NC Pathways to Grade-Level Reading Initiative
Health and Development Learning Team
Meeting Three Summary Report

The NC Pathways to Grade-Level Reading Health and Development Learning Team met for the third time on November 2nd from 1-4 pm at Delta Dental in Raleigh.

The summary reports and presentations from the Learning Team meetings are online at http://buildthefoundation.org/learning-teams/.

Background on the NC Pathways to Grade-Level Reading Initiative is online at www.buildthefoundation.org/pathways.

Meeting Three Summary

Co-Chair Meghan Shanahan of the UNC Gillings School of Global Public Health welcomed 12 Health Learning Team members. Co-Chair Jen Zuckerman was unable to be present, due to a sick child.

Meghan set the context for the meeting by reminding the team members of the top-line goal, the shared Measures of Success Framework, and the goals of the Learning Teams process. She walked through what to expect at each of the four Learning Team meetings and outlined today's activities:

- Prioritize four indicators based on the need and inequity data from Meetings 1 and 2.
- Prioritize indicators based on the connections among the indicators and their impact.
- Recommend four final prioritized indicators and outline the rationale for the decision.

Meghan highlighted the Guiding Principles of the Pathways work and reminded the group of the Working Norms they established at Meeting 1.

Meghan introduced an evolution of the Measures of Success Framework, based on feedback from all three Learning Teams and other stakeholders. This work is iterative, and we are intentionally open to change as we learn more. The current version of the evolved framework is included as Appendix A in this report.*

- A few indicators outlined an emergent and early literacy developmental trajectory. Those indicators were pulled out of the goals and organized as grade-level reading milestones guiding the framework (green arrows).
- Key social/economic living conditions – like poverty – were pulled out of the goals and placed along the bottom of the framework, to demonstrate that they impact every indicator and should be considered in every design strategy, but that the Pathways initiative is not directly designed to impact those indicators. Pathways would design strategies to reduce the *impact of these conditions* on children's early childhood experiences, but would not design strategies to *impact these indicators directly* (difference between reducing poverty and reducing the impact of poverty on a child's health) (grey line at the bottom).*
- The remaining indicators were simplified into 4 goals:
    - Health on Track, Beginning at Birth
    - Supported and Supportive Families & Communities
    - High Quality Birth to Eight Learning Environments

    - Regular Attendance in Early Learning Programs and Schools: Regular attendance became its own goal because there is strong research showing that it is both influenced by many of the indicators we are considering, and it is in turn very influential on the top-level result of grade-level reading.
- Equity and Need were placed at the top of the diagram to show the importance of considering them with every indicator.*

The Learning Team engaged in a conversation around the evolved framework. Full notes on the conversation are included as Appendix B in this report and will be considered, along with feedback from the other Learning Teams. Main points included:

- Might slightly shift the Oral Language Skills indicator to be a bit broader or the Kindergarten Readiness indicator to be a bit narrower to literacy/language skills.
- Poverty reduction is critical for improving child and family outcomes. How will poverty figure into the Pathways strategies for action? Is Pathways focused on strategies to reduce the number of children living in low-income homes or on strategies to mitigate the *impact* of poverty on children's early childhood experiences?
- The evolved framework is helpful and limits the number of indicators, which makes it easier to communicate the framework to families and partners.
- Don't understand why Equity/Need are at the top of the framework.

*<u>Important Note on the changes to the Framework</u>:
As noted above, two Health Learning Team members highlighted the impact of children's living conditions, like living in low-income families, on their outcomes for nearly all the indicators being considered. They proposed that Pathways should do more than design strategies to *mitigate the impact* of living conditions on children's early childhood experiences, and should go further to consider strategies that *address* children's living conditions.

After the Health Learning Team meeting, team members and Pathways key partners were engaged to think more about how Pathways should address poverty and other children's living conditions. The current proposal is that Pathways Design Teams will be asked to design strategies to reduce the *impact* of these conditions on children and families, and they will also consider *closely aligned strategies* to *reduce* the conditions themselves.
For example, for the Healthy Birthweight indicator, a Design Team would think about:

- How to reduce low birthweight births for all children and families (Need)
- How to reduce disparities in low birthweight births by race/ethnicity, income, geography, etc (Equity)
- AND what policies would reduce low birthweight births *and also* reduce the number of children living in low-income families.
    - Ensuring more mothers-to-be have health insurance would both directly reduce low birthweight births AND would reduce economic stress on families.
    - A strategy that would be considered outside the scope of the Pathways work might be changing the state policies on courting businesses to invest in NC. While this strategy might ultimately reduce economic stress on families, it is not directly tied to our outcome of reducing low birthweight births.

