

North Carolina's Plan for a Comprehensive Early Childhood System

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North Carolina's Early Childhood Comprehensive System Implementation Plan was created by a multi-agency state-level partnership that met throughout the ECCS planning period and agreed to develop a plan for a comprehensive, integrated early childhood system that supports school readiness and builds on existing efforts and initiatives. The planning process included the creation and facilitation of the state-level planning group; outreach efforts to key stakeholders; pilot projects designed to test potential system-building strategies; and efforts to continually monitor internal and external environmental factors important to planning efforts.

Young children in North Carolina are served by a wide array of public and private programs to address health, social-emotional, childcare, developmental and educational needs. In addition to interventions and assistance provided to children and family members through state and local governmental agencies, religious and other community-based organizations provide vital services across the state. Stakeholders agree that while North Carolina had developed many of the critical components of a comprehensive early childhood system and has well-developed systems in place to support those components, the systems are not necessarily connected in a way that would facilitate positive developmental outcomes for young children. The concept of "bridging platforms", e.g., a medical home or an early care and education setting that serves as a link to multiple resources for young children and families, was not (and still is not) well established in practice across North Carolina. Additionally, most service agencies maintained (and still maintain) separate data collection and management information systems. In most cases those systems are completely unconnected making it difficult to evaluate outcomes over time. The lack of a shared vision for child and family outcomes across government and non-government agencies was (and still is) fueling the lack of cohesiveness in the system.

The challenge facing the ECCS planning group was to focus on system-level deficits that were getting in the way of continued improvement in child outcomes in North Carolina and to develop strategies that would help stakeholders in various sub-systems "connect the dots". The biggest challenge was (and still is) to create new pathways that connect critical components of the early childhood system in an environment where the old pathways are well worn and quite comfortable. The ECCS planning process was designed to allow a state-level partnership to consider alternatives to the old pathways in order to develop an *integrated* system that works optimally for young children and their families.

A Vision for North Carolina

The **Vision** driving the Plan for North Carolina is as follows: **All children in North Carolina are healthy and ready for school.** The vision for the ECCS Plan was intentionally created to be consistent with the visions of established early childhood partners, e.g., the NC Partnership for Children (Smart Start), North Carolina’s SPARK initiative (funded by the Kellogg Foundation), so that it could serve as a bridge rather than a barrier in system-building efforts. **All children in North Carolina are healthy and ready for school** also invites discussion about the *multiple and interacting* factors that affect child outcomes, including school readiness.

The **Mission Statement** for the ECCS Plan is to create a comprehensive, integrated and effective early childhood system for all children in NC that supports school readiness and *builds on existing efforts and initiatives*. The Mission statement also intentionally honors and reflects the accomplishments of early childhood partners across North Carolina. Adding the phrase “*builds on existing efforts and initiatives*” created another bridge in our system-building effort.

Goals, Strategies and Action Steps

Goal #1: Share accountability for an effective, comprehensive, and integrated early childhood system in NC in a multi-agency state-level partnership.

The state-level partnership (the “Early Childhood Comprehensive System Consortium”) will be a government/non-government partnership that includes parents, government and non-government agencies and organizations that serve young children and families and academic centers that include child and family well being in their research programs.

The ECCS Consortium will be modeled after the ECCS “Think Tank” (the planning group that functioned during the planning phase of the grant program), and many of the members of the ECCS Think Tank will participate in the Consortium. Additional members will be added to address gaps, e.g., adequate representation from Early Head Start and Head Start and Migrant Head Start and families, which became obvious during the planning phase of the grant program

The Consortium will serve as a neutral space designed to allow members to maintain and/or develop strong cross system relationships necessary to address obstacles to system development. The goal is for the group to function as a highly effective, solutions-oriented leadership structure committed to improving child outcomes in North Carolina by focusing on system integration.

The strategies outlined below will facilitate that level of functioning.

Provide a Neutral Space

Recognizing that the work of integrating systems to improve child outcomes can be extraordinarily challenging, an independent, i.e., not a member of one of the organizations represented in the Consortium, and highly skilled group facilitator who is familiar with early childhood services in North Carolina will be engaged to facilitate the group process. The facilitator will provide a degree of impartiality that is frequently necessary when working with highly committed stakeholders from different perspectives.

Initial meetings will be designed to create a forum for communication and joint learning and may focus on topics of mutual interest, e.g., shared indicators for school readiness or financing options used in other states to support components of an early childhood system. Staff will provide relevant technical assistance material and will identify content experts to present well-designed options to members of the Consortium. This initial work will create foundations for future partnerships and may shift the opinions of key stakeholders toward a more systems-development framework. As the group evolves, the facilitator will be able to challenge members to generate meaningful discussion among the diverse participants. Eventually, the group will function as a highly effective, solutions-oriented leadership structure focused on system building as a way to improve child outcomes. One goal is to shift the focus of leadership from *within* agencies to *among* agencies so that the system builds on each partner's position and strengths in order to accomplish shared goals.

During the planning phase of the ECCS grant, DHHS Secretary Hooker Odom created "the Secretary's Book Club" which will extend the neutral space provided by the Consortium. The Book Club is intended as a forum for informal discussion for members of the Consortium and others that focuses on creative thinking rather than problem solving.

Design Family Participation Mechanisms that Work for Families

While the ECCS Think Tank included family members, there were a number of challenges to ensuring meaningful input from families. The membership structure of the Think Tank, the location of the meetings and the time required to review background material, prepare for Think Tank meetings and respond to draft documents created barriers for parents.

