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

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

All of the materials and presentations shared at 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 Two Summary

Team members each sat at one of three tables that corresponded with the Health and Development Outcome(s) they knew the most about. The three tables focused on:

- Outcome 1: Healthy Births and Outcome 2: Access to Health Care
- Outcome 3: Physical and Emotional Health
- Outcome 4: Appropriate Developmental Benchmarks

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 an event at the White House.

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:

- To examine patterns within the Equity data and explore why these inequities are happening in NC; and
- To consider the level of Need in NC around these indicators, including the degree of the problem, the scale of the problem, and the trend.

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

Mandy Ableidinger, Policy and Practice Leader at NCECF, then addressed the data concerns that were brought up during meeting 1.

- A document responding to all data questions was posted on Basecamp.
- Facilitators brought some new data to meeting 2 that was specifically requested by team members. Mandy briefly outlined the new data and encouraged team members to add it to their data notebooks.
- Mandy noted that we will never have all the data we would like to have, in the format we would like to have it. Given that the data will always be incomplete, our charge moving forward is to:
    - Use the data that are available to aid in our prioritization decisions;
    - Also use our experience and expertise to guide our decision-making around prioritizing indicators; and

    - Develop a data development agenda to identify the gaps where the state needs to collect more or different data.
- The group discussed the importance of having data to tell the story, but not allowing the process to get stuck when data are not available. For example, we don't want to eliminate an indicator from consideration for prioritization because there are no good data available – that may still be a crucially important indicator.

Table Work: Why Do the Inequities Exist?

Mandy introduced the Health Inequities Synthesis – a new tool that displays on one page all the insights the team members offered at meeting 1 about the inequities in the data. The Health Inequities Synthesis is also available online at http://buildthefoundation.org/learning-teams/ .

There was a large group conversation around the patterns seen in the Health Inequities Synthesis, which led into the first table exercise.

In preparation for the first table exercise around *why* the inequities noted in the data exist in NC, Mandy introduced the team to a framework of structural or system characteristics that research has shown explain why inequities exist and are powerful levers of change. The characteristics included:

- **Regulatory Environment** – policies, rules around eligibility for programs.
- **Program Components and Support Environment** – program quality, accessibility, affordability, availability.
- **Relational/Connectivity Environment** – shared data, shared goals, co-located programs, integrated, seamless referrals and information sharing.
- **Resource Environment** – funding (what is and isn't funded, is funding sufficient), skills and capacities of providers, sufficient numbers of skilled providers.
- Economic Environment – state economy and available economic opportunities for families.
- **Power/Decision-Making Environment –** who has influence and voice at the state level, and who does not?
- **Mindsets** – Attitudes, values, beliefs, and biases that exist across the populace and among those in power and in decision-making roles.

Each table then moved through a process aimed at answering the question – Why do these inequities exist in NC? Each table looked only at the Outcome(s) they were responsible for, examining between two and four indicators. Facilitators took notes at each table, and Individual Reflection sheets were collected after the meeting. *Insights gleaned from the individual work and the table conversations are included here as Appendix A.*

After the table work, the full group summarized their discussion on why there are patterns of inequities in North Carolina:

Regulatory Environment:

- Policies/rules about eligibility – especially impact the disenfranchised.

Program Support Environment:

- Lack of connection to programs/education for those from other cultures/languages

Resource Environment:

- Geographic Inequities –not enough providers, resources, power brokers in rural areas.
- Poverty is underlying all of the disparities.
    - Segregation; disinvestment in poor, minority communities
    - Lack of community resources
    - Resource and opportunity deserts
- Programs not sufficiently resourced. There are waiting lists and short grant-funded cycles, all of which affect minority, poor, and/or rural families and children more.
    - Ex: school based health centers other programs in schools.

Connectivity Environment:

- Providers and other services are not connected, don't share data

Power/Decision-Making Environment:

- Minorities and low-income people are not represented in seats of power where legislation/policy is crafted.
- Latino/Hispanic populations are relatively new in NC – have less voice.

Mindsets/Biases:

- Systemic biases in assessment tools, reports from providers, and teachers.
- Parent blaming results in lack of trust of system providers, less access to programs and worse health outcomes.
- Undocumented parents, incarcerated parents may feel especially threatened - risk of children being taken.

