NC Pathways to Grade Level Reading Initiative
Health Learning Team
Meeting One Summary Report

The NC Pathways to Grade Level Reading Health Learning Team met for the first time on August 31st from 1-4 pm at Delta Dental in Raleigh.

All of the materials and presentations shared at the meeting are online at http://buildthefoundation.org/learning-teams/

Pathways to Grade Level Reading Initiative Background

The NC Pathways to Grade Level Reading initiative (Pathways) aims to ensure that every child has a clear pathway to an important developmental milestone – reading on grade level by third grade. To accomplish this, diverse partners are working together to make sure that children have everything they need, starting at birth, to reach that early reading milestone on time.

Research tells us that when children have good **health** (starting from birth), high-quality **education** (including early care, pre-kindergarten, and the early grades) and strong and supportive **families and communities**, they have the best opportunity to be on track by third grade.

Pathways has two major goals for all children:

(1) **Children will be reading well by the time school shifts from learning to read to reading to learn**. Research has shown us that reading proficiently by third grade is essential for future school success and life outcomes. In fact, we can predict who is unlikely to finish high school based on third-grade reading scores.

(2) **From the time they are born, children will be healthy, well-educated and living in supportive families and communities.** The three domains that research says are important for early literacy (health, education, and supportive families and communities) are the same things that children and families need for future school and life success.

In order for more children to be successful readers by third grade, partnerships are being created among the state's leaders in early learning and education, public agencies, policy, philanthropy, and business to agree on a common focus, identify key data indicators – measures of success – to track, and outline a set of shared strategies for taking action.

During the first phase of the Pathways work, experts reviewed data about the factors that matter in children's development and created a framework of key measures of success. These measures – things like children's mental health, adults' parenting skills, and neighborhoods where children are safe to play – are the most important building blocks of healthy and well-

educated children and safe and supportive families and communities. Research tells us that if we can ensure more children have these building blocks in place from birth, more children will be reading on grade level by third grade.

Purpose of the Learning Teams

The second phase of the work involves Learning Teams, whose charge is to understand how North Carolina is doing on these measures, including shifts in trends, what groups of children are struggling more than others, and how moving one data point might affect another.

The work of the Learning Teams will lead North Carolina into the third phase of Pathways work – partners, together, choosing which measures of success to begin working on first and outlining strategies for taking action.

Pathways is powered by the NC Early Childhood Foundation in collaboration with NC Child, The North Carolina Partnership for Children, Inc., and BEST NC.

See Appendix A for a list of the Health Learning Team members.

Meeting One Summary

Co-Chairs Meghan Shanahan of the UNC Gillings School of Global Public Health and Jen Zuckerman of the BlueCross BlueShield of North Carolina Foundation welcomed 19 Health Learning Team members. Eleven other members were unable to attend the first meeting.

Tracy Zimmerman, NCECF Executive Director, shared background on the NC Pathways to Grade Level Reading Initiative, highlighted engaged organizations, and introduced (in-absentia) the co-chairs for all three Learning Teams (Health, Education, and Families/Communities). After the co-chairs asked everyone to introduce themselves, Tracy updated the group on how the Pathways Initiative arrived where it is today, including how the Data Action Team chose the Measures of Success.

The co-chairs then highlighted the characteristics that Learning Team members should embody, such as a commitment to being research- and data-driven, a commitment to acknowledging and eliminating systemic inequities, and an eagerness to think outside the box.

Co-chair Meghan Shanahan, who also was a member of the Data Action Team, walked the group through the Measures of Success Framework. The group then broke up into partners to discuss for a few minutes which parts of the Framework are the most relevant to their work.

The co-chairs then walked through the Learning Team responsibilities and what to expect at each of the four meetings of the Health Learning Team. They also outlined the goal of the meeting – specifically, to critically review the indicator data to identify inequities that need to be considered when designing strategies for action.

The co-chairs then highlighted the Guiding Principles of the Pathways work and asked the group to consider at their tables what processes or shared norms they could follow as a group to ensure these principles guide the work of the Health Learning Team. The list of suggestions included:

- Everyone's voice counts.
- Be respectful (especially with differences).
- Working through differences.
- Taking into account and expanding personal agendas/interest.
- Being okay with knowledge gaps and open with sharing info.
- Speak up sooner rather than later.
- Establish two-way communication with families and communities in order to better understand the systems and environments that people are in. Ensure that families have a voice from the beginning.
- Track use of the Guiding Principles, perhaps with a check-in at the end of each meeting.
- Wherever possible, have person-centered conversations, remembering that there are people behind the data.
- Watch getting too much into the weeds or slipping into jargon.
- Find the balance between aspirational and feasible. Be aware of the climate, but don't let it dictate our results.
- Ask "why" five times about the data, to really understand what is going on behind the numbers.