In an effort to address those challenges and make changes for the implementation period, the ECCS staff consulted with the family members of the ECCS Think Tank as well as the Family Liaison Specialist and the Parent Education Program Manager in the NC Division of Public Health. Based on those conversations, a larger number of families will be asked to participate during the implementation period in order to decrease any sense of isolation or burden for any one participant. The plan for the implementation period is to request reviews and input from the Family Advisory Council, a statewide, diverse council of family members who actively participate and advise branches of the Women's and Children Health Section on matters of policy, planning and implementation of services.

In addition to relying on a larger pool of families, the ECCS staff will consult with the Family Liaison Specialist within the Division of Public Health throughout the implementation period. The Family Liaison Specialist serves as staff to the Family Advisory Council and is responsible for training, assisting and advising other staff on family perspectives, family centered care, care coordination, transition planning, medical home and education/community resources. The Family Liaison Specialist will also provide expertise to the ECCS Consortium as needed. Lastly, the ECCS staff will increase contact with families who agree to participate in an effort to respond to any needs for resource materials.

Continue to Listen to “Voices from the Field” to ensure input from local communities
During the ECCS planning process, staff developed a process called “Voices from the Field” to gather input from a wide range of stakeholders across North Carolina. The process used during the planning phase is described in detail in the ECCS Planning Process section below. “Voices from the Field” will continue throughout the implementation phase of the grant to ensure continued input from interested stakeholders. Methods will include: 1) well-designed listening sessions at major conferences sponsored by key partners, including the NC Partnership for Children, the Division of Child Development, the National Training Institute for Child Care Health Consultants, the NC Pediatric Society, etc.; 2) targeted interviews (using an appreciative interview format) with key informants to clarify problems and opportunities and develop strategies designed to address problems and make use of opportunities; and 3) electronic surveys to collect information from a large number of stakeholders on specific issues.

The listening sessions conducted at major conferences were also an opportunity to bringing ECCS concepts *to* the field. During the planning phase of the grant program, the ECCS team introduced ECCS concepts (especially the 5 critical components of an early childhood system) to a wide range of potential partners with local networks in communities across North Carolina by explaining the concepts at listening sessions and by working with conference planners to include system components in programming.

Maintain a connection to policy-level decision makers.

The ECCS Planning group was formally linked to the Department of Health and Human Service’s (DHHS) Children’s Services Advisory Committee to maximize opportunities to affect policy relevant to the early childhood comprehensive system building effort. The Committee is a state-level body appointed by the Secretary of DHHS and includes policy-level leadership in DHHS agencies serving young children and their families and several staff from the Women’s and Children’s Health Branch. During the planning phase, the Committee provided guidance and consultation to the ECCS planning process and receive interim reports and recommendations. It will serve a similar function during the implementation phase.

Selected Strategies for Goal #1
A. Revised the state-level partnership created for the planning process (the ECCS Think Tank) to create the ECCS Consortium that will function throughout the implementation period.
B. Increase input/participation from families.
C. Link to initiatives that have taken the lead role for the critical components of a comprehensive early childhood service system in North Carolina in order to accomplish shared goals (see goal #7). Existing Initiatives include: Medical Home Initiative in North Carolina Developmental Screening and Behavioral Health Training Program North Carolina Parent Education Network Family Advisory Council (until collaborative structure established) EC&E Leadership Network (NC Partnership for Children, The NC Division of Child Development and the Governor's More at Four Program) Shared Indicators for School Readiness Project.
D. Coordinate strategies and action steps with related initiatives, e.g., Institute of Medicine's Task Force on Prevention of Child Maltreatment, the Domestic Violence/Child Wellbeing Task Force, the Department of Health and Human Services Children's Services Advisory Committee, the State Collaborative for Children, SPARK, the NC Partnership for Children, Early Learning Begins at Home Forum, ABCD, etc.
E. Maintain the "Voices from the Field" process developed during the planning phase. Use the process to 1) seek advice/input from existing advisory groups, including the Family Advisory Council, the NC Fatherhood Development Advisory Council, and other stakeholders, and 2) to introduce ECCS concepts to partners in the field.
F. Extend contract with neutral facilitator to facilitate group process for the state-level partnership.
G. Use the state-level partnership process to build consensus on priorities and designate a neutral administrative space to take action on agreements.
H. Use the ECCS Consortium to guide the ECCS implementation grant and to take responsibility for achieving the recommendations for policy, governance, inter-agency agreements and/or structural changes designed to improve outcomes for children.
I. Adjust the state-level partnership structure as necessary, i.e., revise if the legislature creates a mechanism that would serve the same function.
<i>Priorities and specific Action Steps will be developed in consultation with lead organizations between July 1, 2005 – August 31, 2005</i>

2. Use a set of shared indicators for school readiness to evaluate success at all levels of the early childhood system.

The need for shared accountability for child outcomes in North Carolina was an early and consistent theme in the ECCS planning process. In fact, some members of the Think Tank argued that North Carolina would not continue to make progress in improving child outcomes, including school readiness, unless all stakeholders developed a set of shared indicators for success and shared accountability for reaching those indicators. The ECCS

Think Tank developed the *Shared Indicators for School Readiness Project* as part of the ECCS planning process to develop consensus on indicators for school readiness. This was intended as a first step toward shared accountability. A detailed description of the Shared Indicators for School Readiness is provided in the ECCS Planning Process section below.