The Framework was revised again based in these changes. The most recent version can be found in Appendix A as well.

Prioritizing based on Need/Equity Exercise:

Facilitators provided tools that scored and averaged the Need and Equity ratings team members had assigned the indicators at meetings 1 and 2. Team members worked at their tables to choose their top four indicators, based on the Need and Equity data. The following chart shows which indicators the three tables chose:

	Inequity and Need
Healthy Birth Weight	XXX
Well Child Visits	X
Physical Health	XX
Healthy Weight	
Social-Emotional Health	XXX
Oral Health	X
Early Intervention	XX

The full group noted that social-emotional health, healthy birth weight, physical health and early intervention rose to the top. They discussed the reasons why these were the top choices. Main themes included:

- Physical health is a broader category and probably should include oral health and healthy weight, and well-child visits as a strategy.
- Whole child as a timeline – thinking about life course and having greater impact earlier in life, with Healthy birthweight and Early Intervention
- Some of these indicators are states of being and some of them are strategies (well-child visits are something you do and physical health is something you are)
- Early intervention – need is demonstrable and in terms of inequities, there are significant inequities by race and income
- Healthy birth weight – highest for need and inequity. There are so many factors among all the indicators that feed into healthy birthweight, and it's the foundation for all of it
- Social-emotional health is strong and important and linked to all of development.

Full comments are included in Appendix C of this report.

Prioritizing based on Connections/Impact Exercise:

Facilitators then provided tools that allowed team members to see the connections among the indicators, as a measure of impact. All of the indicators in the Framework influence, in some way, our top-line result of reading proficiency by third grade. Some indicators are positioned to have potentially more impact \, however, because of the connections they have to other indicators. By shifting one very connected indicator, we can influence others, and by shifting this larger group of indicators, we are more likely to have an impact on our top-line result.

Team members worked at their tables to choose their top four indicators, based on the Connections data. The following chart shows which indicators the three tables chose:

	Inequity and Need	Connections/Impact
Healthy Birth Weight	XXX	XX
Well Child Visits	X	X
Physical Health	XX	XXX (including oral health)
Healthy Weight		
Social-Emotional Health	XXX	XXX
Oral Health	X	
Early Intervention	XX	XXX

The full group noted that social-emotional health, healthy birth weight, physical health and early intervention again rose to the top. They discussed the reasons why these were the top choices. Themes included:

- Healthy birth weight – When look at impact, solutions to why children are born at low birth weight would also impact many of the other indicators. To improve healthy birthweight, must focus on the mom before pregnancy and before birth.
- Well child visits – ultimately not chosen because it's a strategy rather than a condition.

Full comments are included in Appendix C of this report.

An important theme to note from the conversation was that they were most comfortable choosing physical health, because they felt that any analysis of how to improve children's physical health would be definition need to include a discussion of things like oral health and healthy weight. There was a particular interest in oral health, so they noted that they would like to see that considered when considering physical health.

The group had a final discussion to prioritize their top four indicators, and chose:

- Healthy birthweight
- Early Intervention
- Social-Emotional Health
- Physical Health

They then answered as a group the following questions. Main themes noted here.

- *Why else is it important to prioritize this set of indicators?*
    - Focused on outcomes and not the strategies
    - Timeline for the child
    - The ones that didn't get chosen can roll into those that were
    - These four get at all children, all subgroups of children, and targeted interventions will address all children

- *If the state were to address these indicators, would the state start to make significant progress towards the aim of getting all children proficient by the end of 3rd grade?*
    - (Head nods)
    - Depends on commitment, resources, and longevity – this is long term work
    - Need ongoing education about these indicators because of constant change in state government. Need awareness for policy makers, public, professionals

- *Any concerns about this set of indicators?*
    - Don't divorce oral health, healthy weight, and well-child visits from physical health
    - Early Intervention data are not currently disaggregated how we want it
    - Also limited data around socio-emotional health

- *Would you support a focus on these indicators in the next 3 to 5 years? And would you want to be involved in making change in these areas?*
    - Yes!
    - Can't just be more money to get more programs in a few communities. Need to look at this systematically.
    - Already some synergy in the state around healthy birthweight and social-emotional health indicators.

Full comments are included in Appendix C of this report.