Mandy Ableidinger, Policy and Practice Leader at NCECF, then walked the group through the data they will be considering during the Learning Teams process. The Pathways work is a data- and evidence-driven process. Two types of data are presented:

- **Data regularly tracked in NC**: Where possible, NC data was presented that highlights trends over time; race/ethnic, income and geographic disparities; and comparison with national data. Data comes from national surveys or state and local administrative agencies, and may reflect the experiences of a particular population (i.e., children receiving Medicaid) or all children in the state.

- **Data not regularly tracked in NC**: For those measures that do not have a consistent data source as described above, we identified proxy, supplemental data in order to provide some information for making decisions about those indicators. These data carry caveats – they are often slightly different indicators from the ones in the Framework, they may be for certain subgroups rather than all children across the state, they may come from a one-time data source, and/or they may be national data.

Those indicators that are not regularly tracked in NC will comprise the Pathways Data Development Agenda. One of the goals of the Pathways project is to continue data advocacy around those data development agenda items to encourage NC leaders to begin collecting data systematically around all the measures of success in the framework.

Mandy walked the group through the data book, pointing out the different types of charts, chart features, and how to interpret the data. We noted the importance of disaggregating data to see inequities that would otherwise be masked by statewide numbers.

The Health Learning Team then spent the rest of the meeting examining the data, specifically considering the question of equity. For each outcome, and each indicator in that outcome, each small group (table) moved through a process that included:

- Individual reflection – What seems important here?
- Small table conversation – What do you see in terms of inequities? Which ones are most important to pay attention to? Which groups seem most disadvantaged?
- Small table equity rating – To what extent does this indicator represent an area where great inequities exist?
- Identifying the greatest inequities across the indicators.

Each table graphed its thoughts on the wall, adding sticky notes to columns headed by various subgroup titles (African-American, Hispanic, Other, White, Low-Income, Geography), as well as columns for Successes in Reducing Inequities and Data Questions.

The results of the small-group work are included in this report as Appendix B.

After the small group work, there was a large group discussion around the results of the table conversations. Some of the comments are included below:

- The disparity picture is much more complicated than I had thought about. There's racial/ethnic disparities, income disparities, age disparities and geographic patterns, and those overlay and impact each other. It's not simple and clear-cut.
- "Within group" differences would be interesting, too, and it's harder to get data that way (i.e., for the Hispanic population, disaggregating by country of origin or by length of time in the US)
- Even with all the data that was pulled on these indicators, there are still gaps and it's hard to make decisions because of that.

Tracy thanked the group for coming and reminded them that the next meeting is October 5, in the same room.

The powerpoint presentation for the meeting is available online at http://buildthefoundation.org/learning-teams/

Appendix A: Health Learning Team Members (as of meeting 1)

Jennifer	**Zuckerman**	**Blue Cross Blue Shield NC Foundation**
Meghan	**Shanahan**	**UNC Gillings School of Global Public Health**
Rocio	Anderson	March of Dimes
Sheila	Arias	Parent Representative
Laila	Bell	NC Child
Ronny	Bell	Wake Health
Chris	Bishop	Nurse-Family Partnership
Rachael	Burrello	Ready for School, Ready for Life
Kevin	Cain	John Rex Endowment
Janice	Freedman	North Carolina Healthy Start Foundation
Brisa	Hernandez	Carolinas HealthCare System
Charlene	Hunt	Wake Health
Melissa	Johnson	NC Infant & Young Child Mental Health Association
Sharon	Loza	Children's Places and Spaces/Marbles Kids Museum
Victoria	Manning	Skeebo Foundation
Norma	Marti	NC Division of Public Health, Children & Youth Branch
Suzanne	Metcalf	Prevent Child Abuse NC
Duncan	Munn	NC Early Childhood Foundation Board of Directors
Heather	Pane Seifert	Duke
Sydney	Phillips	Down East Partnership for Children
Libby	Richards	Triangle Community Foundation
Michelle	Ries	North Carolina Institute of Medicine
Melinda	Schlesinger	Wake County Smart Start
Candy	Scott	Partnership for Children of Cumberland County
Pamela	Shue	NC Division of Child Development and Early Education
Barbara	Still	Project Enlightenment Foundation
Marshall	Tyson	NC Division of Public Health, Children & Youth Branch
Darden	White	Center for Child and Family Health

Appendix B: Synthesis of Table Work

For this exercise, participants worked at their tables to examine the data for each indicator and answer questions like:

- What inequities seem really important to pay attention to?
- Which groups are most disadvantaged according to this data?
- Which areas of the state are most disadvantaged according to this data?