During the implementation period of the ECCS grant program, we will focus on the more difficult work of ensuring that all programs serving infants and young children and their families use the shared indicators to guide their decision making. Ideally, strategic planning, operations and accountability systems will reflect the shared indicators for school readiness. Application to agency planning, operations and accountability systems will require the leadership of every member of the ECCS Consortium as well as the DHHS Children’s Services Advisory Committee. It will also require a series of workshops or sessions designed to explain the results of the Shared Indicators for School Readiness Project and the benefits of incorporating those indicators into all planning, operations and accountability systems. We anticipate the need for technical assistance and follow up sessions coordinated by ECCS staff. As agencies and organizations throughout North Carolina begin to apply shared indicators to their planning, operations and accountability systems, the ECCS staff will coordinate a series of sessions designed to highlight successful strategies and encourage even broader application.

Selected Strategies for Goal #2
A. Complete the Shared Indicators for School Readiness Project designed to create a set of shared indicators for ready children, ready families, ready schools, ready communities and ready states.
B. Present the results of the Shared Indicators for School Readiness Project to a large group of stakeholders who represent the five critical components of a comprehensive early childhood system at the June 29, 2005 Summit.
C. Encourage all state agencies, community and philanthropic organizations to use the set of shared indicators in their strategic planning, operations/service delivery and accountability systems.
D. Revise the Kindergarten Health Assessment to reflect the shared indicators for school readiness.
E. Establish common measurements to evaluate progress toward school readiness.
F. Explore the possibility of collaborative evaluation.
G. Follow up with key stakeholders to evaluate participants’ success in incorporating shared outcomes and indicators into their planning, operations, and accountability systems. Organize a series of sessions designed to highlight successful strategies and encourage broader application
H. Link this effort to the shared outcomes and indicators project conducted by the State Collaborative for Children.
I. Develop a system to identify and track children from the prenatal period through early childhood transitions. Use shared indicators to evaluate effectiveness/quality of services provided across systems.

Selected Strategies for Goal #2, continued
J. Consider the Early and Periodic Screening and Developmental Tracking (EPSDT) system as a method for tracking.
K. Consider comprehensive implementation of Early Periodic Screening, Diagnosis and Treatment as a framework for tracking child well-being, health and mental health status of children 0-5 or up to 21 if Medicaid eligible.
<i>Priorities and specific Action Steps will be developed in consultation with the Investors and Strategists from the Shared Indicators Project between July 1, 2005 – August 31, 2005</i>

3. Develop a shared early childhood data system.

During the planning phase of the grant, the ECCS Think Tank agreed to address the challenges associated with developing a shared early childhood data system in North Carolina. These challenges include technology-related difficulties, e.g., asking different systems to talk to each other, as well as the challenges associated with protecting confidentiality when sharing information.

Discussions about the benefits of a shared early childhood data system base were well-underway before the ECCS planning process was initiated, and some subcomponents of the early childhood system have had some success in moving toward a shared data system.

One of the most significant barriers to broader system integration has been the inability to link early childhood databases. Another significant obstacle is related to concerns about confidentiality despite the fact that some Divisions of state agencies in North Carolina have a unique identifier system designed to address those concerns.

In order to make progress toward a shared early childhood data system, the ECCS implementation period includes a time-limited strategic process that will focus on addressing barriers to progress, including technological barriers, barriers associated with concerns about confidentiality, and other barriers that emerge during the strategy sessions. ECCS staff will identify appropriate experts to guide the process and decision-making. During the first year of the implementation phase, a series of strategy sessions designed to facilitate the development of a shared early childhood data system will include the following:

- A review of the current status of the early childhood data system(s) in North Carolina;
- A discussion about intended use for data and shared data systems clarifying the difference between using data systems to evaluate child and family outcomes and using data systems to evaluate population outcomes;
- A review of successful models developed in other states or at the county level in North Carolina;

- An analysis of commonalities in existing data systems;
- A consideration of the benefits of using the unique identifier system in North Carolina;
- An assessment of the steps necessary to combine data or enhance data sharing among information systems;
- A series of pilot projects designed to test possible data sharing strategies suggested by experts.

Selected Strategies for Goal #3
A. Review the Mecklenberg County model to evaluate feasibility for a statewide application.
B. Follow up on technical assistance submitted to HRSA.
C. Consider the benefits of a unique identifier.
E. Evaluate existing data systems for commonalities.
F. Assess steps necessary to combine data or enhance data sharing between information systems.
G. Evaluate data linking and/or appropriate sampling to measure outcomes.
H. Balance the child and family interest in securing individual outcomes with a system interest in evaluating population outcomes.
<i>Priorities and specific Action Steps will be developed in consultation with the ECCS Consortium between July 1, 2005 – August 31, 2005</i>

4. Ensure that providers in the early childhood system have core competencies in early childhood (based in developmental science) and the practical strategies and community relationships necessary to provide effective services to children and families.

A number of related initiatives in North Carolina, e.g., the Institute of Medicine’s Task Force on Preventing Child Abuse and Neglect and the Child Well-being and Domestic Violence Task Force, are calling for training and workforce development for providers serving children and families. During the ECCS planning process, the ECCS Think Tank called attention to the need for pre-service and in service training and professional development that is based in developmental science. The goal is to ensure that providers apply *what we know* from developmental science to *what they do* in practice.