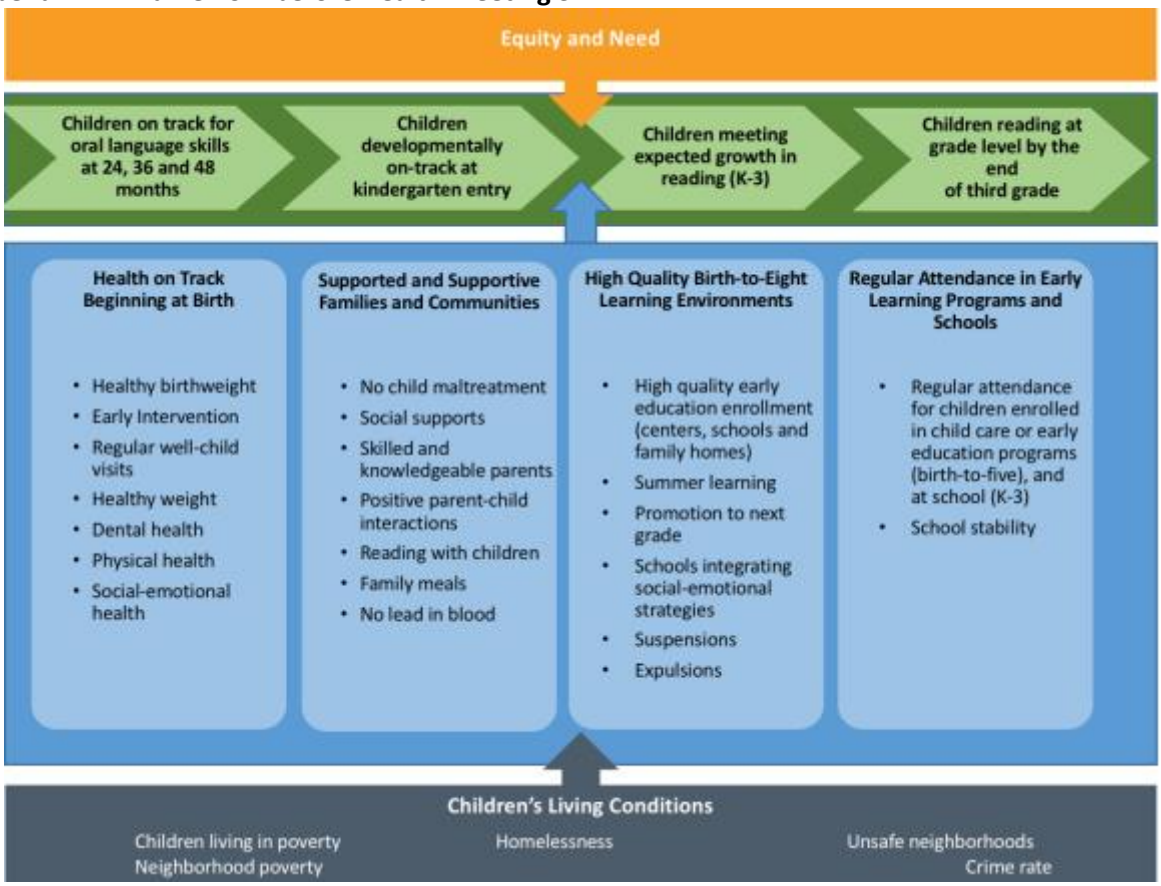
Wrap-Up and Next Steps

The meeting concluded with a reminder of next steps. The priority indicator decisions will be recorded, and the group discussions will be organized into a rationale for why those indicators were chosen. At the last meeting on December 8th, Health Learning Team members will present their prioritized indicators to the Family and Community and Education Learning Team members. The full group will develop an integrated list of recommended indicators and discuss the root causes identified at Meeting 2.