Tables mapped their conversations on the wall – these notes are included below.

Each table then determined to what extent each indicator represents an area where great inequities exist:

- Great inequities in this indicator area: Data on this indicator highlight significant racial or income inequities.
- Some inequities in this indicator area: Data on this indicator highlight some racial or income inequities.
- Little or no inequities: Data on this indicator reveal few racial or income inequities.
- Equity data not available: Race and income data was not available to evaluate this indicator.

These ratings are included below.

Finally, the small groups noted which indicators were rated as "Great Inequities." Those are highlighted below, and noted in the final chart in the report.

Outcome 1: A Healthy Start									
	Success in Reducing Inequities	**Income disparities**	**Geographic disparities**	**Hispanic**	**White**	**African-American**	**"Other" race**	**Other notes**	**Data questions**
Indicator: Birth Weight	Asian/Pacific Islander has most significant decrease _____ No change over time	No data _____ Don't have data here but expert says income is not a protective factor among African Americans	Highest concentration in northeast and far west _____ Higher in rural counties _____ Rural has higher rates _____ Based on county data (map), lowest income areas have higher rates *[Facilitator Note: Lowest income areas on map also overlap with higher minority areas. Racial/ethnic disparities*	Currently best rate but the Hispanic/ Latino paradox is that the babies are doing better but have all risk factors (family). Need to observe over time. _____ At first glance birth-weight looks good. Disaggregating data further would be helpful	Seeing a lot of neonatal abstinence syndrome now - almost all white (not birthweight, but equally bad outcomes) – need to avoid simple answers and stigmatizing certain groups	Consistently highest rates/not much change over time _____ Twice as much as lowest group _____ African American 2x Hispanic		Above national average. No significant change over time. _____ Changes in rate can hide/show based on proportion of population. _____ Different trends by race and ethnicity _____ Need to not stigmatize certain ethnic groups because birth outcomes are complex. _____ Birth weight is an important predictor of other health indicators	Other interesting ways to cross-reference this data: Mothers' education, Medicaid vs. not Would like to see how disaggregated data compares to other states Would like to see breakdown of "Hispanic" category Disaggr. Other race categories by ethnicity? Are changes within disaggregated groups statistically significant?

			may account for the map, rather than income disparities] _____ Staggering disparities. What are the drivers of these disparities? _____ Western NC and Northeastern NC Clusters	_____ Hispanic "best" - Why? Expert says Hispanics start to look more like the state average as they stay in US longer					

Outcome 2: Access to Healthcare									
	Success in Reducing Inequities	**Income disparities**	**Geographic disparities**	**Hispanic**	**White**	**African-American**	**"Other" race**	**Other notes**	**Data questions**
Indicator: Well-Child Visits	White non-Hispanic and Black non-Hispanic are similar	Income data may be available in survey data NC by Income (looked up the data): 0-99% FPL: 78.5%; 100-199%: 78.6%; 200-399%: 85.4%; 400+: 88.6%.		Below state average			Other non-Hispanics have lowest percentage of well-child visits _____ Other non-Hispanics had lowest rate (76.2) _____ "Other" race group is below state average	No change over time _____ Well-child visits have decreased *[Facilitator note: This slight decline may not be statistically significant]* _____ NC has lower percentage no matter race/ethnicity _____ Disparities don't look as significant in this indicator _____ Kids on Medicaid have better access _____ By Age in NC (looked up data): 88.4% 0-5 81.9% 6-11 78.2% 12-17	Break down further by age groups (within birth-to-five category) – Experience of group members is that there is a drop-off in visits after 15 month visit until reach PreK or K. Fluctuation within that window, and this is when behavior problems tend to show up.

