NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

TASK FORCE ON ESSENTIALS FOR CHILDHOOD

NORTH CAROLINA INSTITUTE OF MEDICINE
630 DAVIS DRIVE, SUITE 100
MORRISVILLE, NC 27560

MAY 23, 2014
10:00 am - 3:00 pm

Goals for the meeting: Today's meeting agenda is shaped around policy levers for change to affect children and families. We will also continue our discussion of the intersection with social norms change and policy/advocacy, and discuss the evidence-based programs draft task force recommendations distributed at our April meeting. Please see handout for today's speaker biographies.

WELCOME & INTRODUCTIONS

Kenneth A. Dodge, PhD
Founding Director
Center for Child and Family Policy
Duke University

Kathy Pope
Board of Directors
Prevent Child Abuse NC

Meghan Shanahan, PhD
Research Scientist, Injury Prevention Research Center
Research Assistant Professor, Department of Maternal and Child Health
University of North Carolina at Chapel Hill

Dr. Dodge and Ms. Pope brought the meeting to order and led introductions of Task Force members.

Dr. Shanahan discussed the results of a survey sent to all Task Force members about their Task Force experience to date. The survey was sent to Task Force members with a 50% response rate (24 out of 48). 43% of respondents indicated individuals/organizations not represented on this Task Force, including members of juvenile justice, law enforcement, the Department of Public Instruction, and churches. Task Force respondents suggested that areas for improvement include: clearer process and outcome plan, subgroups that could meet separately, and more time to brainstorm.

Dr. Dodge asked Dr. Zolotor to share the future process and outcome plan for the rest of the Task Force. Dr. Zolotor stated that Dr. Shanahan was named the evaluator for the Essentials for Childhood TF and is tasked with developing an evaluation plan for the Task Force process and an evaluation for the Task Force recommendations and outcomes. Dr. Zolotor reviewed the

content of the previous meetings including the collective impact framework, basic surveillance, evidence-based programs, and social norms. Today's meeting will wrap up our discussion of evidence-based programs and then focus the rest of our discussion on social norms and policy. The outcome of today's meeting is to focus on a set of issues that we can improve through social norms change and/or policy. Moving forward, the Task Force will plan to have 1 or 2 meetings to wrap up the social norms and policy work. Then there will be1 or 2 meetings to finalize recommendations and another 1 or 2 meetings to review the final report. This report will be primarily written by NCIOM staff but all Task Force members should feel collective ownership over the report. The 2005 Task Force and report focused on the different evidence-based programs. This new report will be different and focus on infrastructure, scaffolding, training, shared funding streams, and outcomes. In addition, the NCIOM will host a summit in the late fall or winter to share the report with a broader group of stakeholders.

Dr. Shanahan's full presentation can be viewed here.

EVIDENCE-BASED PROGRAMS RECOMMENDATIONS: DISCUSSION AND PRIORITY-SETTING

Adam Zolotor, MD, DrPH
Vice President
North Carolina Institute of Medicine

Dr. Zolotor gave a brief overview of the potential recommendations on evidence-based programs and encouraged discussion about each them. Recommendation A focuses on funding. Recommendation D captures what the Task Force learned from the Alliance model.

What are we missing?

- Bud Lavery commented that the list of evidence-based programs has not changed in the last decade. We are missing information on local adaptations, implementation, and evaluations.
- Marian Earls pointed out that most EBPs target specific families and do not promote primary prevention. This is an area we've talked about but we return to our comfort level and do not address programs that have the potential to target at-risk populations for earlier prevention.

Selected comments and questions:

- Dr. Dodge noted that there is tension between funding evidence-based programs and supporting innovation. This recommendations is exclusively funding evidence-based programs. How do you trade that off and make that balance? One way is to endorse evidence-based programs but to put a provision or requirement on programs that are not evidence-based. They need to produce evidence in X years (and have funding to evaluate effectiveness) so that they are not thrown out. Dr. Dodge suggested a time limit to produce a rigorous evaluation with the provision that without evidence, funding is removed. The federal program for home visiting allocates 75% of funds to go to evidence-based programs and up to 25% of funds to go to promising solutions with a 3-year time frame to produce evidence.