The main strategy that will be used during the implementation phase is to work with appropriate organizations to ensure that developmental science serves as the basis for training and professional development for all providers working with families and young children. For example, ECCS staff will work with the North Carolina Institute for Early Childhood Professional Development to ensure that early child programs in the community college system are based in developmental science and are consistent with adult learning theory. The Institute serves as an advisory group to the Division of Child Development in the NC Department of Health & Human Services in matters related to developing an educated work force to care for children who are in group care. Other

examples include working through the existing training infrastructures for the North Carolina court system, the Division of Public Health, the Division of Social Services, etc. to integrate developmental science principles into all existing training and staff development programs and working with Community Care of North Carolina to integrate pediatric developmental surveillance into primary care training programs for pediatricians and family physicians.

A second strategy will be to build on a training pilot project developed during the planning phase of the ECCS grant program. The pilot project was designed to develop core competencies early relationships and the neurobiology of social emotional development in a *cross-system* team of 12 trainers. The team includes representatives from the Division of Public Health, the Division of Child Development, the Division of Social Services, the Office of Education Services, the Governor Morehead School, the Child Care Services Association, the Catawba County Parenting Network, the NC Child Care Health and Safety Resource Center. The trainers are committed to incorporating the training into their ongoing training initiatives. They will also conduct one new training program with a member of the team that will focus on responding appropriately to social-emotional problems in young children. Team members have already proposed a new training initiative for Child Care Health Consultants and a new training initiative for informal child care providers (Kith and Kin care).

The cross system, train-the-trainer model piloted during the planning phase of the ECCS grant program will be extended during the implementation grant. The implementation effort will focus on increasing competencies in providers who are serving children with social-emotional difficulties. The ECCS staff has had preliminary discussions with faculty from the Infant Mental Health Training program at Tulane about distance learning models for a training program in North Carolina.

Lastly, in order to strengthen community relationships necessary to provide effective services to children and families, we will repeat the Regional Collaborative Staff meeting held during the planning phase of the grant program. The regional staff meeting was another pilot project developed during the planning phase and was designed to test the benefits of bringing regional staff from DHHS programs (Early Intervention, Mental Health, Social Services, Child Development, Office of Education Services, public Health and Community Care of North Carolina) together in a cross-system staff forum. The benefits identified by participants included the opportunity to make personal contacts with people in related agencies and access to up-to-date information about services that might be helpful to clients. Participants also identified the need for a similar forum in the local communities and for a regular quarterly Regional Staff Meeting to talk about issues related to transitions between programs and sharing data across programs as well as the need for cross-training among Divisions.

Selected Strategies for Goal #4
A. Repeat regional staff meeting.
B. Promote approaches to training and staff development that are consistent with adult learning theory.
C. Promote approaches to training and staff development that include shared basic competencies.
D. Promote approaches to training and staff development that includes cultural and linguistic competencies.
E. Coordinate with related initiatives, e.g., Domestic Violence Child Well Being Task Force, calling for professional development and training designed to improved child outcomes.
F. Promote staff development and training (pre-service and in-service) in all sectors of the early childhood system that is based in developmental science.
G. Use the concept of developmental trajectories as a framework and include approaches to developmental surveillance, medical home concepts, family support principles, effective parent education practices, and social-emotional development. Use the existing training infrastructures for the court system, Early Intervention, Child Service Coordination and other public health programs, Division of Social Services, Child Care Resource & Referral, Community Care of NC, Infant Toddler Specialists, Child Care Health Consultants, Community Colleges and universities.
H. Include positive, effective approaches. Link evidence and emerging best practices.
I. Encourage a cross-disciplinary approach in existing professional development and training efforts. Include training on team approaches to providing services. Include mental health, DD and substance abuse services.
J. Provide pre-service and in-service training and technical assistance by area of expertise (CCHCS/MH/SA/SW).
<i>Priorities and specific Action Steps will be developed in consultation with the ECCS Consortium between July 1, 2005 – August 31, 2005</i>

5. Build a philanthropic/government partnership for early childhood health and development.

During the implementation phase of the ECCS grant program, the ECCS Consortium will develop a philanthropic/government partnership for early childhood health and development. The development of this partnership will be guided by “Building Relationships in Health: How Philanthropy and Government Can Work Together” (2003) from Grantmakers in Health. The document outlines a range of options for participants and offers strategies for building successful partnerships. Several steps were taken toward developing this partnership during the planning phase of the grant, including consulting with Grantmakers in Health about initial steps and proposing the idea to several key philanthropic and government stakeholders in North Carolina. ECCS staff will also participate in a meeting with Grantmakers in Health and a North Carolina philanthropic organization in May 2005.

The plan for the implementation phase of the ECCS grant program is to begin by building on the good relationships that already exist between the NC Division of Public Health and some representatives of the philanthropic community. An initial step will be to create a shared learning forum on school readiness. The forum will provide an opportunity to further develop networks and relationships among philanthropists and government officials. The forum should also provide opportunities to increase participants' understanding of the cultures and priorities in government and philanthropic sectors and to develop a common understanding of the multiple and interacting factors that affect child outcomes, including school readiness. Participants will begin to sort out how public and private resources can be *coordinated* to enhance the effectiveness of both. Following the initial forum on school readiness, ECCS staff will facilitate follow up activities that may include a specific problem solving session or a second forum on a different topic.