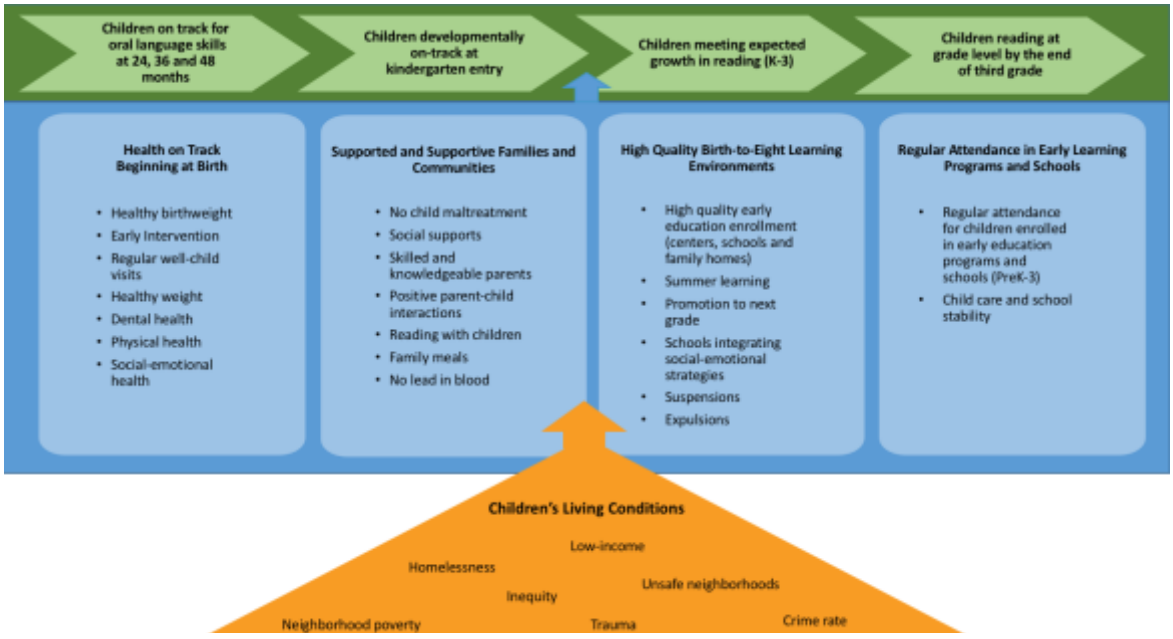
The final Learning Team meeting will include all three teams, and is scheduled for December 8th from 1-4 pm at Fidelity Investments in Durham.

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

Appendix A – Framework before Health Meeting 3:



Framework after Health Meeting 3:



Appendix B: Reactions to Evolved Measures of Success Framework

- Maybe include the word "inclusive" in the "High quality learning environments" goal
- The developmental pathway at the top goes from oral language skills (which is fairly specific) to kindergarten readiness, which includes many domains of a child's development and is very broad. Perhaps narrow the focus of the kindergarten readiness indicator to be specifically around language/literacy. Suggestion: Consider the research base. What does the literature show? Is it just the language/literacy piece that feeds to K readiness?
    - Or maybe the younger one (oral language skills) should be broader, rather than narrowing Kindergarten readiness.
    - Maybe change first one to "Children's oral language skills *on track at*…" to better match the wording of the kindergarten readiness one.
    - To include children who are developing language and literacy in atypical ways (e.g., those who are hard of hearing) maybe change first one to "language skills" instead of "oral language skills."
        - That terminology is broader anyway and would allow us to include important pre-literacy pieces like comprehension, which fits with what the research says is important.
- If the indicators in the green arrows (developmental pathway to literacy) are what we will be measuring, then how do we show progress on indicators in blue boxes?
    - Those will be measured as we go, as well.
- I understand why you pulled out the social/economic living conditions, but it should be noted how critical poverty is as a factor. Who is working on that, if not this initiative?
- Move equity and need banner somewhere else – doesn't makes sense there.
- The evolved framework is helpful and limits the number of indicators.
- If we can focus the indicators even more, it will be better for communication with the general public and for working with partners; easier to understand.

Conversation later in the meeting circled back to the question of whether to include the living condition indicators in the blue boxes. Two members of the team felt strongly that at least one of those indicators should be included as an indicator in the blue boxes. The rest of the team did not weigh in on that conversation.

- Children living in homes under 200% of poverty level is a key indicator. Moving that is the number one thing we could do to shift the rest of these indicators.
- We might need two conversations with the Design Teams:
    - What will it take to accomplish these literacy goals?
    - Who should the literacy community be working with to embed anti-poverty work in our work?