- Dr. Stewart: Are there accepted processes and ways to evaluate promising strategies that many people can agree on?
- Dr. Zolotor: There are accepted standards (multiple randomized controlled trials as the gold standard). The report can include exemplar programs and clearinghouse regulations.
- Mr. Cain: For funding agencies, fostering discussions between program officers to develop a consensus about evidence-based programs with other agencies. We need a mechanism that sets up ongoing review and refinement.
- Dr. Dodge provides three points of evaluation; North Carolina can continue to be an evidence-producing state:
    - Evaluation can be done for less money than you think. It doesn't require very expensive research using administrative data, programs already in place, etc.
    - Evaluators may disagree about evaluation criteria and rigor.
    - The act of evaluating improves the quality because it makes us pay attention to whether we have an impact.
- Bud Lavery: The Task Force should be cautious about using the word "evaluation" where there is an effective/ineffective dichotomy when we are working to promote a continuum of improvement.
- Cathy Pope: It sounds like we need a norms change to show people that program evaluation is not scary and that it is a learning opportunity. Perhaps our NC colleges and unviersities offer more evaluation opportunities
- Tamara Berringer: The evidence is helpful and should be embraced. It is easier to convince colleagues to shift scarce funding when there is solid evidence.
- Walt Caison: Caison supports planning grants because there are cultural issues that need to be changed through social norms. Engaging stakeholders in these communities is very important.
- Dr. Zolotor: Is this implementation science or continuous quality improvement?
- Michelle Hughes: We may need an outcome framework.
- Vickie Bradley: In Cherokee, we need more support in the preconception stage.
- Bud Lavery: If you don't adequately fund infrastructure, the programs won't be able to be implemented with fidelity. Therefore, this underfunding may lead to poorer outcomes.
- Dr. Dodge likes Recommendation E and wishes to expand it to support innovation in financing with a pay-for-success model like in South Carolina. This will help prevention, outcomes, and impact. Private funders (Goldman Sachs) pay for NFP. When NFP shows results, the state will pay back GS with interest, but if not GS loses money.
- Kristin O'Connor: Was there a reason for Recommendation C to focus on NC DPH? We can broaden stakeholders.
- Anna Carter: For Recommendation B, let's not create a new group. Let's build on an existing group or sub-committee. The ECAC has broad membership. We need to make sure we are not creating yet another group.
- Paul Lanier supports Recommendation D and suggests that we make it clear that this is based off of the Washington state model.

REPORT BACK FROM APRIL MEETING: SOCIAL NORMS CHANGE

Group facilitators from April's breakout discussion groups will present their groups' consensus on social norms around children/parenting/families and which of these norms are beneficial, harmful, and/or can be changed.

Adam Zolotor, MD, DrPH
Vice President
North Carolina Institute of Medicine

What are the social norms about parenting?
- Go it alone culture (lack of paid sick leave and maternity leave)
- Children are only their parents responsibility and no one else's
- You can't ask for help; if you ask for help you owe people back or they may judge you
- The lack of acknowledgement that parenting in isolation is challenging
- Parents have more things in common than differences

Michelle Ries, MPH
Project Director
North Carolina Institute of Medicine

Which of these social norms are supportive of families and safe, secure, and nurturing environments?
- Collegiality of parenting (contrast the go it alone and parents in isolation culture)
- It takes a village to take a child
- Parents are a child's first teacher

Catherine Joyner, MSW
Executive Director, Childhood Maltreatment Prevention Leadership Team
Women's and Children's Health Section, Division of Public Health
North Carolina Department of Health and Human Services

Which of these social norms get in the way of safe, secure, and nurturing environments?
- Parenting is private
- Maternal stress, lack of maternity leave, breastfeeding at work
- Lack of community support
- Parenting is isolating and stressful
- Unstable family relationships
- Mixed messages between parenting is private and it takes a village
- Go it alone culture
- No acknowledgement that parenting is difficult and everyone needs support

Angelica Oberleithner
Health & Family Support Program Officer
The North Carolina Partnership for Children, Inc.