Selected Strategies for Goal #5
A. Continue discussion with Grantmakers in Health.
B. Use resources provided by Grantmakers in Health and other successful partnerships to guide the process.
C. Create forums or issue-focused briefings to establish common understandings and strengthen relationships. Begin with a shared learning session on school readiness.
<i>Priorities and specific Action Steps will be developed in consultation with the ECCS Consortium between July 1, 2005 – August 31, 2005</i>

6. Build broad-based support for investing in efforts to produce positive child outcomes.

The implementation phase of the ECCS grant program will include an effort to contribute to existing initiatives that are designed to raise awareness and build public and political will for school readiness. ECCS strategies during the implementation phase include identifying new social market resources to invigorate existing school readiness messages; engaging new partners (leaders other than child advocates) in existing efforts to promote school readiness; and encouraging partners in the early childhood comprehensive system to expand school readiness messages to include language about the importance of a medical home; high quality early care and education, social-emotional development; family support and parent education in order to educate families, stakeholders and decision makers about the costs, benefits and consequences of building *or* neglecting a *comprehensive, integrated* early childhood system.

Selected Strategies for Goal #6
Join existing efforts to raise awareness and build public and political will for school readiness among parents, policymakers, business and community leaders.
Educating families, stakeholders and decision makers about the costs, benefits and consequences of building or neglecting a comprehensive, integrated early childhood system.

Develop social marketing strategies with guidance from others like Frameworks Institute.
Emphasize the importance of the prenatal period and that early childhood begins at birth
Use the power of the “uncommon voice”, i.e., ask leaders other than child advocates to advocate for an effective early childhood system.
Enhance the commitment to medical homes across agencies and communities through social marketing strategies. Action Steps <ul style="list-style-type: none"> • Develop or expand broad public awareness campaign through public service announcements and outreach educational materials targeted to families, professionals and community stakeholders, including policy makers and funders. • Identify and educate providers at all service points to tie/loop to medical home. Use the definition of medical home developed by the AAP. • Develop new professional norms (including traditional and non-traditional associations) to include the expectation that providers assess whether or not a child as a medical home. Continue to use Community Care of North Carolina model to develop professional champions to promote best practice expansion.
Enhance the perception of value/acceptance of family support and parent education by families, providers, communities, funders, and policymakers. Action Steps <ul style="list-style-type: none"> • Create a communication strategy for all to use in advocacy and service delivery. • Develop creative social marketing messages, marketing tools; identify people with expertise to help; and, engage families to be involved. • Create or support existing networks of local providers/parents to develop shared messages to support acceptance and funding of these services.
Develop a community campaign to facilitate an understanding of the importance of social-emotional development in young children highlighting factors that contribute to social-emotional well-being.
Reframe and engage public investment (including business) for quality child care. Action Steps <ul style="list-style-type: none"> • Develop messages around the importance of affordable, quality childcare, impact on childcare to business and industry and government productivity. • Evaluate other states’ state/local and private investment strategies. • Evaluate public awareness initiatives in other states to look at how they try to increase public support for early care. • Link with North Carolina’s economic future and retooling workforce to improve outcomes for North Carolina.

7. Improve our systems of care by using evidence-based practices to positively affect child outcomes for all critical components of a comprehensive early childhood system.

Whenever possible, the ECCS staff and Consortium will link to initiatives that have taken the lead role for the critical components of a comprehensive early childhood service system in North Carolina in order to accomplish shared goals. Specifically, ECCS staff and the ECCS Consortium will contribute to and receive guidance from these initiatives

in order to promote the use of evidence-based practices to positively affect child outcomes. General strategies outlined in the ECCS Plan include addressing barriers related to reimbursement policies for each of the critical components, facilitating training to support the ability to implement best practices in each of the critical areas, addressing organizational obstacles, e.g., separate enrollment procedures for related services, to integration, and creating public education initiatives to increase demand for an integrated, comprehensive early childhood system. Staff from the North Carolina Division of Public Health Women's and Children's Health Section are active participants or leaders in the lead initiatives outlined below which will facilitate the link with the ECCS implementation process.

Medical Home

The lead organization for this component is the Medical Home Initiative in North Carolina, an umbrella organization that includes a number of organizations working toward instituting best practices related to medical homes in North Carolina. The organizations include the NC Division of Public Health's Public Education Campaign on Medical Home and Medical Home Initiative for Children with Special Health Care Needs; the East Carolina University Medical Home Project, Chapel Hill Pediatrics, Family Support Network of NC, the Guilford Health Partnership, the Office of Research, Demonstrations and Rural Health Development; the Medical Home for Children who are Deaf and/or Hard of Hearing Grant, the State Learning Collaborative on Medical Home, the Family Liaison Specialist and the Family Advisory Council. Organizational leadership for the Medical Home Initiative in NC is housed within the Specialized Services Unit of the Children and Youth Branch in the North Carolina Division of Public Health. Many of the members of the Medical Home Initiative were involved in the ECCS planning process and helped shape the ECCS Plan of North Carolina.

Social-Emotional Development

North Carolina does not have an Infant Mental Health Association, and following a major reorganization, the North Carolina Division of Mental Health is focusing its attention on children and adults with complex and severe mental health issues. While no other statewide organization provides leadership in the area of social-emotional development for infants and young children, the Children and Youth Branch within the NC Division of Public Health is developing an initiative that is addressing that gap. The Developmental Screening and Behavioral Health Training Program for Infants and Young Children is designed to provide training for pediatricians and family physicians and will build on models that have been piloted successfully in two communities in North Carolina. As part of the development of the Program, the Children and Youth Branch is creating an organizational structure (Advisory Consortium) that will include new providers, experienced providers from the pilot projects and other interested stakeholders, including ECCS staff (clinical psychologist with a special interest in young child mental health). The consortium will provide the link to the ECCS implementation grant program for the purposes of accomplishing shared goals related to social-emotional development.