Outcome 3: Physical and Emotional Health									
	Success in Reducing Inequities	**Income disparities**	**Geographic disparities**	**Hispanic**	**White**	**African-American**	**"Other" race**	**Other notes**	**Data questions**
Indicator: Good Health		Substantial disparities 200% FPL seems to be tipping point _____ Big jump: more $, better health _____ Higher income, better report health of children.		Advantage at birth has been reversed _____ Fewer Hispanic parents rate children's health as very good or excellent _____ Hispanic parents report lowest rates of child's health as excellent or very good			Substantial disparities		Can get better breakdown by age to look specifically at young children? _____ Is this parent race or child race?

	Success in Reducing Inequities	Income disparities	Geographic disparities	Hispanic	White	African-American	"Other" race	Other notes	Data questions
Indicator: Healthy Weight			Macon, Columbus, Sampson, Duplin, Robeson have higher rates _____ Lincoln has lower rates than surrounding _____ Onslow and Cumberland low rates (both military)	Higher % are obese and overweight		Relative parity w/white			Does NC follow national trend on weight?

	Success in Reducing Inequities	Income disparities	Geographic disparities	Hispanic	White	African-American	"Other" race	Other notes	Data questions
Indicator: Social-Emotional Health		Income disparity - 10 pts. _____ Disparities by income				African-American significantly lower (20 pts) but concern about teacher report data (bias) _____ Disparity (could be measurement issue/systems issue)			

	Success in Reducing Inequities	Income disparities	Geographic disparities	Hispanic	White	African-American	"Other" race	Other notes	Data questions
Indicator: Dental Health	Rates have decreased over time. _____ Increase in higher income levels.	Big income disparities _____ Disparity in tooth decay by income (200%+ is tipping point) _____ No NC income data on dental _____ Significant break above/ below 200% FPL line	6-31% is the spread among counties _____ South West has higher rates _____ Rural counties have high % of tooth decay _____ Counties bordering VA have high tooth decay _____ Border counties/ rural highest rates of untreated tooth decay	Above state average for dental cavities.		Above state average for dental cavities	Big racial disparity- Asian _____ Asian children high rates tooth decay _____ Big racial disparity- American Indian _____ American Indian children have highest % tooth decay _____ American Indian rates significantly higher than NC average		Interesting to consider effect of ECU dental school on rates in Eastern NC _____ Don't have NC dental by income. US data older (2004). Is there also a big jump in NC rates ages 6-8?

Outcome 4: Appropriate Developmental Benchmarks									
	Success in Reducing Inequities	**Income disparities**	**Geographic disparities**	**Hispanic**	**White**	**African-American**	**"Other" race**	**Other notes**	**Data questions**
Indicator: Early Inter-vention								Need more work in high-risk EI categories _____ Need linked database to get more detail	# of children qualifying for EI over time _____ What age do children enter El services?
Indicator: Early Language Skills	Expressive Proficiency low for all ethnicity/ races	Higher income = more expressive vocabulary proficiency _____ Low income, lowest vocabulary proficiency		Oral language disparity _____ Disparity between Latino and white is similar to disparity between lowest 20% and highest		Oral language disparity			
Indicator: School Readiness		School readiness gaps _____ Income impacts 3 school readiness domains		School readiness gap _____ Hispanic lowest on school readiness					Fix data on race/ethnicity on school readiness _____ Is data on school readiness available by age?

Indicators were ranked as having "great," "some," or "little or no" inequities, or there was not enough data to say. All three groups were asked to rate each indicator; their responses are noted by the ✓ marks below. Some groups did not rank some indicators.

	Great Inequities	Some Inequities	Little/No Inequities	Not enough Data	Notes
Outcome 1: A Healthy Start					
Indicator: Birth Weight	✓✓✓				Significant racial and geographic disparities
Outcome 2: Access to Healthcare					
Indicator: Well Child Visits		✓✓✓			Tables were uncomfortable rating this one; more data by income, geography would help
Outcome 3: Physical and Emotional Health					
Indicator: Good Health	✓✓✓				
Indicator: Healthy Weight		✓✓			Hispanic disparity; African-American not so different from White; Some geographic disparities
Indicator: Social-Emotional Health	✓✓				There is at least a perceived discrepancy; tables had concerns about bias of reporters and cultural sensitivity of the measures
Indicator: Dental Health	✓✓✓				Racial, income and geographic disparities
Outcome 4: Appropriate Developmental Benchmarks					
Indicator: Early Intervention				✓✓✓	Not enough data to say.
Indicator: Early Language Skills	✓✓✓				Skills are low for all groups.
Indicator: School Readiness	✓				Hispanic disparity; income disparity; lots of variance based on which aspect of school readiness is considered. Two tables ran out of time on this indicator