Which of these social norms are most influential/malleable?

- Destigmatizing services
- It's not just for those who are at risk; it's for everyone

Marcella: We know about these social norms. How will we reach these families?
Sen. Berringer shares her foster parent experience in the 1990s.
Elaine Cabinum-Fueller: Who are the local leaders? We need to identify these people. It can't be a mass media message across the state.
Susan: Is social marketing going against our focus of EBPs?
Michelle Hughes: The First 2000 Days campaign is so successful because it is linked to evidence and science. We want healthy brain development for kids to be successful. It's probably more effective to emphasize the science of parenting (instead of the art, moral side). Brain development is non-judgemental.

Evidence-Based Policies To Affect Children and Families: Perspectives from the Literature

Joanne Klevens, MD, PhD
Epidemiologist
Division of Violence Prevention
Centers for Disease Control and Prevention

Dr. Klevens presented an overview on the shift from "prevent child maltreatment" to "assure safe, stable, nurturing relationships and environments," in addition to an overview of the current policies that are in place to support a prevention strategy for child maltreatment and ACEs. "Essentials for Childhood" was a message that resonated with the public, the effort was branded. Using CDC Director Dr. Tom Frieden's health impact pyramid, adapted to address child maltreatment, Klevens discussed policies that focus on reducing poverty, increasing the stability of residence, providing high quality and affordable child care, providing high quality and affordable pre-K, facilitating children's access to health care, and facilitating parents' access to health care. Producers of "Unnatural Causes" have developed a documentary, "The Raising of America," to shift the narrative of parenting norms that the CDC is evaluating and helping to disseminate.

Social Norms and Policy Recommendations: What is Feasible?

Facilitator: Adam Zolotor, MD, DrPH

The Task Force had a group discussion of changing social norms and using policy levers to address safe, secure, and nurturing relationships and environments. Designated Task Force members and invited experts spoke briefly on existing policies and context in NC. We also discussed the intersection between the social norms identified in the morning discussion and policy levers for change.

Focus on changeability in the next 5 years. Pick 2-3 buckets to discuss more in the future.

Anna Carter, President at Child Care Services Association (CCSA)
Ms. Carter discussed the policies around child care access, quality, and affordability.
We are more fortunate than many states because we have had a lot of support for early child initiatives. We have 240,000 children 0-12 in child care (during and after school). This is a mix of private pay and subsizied child care. We serve 72,000 children through subsidies - parents are income eligible and/or the children have developmental needs. 16,000 children are on the subsidy waiting list. It was 40,000 children six months ago. There is an 8-10% subsidy co-pay for parents. NC is one of the first to have a star-rated license program (1-5 stars). Over 60% of child care facilities are 4 or 5 star level facilities. There are fewer 1 and 2 y/os in higher quality child care than 4 or 5 y/os, due to higher costs and lower ratios for workers. Providers have not had an increase in reimbursement payments since 2007. They are doing workforce study in the next two years. On average, child care teachers make $10 per hour. 26,500 kids are being served in pre-K. These numbers have decreased. We were over 30,000 children a few years ago. We are one of the few states who meet all of the high standards recommended at the national level. We have HeadStart programs with 18,000 kids. Smart Start is able to support kids as well. In Durham County, the partnership is able to provide support using the county median income (instead of state). There is more flexibility with Smart Start dollars than with state dollars.

Adam: What happened to move 40,000 from waiting list to 16,000?

- Anna: Around December, there was a reversion/reallocation of subsidy dollars. The DCDEE took dollars back and reallocated them back to other counties.

Adam: Who is on the waiting list? What are the priority areas?

- TANF eligible, CPS, developmental needs

Kevin Cain: Are there other key demographics for your workforce?

- 36,000 teachers. Generally, they're younger. The workforce is highly educatied where most have an associate's degree or higher. Many of them are a beneficiary of welfare as well.