Parent Education

The North Carolina Parent Education Network (NCPEN) is a collaboration of parenting education organizations and agencies in North Carolina. North Carolina Division of Public Health staff responsible for the Fatherhood Initiative and the Parent Education Program serves in a leadership position in NCPEN. The Network is working to build the field of parenting education in the state with a focus on partnerships between parents and child care providers, teachers and parent educators. Members of NCPEN were part of the ECCS planning process and are interested in continuing to work together during the implementation phase. Strategies included in the ECCS Plan address shared goals related to funding parent education services for all children and families and ensuring best practices among parent education providers in the state. The ECCS staff and the ECCS Consortium will also work with parent education programs that are not under the NCPEN umbrella.

Family Support

A number of agencies (public and private) provide a range of services designed to assist families and caretakers to optimally provide for the health, social-emotional and developmental needs of young children. Organizations include the Exceptional Children's Assistance Center, the Family Support Network of North Carolina, the Family Resource Centers and Family Support Programs within the NC Division of Social Services, the North Carolina Family Resource Coalition and a number of services and programs within the North Carolina Division of Public Health, including services provided by the Family Liaison Specialist and the Family Advisory Council, the Child Service Coordination Program, the Maternal Care Coordination Program, etc. Services are wide-ranging and vary by program and by funding source. While there is the potential for a confederation or collaboration of family support organizations in North Carolina, there is really no single structure in place that serves that function. The lack of a single lead organization or a collaborative structure for family support programs presents a challenge for the ECCS implementation process. An initial step during the implementation period will be to try to address the need for an effective collaborative structure. While that is underway, the ECCS staff will rely on the Family Liaison Specialist and the Family Advisory Council to address goals related to family support.

Early Care and Education

The North Carolina Partnership for Children (Smart Start), the North Carolina Division of Child Development and the Governor's More at Four Pre Kindergarten Program maintain a strong collegial network that leads most, if not all, efforts to improve the early care and education system in North Carolina. The leadership in those organizations played key roles in the ECCS planning process, and the network will be a core partner in the ECCS implementation period. The network has links to Early Head Start, Head Start, Migrant Head Start, Title 1 and Even Start and the North Carolina Preschool Service for Children with Disabilities Program. ECCS staff and the ECCS Consortium will maintain the link to the early care and education leadership network as well as the Early Intervention Program and Preschool Services within the Department of Public Instruction during the ECCS implementation period in order to accomplish the goals outlined in the ECCS Plan.

For strategies related to the Healthy Child Care America Objectives, the ECCS staff will work with the Child Care Health Consultant in the Division of Public Health and the Healthy Child Care Initiative (a collaborative effort developed by the Divisions of Public Health and Child Development and the UNC School of Public Health). Healthy Child Care NC activities are based on a public health, population-based model under the leadership of the state-level child care health consultant. The state-level Child Care Health Consultant is responsible for leadership in policy development, planning, implementation and evaluation of childcare health services in NC. She provides training, consultation and technical assistance at the regional and local level in order to meet the objectives of the Healthy Child Care America grant (quality through standards, infrastructure building, and access to medical homes and health insurance through early care and education providers).

Selected Strategies for Goal #7
<p>Medical Home Promote/provide training for a universal developmental surveillance model (identify all children pre-natal or at birth) that includes a role for primary care providers.</p>
<p>Encourage all providers who serve young children (social service agencies, early care and education providers, pediatricians, family physicians, pediatric dentists, hospitals, schools, early intervention programs, child care health consultants, Child Service Coordinators, home visiting programs, mental health and substance abuse providers, etc.) to incorporate the expectation that children have a medical home into their practices and program standards. Develop outreach to appropriate providers to explain advantages of a medical home and to strengthen links/communication between medical home and providers.</p>
<p>Link primary care providers to child care providers and community resources.</p>
<p>Consider a common and simultaneous enrollment into all programs.</p>
<p>Address barriers to a medical home for those who can't pay for medical care.</p>
<p>Address operational obstacles to being/becoming a medical home.</p>
<p>Continue to use Community Care of North Carolina model to develop professional champions to promote best practice expansion, including effective developmental surveillance that includes social-emotional development, providing anticipatory guidance, etc.</p>
<p>Make sure all public and private health insurers cover the critical components of a medical home to increase provider capacity to provide medical homes.</p> <p>Action Steps</p> <ul style="list-style-type: none"> • Identify clinical components of medical home that are essential and expand the benefit package for Medicaid, HealthChoice and all private payors to require reimbursement for the essential components (e.g., care coordination, extended office hours, on-call providers for nights, weekends and holidays, clinical expertise, routine provision of preventive health care practices). Endorsement of those components by professional bodies such as AAP and American Academy of Family Physicians should be made to CMS. • Demonstrate cost effectiveness of providing essential components in projects

