proxy Measures

Rather than tracking and reporting on child and family social-emotional health **outcomes**, Oregon has chosen to incentivize, track and report on whether health plans are doing the **activities** that lead to better social-emotional health outcomes for children.

Purpose: Drive health plans to address system-level factors that impact the social-emotional health services that young children and families receive and how they receive them, and for which there may be payment or policy barriers that need to be addressed.

Oregon's Medicaid Process Proxy Measures

They will track whether health plans are:

- **Identifying factors that impact SEH, including social determinants, and screening for them**
 - *Example Activity: Conduct cross-sector training on how to identify SEH delays and pathways to follow up*
- **Assessing the capacity and utilization of behavioral health services for young children and their families**
 - *Example Activity: Analyze claims data on utilization of behavioral health services for young children and asses for disparities.*
- **Addressing policies and payment for behavioral health services within primary care and specialty behavioral health care.**
 - *Example Activity: Address prior-authorization requirements for behavioral health services.*

Colorado's QRIS Process Proxy Measure

Colorado is incentivizing early learning programs to screen for social-emotional health concerns by offering points in the QRIS system for programs that conduct a social-emotional screener.

Purpose: Drive up social-emotional screening rates in early learning settings.

Tools Commonly Used in NC



Characteristics for Prioritizing Measures

- Strong psychometric properties
- Administration time and ease of use
- Culturally/linguistically responsive (75%)
- Potential to be used cross sector (56%)
- Includes parent/caregiver input (50%)
- Includes strengths/competencies (50%)
- Research-based indicators of SEH (38%)
- Cost (38%)
- Aligns with other statewide efforts (34%)
- Intended use of tool (31%)
- Type of SE domains measured (28%)
- Incorporated in existing data systems (28%)
- Considered by national experts (25%)
- Opportunity for innovation (19%)

- *Based on responses from 19 Data Workgroup and 13 Advisory Group Members (Total=32)*

Small Group Work



Time to Dig In

- Divide into four workgroups:
 - Two groups to discuss screens/assessments (yellow dot)
 - Two groups to discuss proxy measures (blue dot)
- Take a few minutes to review handouts
- Discuss questions. One person takes notes (~30 mins)
- Two groups discussing same bucket combine and share key thoughts on prioritizing measures, connection to racism, and identified needs/resources (~15 mins)

Questions:

- Based on the information provided and the expertise in your group, what are your initial thoughts on what measures you are most interested in recommending, which measures you would eliminate from consideration, and which measures you would like to learn more about?
- What does structural racism have to do with this?
- What other information do you need to make decisions and come to consensus by Meeting #3? List potential resources and experts. Identify people in the group to follow-up by next meeting.

Reflections



Next Steps

- Group members follow-up on identified needs and resources
- NCECF reviews and incorporates feedback
- Meet on December 9th, 9:30am-1:30pm, HQ Gateway Raleigh (Mary will follow-up with those that can't make this meeting)
 - Review population-level surveys
 - Deeper discussion and review of measures
 - Begin prioritizing measures by consensus

Evaluation

An evaluation link has
been emailed to you
(hard copy also available)

Please take five minutes
to fill it out now

We value your input!
Your feedback will be
used to plan future
meetings.



Thank you!





Promote Understanding

Promote public understanding of and support for policies that promote children's birth-to-eight years for academic and lifelong success.



Spearhead Collaboration

Convene and spearhead collaboration to bridge North Carolina's birth-to-five and kindergarten-to-third grade systems.



Advance Policies

Advance policies that create a stronger NC today and tomorrow by supporting each child's birth-to-eight development.



www.buildthefoundation.org



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