Table Work: Rating the Indicators on Need

Mandy introduced the next exercise – rating the overall Need across the state on each indicator. The group thought about Need in three ways:

- Degree of the problem: How badly or well is the state performing on this indicator?
- Scale of the problem: How many children and families are affected by this indicator?
- Trend: Is the state's performance on this indicator stagnant, getting worse or better, or expected to get worse or better?

Mandy highlighted the data resources that were available for the table conversations, and the tables began rating the indicators in the Outcome(s) they were responsible for. *Need ratings are included here as Appendix B.*

The tables also asked themselves the question – "Why are these Needs present in NC?" *Their insights, and those from the larger group discussion, are included here as Appendix C.*

Data questions from the meeting are included here as Appendix D.

Wrap-Up and Next Steps

The meeting concluded with a reminder of next steps. The next meeting will focus on the connections among indicators, and the team will make prioritization recommendations to present to all three Learning Teams, which will be meeting together in December for Meeting 4.

The next Health and Development Learning Team meeting is scheduled for November 2nd from 1-4 pm at Delta Dental.

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

Appendix A: Synthesis of Table Work on Why the Inequities Exist

Outcome 1: Healthy Start
Outcome 2: Access to Health Care

Birth Weight	**Well Child Visits**
Regulatory Environment	
Racial disparities in access to prenatal care	No access to coverage
Insurance coverage	Affordable Care Act has helped
Medicaid coverage	undocumented residents not eligible for certain public assistance
Employer-based insurance	employer policies limit ability to take time away from work
Income disparities	Medicaid: Quality of coverage
Are these racial disparities too?	
Rate of smoking	
Rates of substance abuse disorders	
African American and American Indian - income correlation	
Indian Health Services? American Indian population may have better access, so why higher rates of low birth weight?	
Insufficient accounting of racial disparities when we are only determining eligibility [for Medicaid] by income	
Program/Support Environment	
Income disparities in type of insurance coverage	poor = Medicaid = lack of providers
high deductible plans	families sense not receiving equal treatment
access to specialty care/out of network coverage	Transportation
Rural population fewer programs?	Health literacy
	Providers, Practice environment – language, services that are not reimbursable. Extended hours
	Parent knowledge
Relational/Connectivity Environment	

co-located? Isolated & hard to get to	
Resource Environment	
Rural shortage of providers	Transportation
Disparities in employment rates (leading to income inequality and also type of insurance coverage)	Employment status. Employment – type of work environment: paid sick leave
Pre-natal care access	Single vs. dual parent households
	Community resources: transportation, child care, family support, school health centers
Power/Decision-Making environment	
Commission on Indian Affairs?	
lack of voice, health promotions	
Mindsets	
Negativity	Fear of arrest, deportation
What are we missing in capturing cultural/social norms that may have impact?	
Mindset – further back before pregnancy	

Outcome 3: Physical and Emotional Health

Good Health	**Obesity**	**Social-Emotional Health**	**Tooth decay/Dental**
Regulatory Environment			
Health policies don't support families - safe environments, etc.	Limited physical activity in school day – impacts poor minority kids more because unsafe neighborhoods		Difficulty navigating the system of insurance among public; especially immigrants (undocumented and documented)
Many issues same as dental	Limited funds to schools, so cafeterias needing to make money, and to do that, have to serve foods that are popular with kids- more in poorer school/more minority kids		Undocumented immigrants not eligible for public benefits? (not sure about this)

Undocumented immigrants less likely to be eligible for insurance, programs. Mostly Hispanic	Potentially positive/equalizing influence - child care meal program where all kids eat same breakfast, lunch and snacks		Dental insurance is limited and not available to most, especially those not eligible for Medicaid
			Dental care costly - even with insurance
			Medicaid coverage?
Program/Support Environment			
health services not offered on convenient days/times	accessibility - limited by transportation & location of programs	Media blitz on this lately, but if not in range of the radio stations, etc., less knowledge about this issue.	Services not offered on days (Friday) and times (after hours) that are convenient
environment doesn't support good health	education on obesity doesn't reach all groups the same – language, culture, income		not affordable, available, accessible
There are not enough health/nutritional programs to educate children and families			transportation; especially harder for the rural poor
education/programs not culturally /linguistically appropriate			
families have difficulty navigating complex health system			
Relational/Connectivity Environment			
			dental & general health are siloes. Don't connect data across systems
			few dental clinics at local health departments (we think)
Resource Environment			
not enough providers in rural areas	poor, minority kids overrepresented among families who can't afford sports programs (YMCA, soccer leagues, etc) –	less knowledge/training on social-emotional health among	not enough providers who accept Medicaid