Adam: Are there opportunities we're not taking advantage of to leverage federal resources?

- Our state contribution is decreased in the last few years. There is an expected match at the state level to match federal dollars.
- Head Start dollars and preschool dollars will coming
- Race to the Top Early Learning Challenge dollars for four years starting in 2012. It has been a challenge to get the activities up and moving. This has provided support for existing and innovative programs.
- Our state dollars are an issue. United Way support with private dollars.

Susan: Early child care is funded differently from spending on K-12 education. Policy can drive subsidy changes. There is a lot of variability among counties who implement subsidies. The child care market is financed largely from parent fees.
Anna: Is it better to serve more kids? Or fewer kids at higher quality? Subsidy kids need to be in 3, 4, or 5-star care centers.
Donna: The First 2000 Days program is the first time we're working with economic

development teams.
Laura Kellison Wallace: The aging demographic is also tilting the funding away from early care to elder care in NC.

Laura Kellison Wallace, MSW, founder and principal consultant of Highwire Solutions, LLC. Ms. Wallace discussed the policies SAS has in place to support workers and families, including emergency leave, family medical leave, parent education, elder care, onsite social workers, parental leave, and onsite health care. The irony is that there are may services provided for this population that is at lesser risk. Managers' perspectives are not included enough in these discussions. Where is the hook for the employer to support these policies (without being continuously under staffed)?

DHHS Report: Work Family Supports for Low-Income Families

Adam: Local context?

Bring back family medical leave for employees over 50. What might this look like? Go to the employer and start having these conversations. The higher up you get, the more flexible your work arrangements are. The cultural norms around FMLA (and awareness) are different, in addition to the norms around maternity and paternity leave.

ACA provisions to support breastfeeding

- Companies with 50+ need a space for breastfeeding (not a bathroom)
- They need to have interval breaks (unpaid)

The majority of dollars come from small businesses (and not corporations).
Support existing resources and organizations.

Cheryl L. Kovar, PhD, RN, CNS, Family Planning/Reproductive Health Nurse Consultant for the North Carolina Division of Public Health/Women's Health Branch. Dr. Kovar discussed policies around contraception access in North Carolina. 15,000 men and women were served last year up to 185% of the federal poverty line. Minors' consent law for any unemancipated minor to get treatment/services regarding contraception and sexual health. Confidentiality law for minors says that the information should be released to protect the life and well-being of the child. If the parent/guardian contacts the physician and asks about the treatment or services provide to the minor, the physician MAY release the information.

The Healthy Youth Act of 2009 was enacted in 2010 for comprehensive sexual heath education in the school system. There is no oversight or consequences for not teaching comprehensive sex ed. Some school boards and principals oppose the condom demonstration or distributing condoms at school health offices.

Dr. Kovar discussed ACOG's recommendations around long acting reversible contraceptives (3 IUDs and the implant)

- Over 99% effective in preventing unintended pregnancy

- Intsead of going from birth control, to Depo, to rings, etc.
- There are a lot of physician misconceptions (adolescents can't use these forms of contraception, etc.)
- School-based clinics/health centers

Reimbursements for school-based clinics

Donnie Charleston, MA, economy policy manager at the Institute for Emerging Issues at North Carolina State University.
Mr. Charleston discussed the recent tax reforms in North Carolina (EITC, sales tax, child care credit, etc.) and their impacts on low-income families. Mr. Charleston's presentation can be viewed here.

Project director Michelle Ries to develop a survey for Task Force members on policy solutions to increase SSNRs and Es for North Carolina's children:

On a scale of 1-5, which policies:
Require a lot of resources
Are changeable (long term and short term)
Are politically feasible
Have greatest sustainability

Adam Zolotor, MD, DrPH, vice president, NC Institute of Medicine.
Dr. Zolotor discussed current policies around access to health care for children and adults in North Carolina, using data from the uninsured data snapshot from 2012.
48% of our children are covered by Medicaid and CHIP. 44% of children are covered by private insurers.