<p>funded by Division of Public Health. For example, link care coordination to decreased service duplication, decreased use of emergency department, and increased compliance.</p> <ul style="list-style-type: none"> • Provide an analysis of the link between “medical homeness” and return on investment; can then add components and show additional return on investment. Use scales for accessing “medical homeness” that have been developed • Advocate for an all insurer requirement by commissioner of insurance. • Cover undocumented population and eliminate the 5-year waiting period for child health insurance for legal aliens. • Reimburse for the disproportional share of resources required by children with more complex needs. • Identify most significant concerns parents have regarding their child’s health and development and determine how well those needs are being addressed.
<p>Develop registry or tracking to follow child to receipt of all services and demonstrate effectiveness of providing a medical home. Check if this exists in other states.</p> <p>Action Steps</p> <ul style="list-style-type: none"> • Get vital records to use the common name algorithm for newborn registry (Division of Medical Assistance already uses it to track service use); get commitment over next year for all DHHS agencies to sue this ID#. • Work with lawyers to address potential privacy issues; begin working now with DHHS Information Technology group and Institute of Government. • Make sure identification/tracking is used on all screening; two year process. • Get info from Division of Medical Assistance and insurance commission to compare child with and without a medical home. (6 month process to put system in place). • Look at how degree of “medical homeness” affects service utilization and outcomes (service utilization can be looked at yearly, outcomes will be tracked over 2-5 years to see impact). • Analyze cost of services once utilization rates/patterns are understood and link to outcomes.
<p>Develop a map of transition points in service system; connect for continuity of care.</p> <p>Action Steps</p> <ul style="list-style-type: none"> • Understand complexity of the current systems and create a visual to use in planning. Develop flow charts of a child who is normal/well and a child who has a premature/chronic condition/CSHCN. Illustrate medical, insurance, behavioral, social, educational and early care “touches.” • Ensure smooth transitions/handoffs between major systems for children. Typically no contact is required unless there are problems, but we can look for opportunities for prevention. Address the void in medical contacts between the 18-month checkup and the kindergarten checkup. • Change financial eligibility for Medicaid to maintain eligibility for services to 185% poverty through age 5, rather than decrease as child ages. Explore other states’ approaches to family insurance and benefits for CHIP and commercial payors. • Increase eligibility of CHIP to 250% of poverty.

<p>Family Support/Parent Education</p> <p>Acknowledge the need for leadership and collaboration to provide cohesive family support and parent education services to all families in NC.</p> <p>Action Steps</p> <ul style="list-style-type: none"> • Joint strategy sessions among planning groups at state and local levels such as Institute of Medicine’s Task Force on Prevention of Child Maltreatment; Domestic Violence Child Well-Being Task Force, NCPEN, Early Learning Begins at Home, resource and referral lines, etc. • Catalogue other activities.
<p>Create a common, shared definition of parent education and family support across agencies and communities.</p> <p>Action Steps</p> <ul style="list-style-type: none"> • Develop a collaboration structure at the state and local level that includes cross-training, education of staff, definition of family support and parent education for adoption by state agencies and nonprofits, funders, parents, and identify leadership to get messages across the state.
<p>Address the need for funding for family support and parent education services for all children/families, including fathers and grandparents.</p>
<p>Determine and promote the most effective practices for strengthening families and ensuring child safety and well-being, including prevention and life cycle approaches.</p> <p>Action Steps</p> <ul style="list-style-type: none"> • Catalogue effective practices, define and disseminate. Model after Institute of Medicine’s process to identify best practices in prevention of child abuse and neglect. • Tie funding to use of most effective practices. • Provide opportunities for groups to offer their best practices with evidence. • Develop a consultation model to show people how to use these. • Agree to create a “laboratory” for using best practices and adult education models for training parents and providers. • Promote expectation of Parent Education credential. • Monitor and evaluate common outcomes.
<p>Encourage individual organizations to include effective family support and parent education in their strategic plans. Work toward a common mindset and language for family support and parent education imbedded in program philosophy.</p>
<p>Encourage funders to only fund programs that include family support and parent education components.</p>
<p>Social-Emotional Development</p> <p>Systematize prenatal and ongoing psycho-social assessments for mothers and fathers and others who will nurture and care for young children and triage people into supports that meet their needs. Including but broader than depression screening.</p>

<p>Increase the community’s capacity to provide a continuum of effective mental health services to infants, young children and parents/caregivers. Increase capacity for primary prevention services as well as those designed for secondary prevention and treatment.</p> <p>Action Steps:</p> <ul style="list-style-type: none"> • Promote the development of an Infant Mental Health Association in NC • Convene a statewide forum on early childhood mental health • Expand Medicaid policy to include specific diagnoses and treatment for infants and young children.
<p>Provide all infant/toddler child care programs and other early childhood environments with access to mental health training, consultation and support.</p>
<p>Provide agencies serving young children at increased risk for social-emotional problems with access to mental health training, consultation and support.</p>
<p>Provide primary care settings with access to mental health training, consultation and support.</p>
<p>Address the needs of children in Child Protective Services and foster care regarding social-emotional development.</p>
<p>Promote psychosocial screening of parent/caregiver; child relationship and functioning as a part of developmental surveillance.</p>
<p>Continue negotiations with the Infant Mental Health Training Program at Tulane to create a distance learning training model for NC.</p>
<p>Promote the inclusion of early childhood mental health principles and relationship-based service strategies into pre-service and in-service training for physicians, early intervention professionals, early care and education providers, and mental health professionals.</p>
<p>Include a measure of social-emotional development in the Kindergarten Health Assessment and in other school readiness screening tools.</p>
<p>Early Care and Education</p> <p>Coordinate with state Child Care Health Consultant to accomplish Healthy Child Care America objectives (quality through standards, infrastructure building, and access to medical homes and health insurance through early care and education providers).</p>
<p>Fully develop/expand the role of Child Care Health Consultants to include consultation regarding social-emotional development.</p> <p>Action Steps</p> <ul style="list-style-type: none"> • Engage experts (childcare health consultation); • Make sure adequately trained to do developmental surveillance and to support teachers.
<p>Explore reimbursement mechanisms for services provided by Child Care Health Consultants.</p>
<p>Promote a universal developmental surveillance model that includes a role for Early Care and Education providers.</p>
<p>Emphasize the concept of Early Care and Education settings as a place for strengthening families and preventing problems and as a platform/connector to other important services for children and families.</p>