		professionals who work w/ small kids	
Not enough providers accepting Medicaid – especially rural	More fast food in poorer neighborhoods; fewer grocery stores	Families in poverty – fewer well visits – less notice of social/emotional health	not enough providers working in rural areas
lack of funding for education programs	Transportation to grocery stores for healthy food often not available for poorer/minority communities	County difference in resources for these services	few pediatric dentists in the state
if program do exist, they usually run for 1 year at the time and they only concentrate in small geographical areas	Healthy food is more expensive.	Social-emotional health is worse for kids in families that are stressed – and minorities/kids in poverty are overrepresented among families that are stressed.	too little income to afford dental care or dental insurance
Too many food deserts in low income neighborhoods			American Indians are often rural poor
housing for low income kids & transportation – place matters. Social determinants of health			Inequities based on where people live & income
			limited good food - income
Power/Decision-Making environment			
minorities not represented well, don't have power	junk food restaurants & beverage companies have more power than poor/minority communities		American Indians/Asians (minorities in general) not represented well among decision makers
voice, but not power: families, advocates, teachers, Early Ed, PH education			parents do not have voice
			Legislature
Mindsets			

Data comes from parents self-reporting and may not reflect accuracy in actual child's health status. Example: a parent may consider that a robust child may be a sign of good appetite and health	parents think obese kids are not overweight.	Mindsets of people in power: Preference for remediation over prevention	Dental health not considered as important as general health.
programs and services are not culturally & linguistically appropriate.	foods in different cultures are more/less healthy. Latinos & AA? - sugar water, sweetened drinks	Bias – against African American boys especially In reporting by teachers, other professionals.	less "power" among dentists' association vs. physician association.
	Some of disparity is probably genetic (Hispanics vs. Asians)		parents not educated regarding need for dental care. Especially those without money.
			lack of non-sugar drinks; use of sugar and lack of access to healthy foods and drinks; especially those living in poverty
			Information has changed and parents aren't aware.

Outcome 4: Appropriate Developmental Milestones

Early Intervention	Oral Language Skills	School Readiness
Regulatory Environment		
No universal Pre-K	Undocumented may be ineligible for services	Are all screeners using the same tool/instrument?
limit to # of parents who receive subsidies	not enough focus on earliest literacy	undocumented may be ineligible for services
income determines subsidy and working parents lose subsidy	how are we assessing dual language learners?	Too many restrictions on subsidy; eligibility has been made stricter. Limited slots for subsidy
	provide literacy services at the level needed - in terms of population	Pre-K program is not universal; disproportionately impacts poor/minority kids

	Pre-K program is not universal; disproportionately impacts poor/minority kids	Intervention protocol/strategies for when risk/issue is identified
	Paid parental leave impacts	
	eligibility for subsidy has been made more strict	
	limited slots for subsidies	
	Intervention protocol/strategies for when risk/issue is ID	
Program/Support Environment		
limited high quality childcare	Programs not available at times/places convenient for families	programs & screenings - not available at times/places convenient for families.
staffing turnover - bad pay	Parent education: not getting info to families about what they can do at home and what is developmentally normal	Transportation is an issue for low income families to get children to Pre-K programs
kids end up with home-based child care or no care	access to books	Pre-K program/Head Start limited
	MDs need focus on development assessments earlier	Parent education around child development skills
		access to books
		MDs need focus on development assessments earlier
		Not enough supports for socio-emotional development birth to 5 years
Relational/Connectivity Environment		
state has insufficient data to help drive work	pediatricians don't know what supports exist, so they don't make referrals	screenings - are they being done by enough community actors/programs?
	service providers working in silos	Is there a database for screening results?
		Data collection is improving but not consistent
		Limited data limits conversations & decision
		Poor overall physical health impacts ability to learn
Resource Environment		