Appendix C – Notes from Full Group Discussions on Prioritization Exercises

Inequity/Need Prioritization Exercise

- Debating between physical health and well-child visits – physical health gives more latitude for strategies than well-child visits.
- Similar conversation at another table – if trying to move a discrete indicator, it may be easier to move that indicator and have greater impact than a more nebulous/broad indicator.
- Also looked at whole child as a timeline – thinking about life course and having greater impact earlier in life, with Healthy birthweight and Early Intervention.
- Some of these indicators are states of being and some of them are strategies (well-child visits are something you do and physical health is something you are).
- Anything that is a measure of a program's effectiveness (Early Intervention measure) is different from some of the others.
- Also, what are we actually measuring with Early Intervention? – is it outcomes, access, who needs it? We should think of it as access *and* outcomes.
- Early intervention – need is demonstrable and in terms of inequities, there are significant inequities by race and income, access is influenced by Early Intervention system and broader early childhood community (at the local level) – where connections are strong, kids have better access.
- Oral health was selected because typically underfunded, it tends to be disconnected from physical health, if kids have cavities and pain they can't focus, can't eat healthy foods, miss school, Medicaid gives access to dental care and aren't making use of it (providers don't accept it). There may be a lot of strategies in oral health.
- Oral health didn't make the list for another group because she thinks we have artificial silos, why doesn't oral health get subsumed by physical? Oral health is part of the bigger picture of physical health.
- But the way oral health is funded is separate from physical health.
- Healthy birth weight – this indicator is the highest for need and inequity. There are so many factors among the indicators that both feed into this indicator, and healthy birth is the foundation for all of it.
- Social-emotional health is strong and important.
- Socio-Emotional health is linked to all of development, very integrated.
- Physical health encompasses healthy weight, so don't need to separate it out

Connections/Impact Prioritization Exercise

- Healthy birth weight – Chosen partly because when look at impact, solutions to why children are born at low birth weight would also impact other things (looked at connections to "as influenced by" indicators).
- If don't have healthy baby born, you have to work a lot harder to move the needle, lots of band-aids, intervention for low birth weight needs to be on the mom before pregnancy. Important to remember that healthy birth weight is influenced by indicators we aren't considering (i.e., those that relate to the mother's health pre-pregnancy) so it doesn't look as connected as it really is.
- Well child visits – chosen because the numbers are high, it is foundation to a lot of things, thought that the things that are influencing it had a higher weight (thinking about dependent and independent variables), weighted the influencers over the influenced by; one group felt that

there were a lot of other things that wasn't reflected in the literature, so didn't choose well child visits because they thought that other things were influencers too; other group thought it was a strategy rather than a condition, so didn't choose it. Going to a visit doesn't cause you to have a better weight, the visit itself isn't going to improve physical health, you can be identified at a visit to get help for that, but just because you go to a visit it doesn't mean you will have better health.

Final Prioritization Discussion

Why is it important to prioritize this set of indicators?

- Focused on outcomes and not the strategies (but can still talk about strategies), focused on influencers and influenced, there is a variety of ways for the interventions (lots of variety of strategies – how you would change healthy birth weight is different than EI).
- There is a timeline here.
- The ones that didn't get chosen can roll into those that were.
- Physical health was a broad category.
- We can track information across these indicators (some disagreement in the room – suggestion that there is not good data for some of these, like social-emotional health).
- Good data systems individually for these data, with integrated data systems we will be able to track how they are doing in all four – once ECIDS system gets integrated and see how clearly one is affected the other. We need to push for this.
- These four get at all children, all subgroups of children, and targeted interventions will address all children.
- Attendance group of indicators – there isn't an attendance group, so it will be discussed by education group, some people thought it may be better suited to go back into the education group.

What are your concerns about the indicators?

- Only concern is how to frame it and communicate it to others, so we aren't divorcing oral health, healthy weight, and well-child visits from physical health.
- Early Intervention data are not currently disaggregated how we want it, we will need to work with EI to get it how we want it.
- Also limited data around socio-emotional health.
- Discussion around data development agenda and being sure we don't prioritize all indicators we don't have data for; need to include this in feasibility conversation.
- We all think physical health is critical, but the data here is parent report of child's health which may not be a valid report; we may need to draw upon other indicators to bolster this indicator. Facilitator noted that per the research, it is valid for young children.

If we address these indicators, would we achieve our aim?

- (Head nods)
- Depends on commitment, resources, and longevity – this is long term work.
- Need ongoing education about these indicators because of constant change in state government. Need awareness for policy makers, public, professionals.

Would you support a focus on these in the next 3-5 years?

- Yes (head nods)!

- Can’t just be more money to get more programs in a few communities. Need to look at this systematically. How do we achieve this across the state, each community needs to do this and work cross-sector to do it. Not going to get us where we want to be if we just do programs.
- Around the healthy birth weights, there are several state initiatives working on this, also Essentials for Childhood are focused on socio-emotional health, so there may be synergy here around those indicators (rationale for prioritizing those).