Address the workforce development issues in early care and education by supporting the work of the Division of Child Development, the NC Partnership for Children, the professional development consortium in NC, and others. This includes developing a coordinated staff development/training/technical assistance (work force development) model for early care and education providers.
Increase the number of well-trained early care and education providers by providing incentives for training.
Participate in the development of Infant Toddler Standards (DPI & DHHS initiative) to encourage inclusion of activities that would support the development of an integrated, comprehensive early childhood system, i.e., connection to medical home, family support, parent education and social-emotional services.

North Carolina’s ECCS Plan: Organizational structure for Implementation Phase

The ECCS Implementation grant will be managed in the Children and Youth Branch of the Women’s and Children’s Health Section (NC Division of Public Health/Department of Health and Human Services). Since grant funding for the ECCS program supports one position, our capacity to carry out implementation activities is a function of the Department of Health and Human Service’s willingness to invest in system-building as a means toward improving outcomes for young children and the ECCS team’s ability to develop and/or enhance cross-system relationships necessary to achieve common goals and bring relevant resources to the table.

Fortunately, there is ample evidence for both conditions from the planning phase of the ECCS grant program. In 2004 the Division of Public Health obtained the support of DHHS Secretary Carmen Hooker Odom to use the Early Childhood Comprehensive Systems grant as a core vehicle for increasing coordination and collaboration within and outside the department with respect to early childhood issues. Key government and non government stakeholders participated in all phases of the planning process and are committed to continuing system-building efforts in the implementation phase. The DHHS Children’s Services Advisory Committee was charged to address children’s issues throughout the department and chose to focus its initial attention on early childhood systems issues. The ECCS planning process included an intentional link to this policy-level committee, and there is a commitment to continue the relationship throughout the implementation phase of the grant program. Several WCHS staff are members of the Children’s Services Committee, which is chaired by an assistant secretary of DHHS.

The ECCS team addressed several significant obstacles to its system-building agenda in the early phase of the planning period. The most difficult obstacle was related to the discomfort associated with the addition of a new voice to well-established early childhood discussions in North Carolina and doubts that the new voice would bring anything useful to the table. Other obstacles included concerns that the ECCS grant would replicate efforts of existing work groups, task forces, and projects; doubts that the ECCS process would ensure meaningful input from local communities and skepticism that the planning process would lead to policy change to support school readiness. See

the Planning Process section below for more details. The ECCS team addressed all of these obstacles, and the ECCS grant program is now seen as an important opportunity to make significant progress toward building an integrated and comprehensive early childhood system for children and families. Stakeholders signed a joint declaration of commitment to the implementation phase of the ECCS grant program.

The ECCS management team within the Women's and Children's Health Section will consist of the ECCS Grant Coordinator who is a clinical psychologist with expertise in young child mental health; the Program Manager for the Specialized Services Unit who is a nurse with expertise in children with special health care needs and the medical home concept; the Branch Head for the Children and Youth Section who is working collaboratively with several organizations (NC Pediatric Society, UNC School of Public Health, Division of Child Development, etc.) on issues related to early childhood systems; the Section Chief for the Women's and Children's Health Section, a physician with expertise in women's health issues and administrative responsibilities at the Division and Department levels. We will also invite a staff member from the Women's Health Section to join the ECCS team in effort to add the maternal health perspective to the early childhood system-building initiative.

Abbreviated ECCS Implementation Schedule for next three years

The Implementation Schedule for the next three years essentially includes the following phases:

No cost extension July 1, 2005 – August 31, 2005

Main goals:

- Create ECCS Consortium modeled after the ECCS Think Tank and agree on roles, plan for accomplishing tasks, and schedule;
- Confirm roles for all members of ECCS team within Division of Public Health;
- Define working relationships with organizations that have taken the lead on the critical components of a comprehensive early childhood system;
- Refine priorities, strategies and action steps in a series of meetings with those organizations;
- Extend contract with neutral facilitator for Consortium meetings;
- Establish mechanisms to continue "Voices from the Field" process and connection to policy-level decision makers;
- Continue environmental scanning activities and report changes to all stakeholders.

Year 1 September 1, 2005 – August 31 2006

Main goals:

- Work simultaneously on all goals outlined in the current Implementation Plan;
- Evaluate progress at 4 month intervals;
- Report progress to all stakeholders;
- Adjust Plan, strategies and action steps as necessary.

Year 2 September 1, 2006 – August 31, 2007

Main goals:

- Continue to work simultaneously on all goals outlined in Implementation Plan as revised throughout implementation period;
- Evaluate progress at 4 month intervals;
- Report progress to all stakeholders;
- Adjust Plan, strategies and action steps as necessary.

Year 3 September 1, 2007 – August 31, 2008

Main goals:

- Complete work on all goals outlined in Implementation Plan as revised throughout implementation period;
- Evaluate progress at 4 month intervals;
- Report progress to all stakeholders in a final report;
- Adjust Plan, strategies and action steps as necessary;
- Develop next steps following implementation period.