Smart Start and other programs suffer spending cuts - result in more limited criteria for subsidy eligibility	Limited funding for early literacy programs – fewer served	Limited funding for early education means Pre-K options limited; Not enough funding to serve all at risk children
subsidy limits	can't always find providers with the preferred qualifications	Lack of CCHCs – disparity in physical health, safety & assessments
limited skills of child care workers	services are not at times & locations that work for low income families	poor pay/turnover - Providers are not well compensated which impacts quality
high rate of turnover	Low pay, fewer providers (leads to limited access)	limited geographical areas
No universal Pre-K	instability of home/stress	Too many restrictions on subsidy as far as eligibility
	Resource deserts	instability of home/stress
		Resource deserts
		limited # of skilled providers
Power/Decision-Making environment		
rural vs. city	family voice often left out; not part of decision-making	Individuals with inequities are disenfranchised & have limited power
	not enough supports/or buy-in from policy makers	Limited Hispanic voices
		Those that need intervention have smallest voice
		family voice often left out
Mindsets		
Recently, early intervention cross over has become an important issue (politically)	blaming parents for poor outcomes	blaming parents for poor outcomes; makes parents feel defensive, have distrust of “the system”
	early childhood professionals are not valued to the point that they are fairly compensated.	Some feel children should be at home w/Mom -
	Biases assessment	Intolerance with working with children with social/emotional challenges
		EC professionals not fairly compensated
		Biases assessment

Appendix B: Need Rating Worksheet

Team members rated three aspects of Need, on the following scales:

- Degree of Need: High, Medium, or Low
- Scale of Need: Affects Significant Numbers of Children, Modest Number of Children, or Few Children
- Trend: Getting Worse, Holding Steady, Getting Better

	Degree	Scale	Trend	Notes
Outcome: A Healthy Start				
Birth weight	High	Significant	Steady	
Outcome: Access to Health Care				
Well Child Visits	High	Significant	Steady	What is happening with the population? Size? Policy changes?
Outcome: Physical and Emotional Health				
Good Health	Medium	Modest	Steady	Some hesitation with using this indicator from one group member.
Healthy Weight	High	Significant	Steady	Data suggests degree is not as high as other states, but experience says high degree of need on this indicator.
Social-Emotional Health	Medium	Significant	*Insufficient data*	Lacking NC data on this indicator; used Early Intervention social-emotional outcome data to rate. NC is in the middle of states on that indicator. However, that data speaks more about NC's Early Intervention program quality than the Need in the state around social-emotional health.
Dental Health	Medium	Modest	Steady	
Outcome: Appropriate Developmental Benchmarks				
Early Intervention	High	Significant	Steady	Trend likely to worsen because of funding, economy, expectations.
Oral Language Skills	High	Significant	Steady	Trend likely to worsen because of funding, economy, expectations. Linked to Early Intervention outcomes.
School Readiness	High	Significant	Steady	Trend likely to worsen because of funding, economy, expectations.

Appendix C: Why Seeing these Overall Needs in NC?

Regulatory Environment:

- Health coverage/changes in reimbursement (for Medicaid providers)
- Affordable Care Act enrollment impact
- Tax policy: EITC ended in NC

Program Support Environment:

- Barriers to utilization of services
- No solid state-level health/nutrition program that can support local efforts
- Need better structure and more efforts to educate people when changes to policies happen

Resource Environment:

- Employment and economic climate (recession & come back)
- Resources for providers
    - Local/cross local connections
    - Relationships between resources
    - Impact connectivity to care and health outcomes
- Resource deserts
- Social determinants of health
    - Place matters
    - Income matters – family poverty
        - Education impacts income
        - Employment opportunities impact income
    - All of it impacts connectivity to services

Connectivity Environment:

- Lack of connection between insurance enrollment & provided services
- Lack of connection among providers impact access to care and health outcomes
- No resources allocated for data collection and evaluation

Power/Decision-Making Environment:

- Lack of valuing prenatal 0-5 age category among those in power
- No depth of understanding or prioritization from those in power around importance of social determinants of health for determining health outcomes.
- Change takes a long time, so legislators can't get "credit" – so don't take action on long-term change
- Legislators tend towards remediation instead of prevention

Mindsets/Biases:

- Parent blaming

Other:

- Demographic characteristics of mothers (re: birth weight and birth outcomes)
- Tobacco use

Appendix D: Data Development Agenda

- Ultimately need county-level or lower data for all indicators (census tract?)
- For Healthy Weight data – could use national growth charts?
- For Well child visits - need rural/urban data; Can we see non-Medicaid?
- Birthweight - Need breakdown of data for American Indians by area/tribe
- Disparities in access to care - no data on rural