Create the Context for Healthy Children and Families through Policies

Chapter 6

Guided by the Social-Ecological Model of Child Maltreatment described in Chapter 2, the Task Force examined state- and agency-level policies and how they may influence and promote safe, stable, and nurturing relationships and environments for North Carolina's children. Goal 4 of the Centers for Disease Control and Prevention's (CDC's) Essentials for Childhood Framework focuses on the development of policies to ensure children lead healthy and safe lives. Involvement of both the public and private sectors is essential for policy development. Policy stakeholders may include legislators, state and local health departments, media, business leaders, schools and child care providers, faith-based organizations, and community organizations. The Task Force identified several areas in which policy approaches can enhance child development and educational success, reduce risk factors for child maltreatment and adverse childhood experiences, and improve families' economic security and job opportunities.

Early Child Care and Education

Early childhood is a key developmental period, with infants, toddlers, and preschoolers rapidly acquiring new knowledge, developing skills and language, and making new neuronal connections. Stimulating environments with stable and nurturing relationships can improve brain development and language acquisition, in contrast to environments in which children experience toxic stress and the accompanying adverse effects.[1,2]

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A broad research base has taught us that infants acquire a range of abilities related to language, human interaction, counting, spatial reasoning, causality, and problem solving. There is some data to support specific types of stimulation for infant development in some areas. For example, preschool language skills and vocabulary size have been related to the amount that parents talk to infants and young children.[3]

Speech qualities including explaining, giving choices, and listening are more predictive of language development than sheer volume of talking.[3] In a large study of 5 year olds followed over time, vocabulary comprehension at age 5 ranged from that of a typical 2 year old to that of a typical 10 year old, and these differences persisted over time.[4] One study demonstrated that 5 year old children of low socioeconomic status (SES) had lower language test scores and lower development of a brain region highly involved in language known as Broca's area.[5] The authors postulated that it was not SES per se that 'caused' Broca's area to be less developed, but that this was due to decreased opportunities to learn. Children of low SES backgrounds may have fewer such opportunities in early childhood. As children's academic success at age 5 serves to predict future academic achievement, early care and education provide key opportunities for intervention.

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High quality, center-based care can augment the social and developmental nurturing provided in the home, and improve school readiness and future academic and workplace success. This is particularly important for low-income families that may not have the same resources or skills to provide an enriching academic home environment. For example, families with low socioeconomic status have been shown to have fewer children's books in the home.[6] However, high quality child care is in short supply in many communities and the cost of high quality, center-based care may be prohibitive to many families. Though many poor and near poor families may be eligible for child care subsidies, subsidy wait lists preclude many needy families from the opportunity for high quality, center-based care. The Task Force determined that both improving the quality of center-based care and improving access to this care were key priorities for North Carolina's children and families.

Second to the home, the early care and education environment is the place where children ages 0-5 spend the most time. In 2011, approximately 24% of children ages 0-5 were enrolled in licensed care in North Carolina in any given month. Many more children spend some portion of the year moving in and out of care as parents' work schedules change.[a] Nationally, 83% of children spend some time in non-parental care or education arrangements and 64% of children spend some time in formal early care or education the year before kindergarten.[7] Because so many young children spend time in formal child care or preschool arrangements, these settings are important opportunities for learning, nurturing, and early brain development.

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Early care and education settings are able to influence children's development through nurturing and stimulation. For example, the state can set caregiver ratios, teacher education requirements, a behavioral support system, and a curriculum in center-based care. The state can also set criteria for quality ratings that focus on social and emotional development, language acquisition, and teacher/child interactions. The Task Force examined the current quality rating system in North Carolina and focused on policy recommendations around improvement and enhancement of this system.

Research on Early Care and Education

There has been substantial research on the impact of high quality child care programs on early childhood development and academic success. The sentinel studies, the Perry Preschool Project, the Abecedarian Project, and the Head Start Impact Study merit special attention.

The Perry Preschool Project randomized 123 low-income African-American children in Ypsilanti, Michigan in high quality center-based care or control conditions (usually home or relative care). Children have been followed through age 40. Children who were in centered-based care were enrolled in

a Pat Hansen, MPH. Project Manager, Shape NC, The North Carolina Partnership for Children, Inc. Email communication. January 18, 2013

full-time child care for two years from approximate ages 3-5. Most teachers had a master's degree and all had completed training in child development. There were no more than 16 children in a class and two lead teachers as well as a teacher's assistant. The preschool classes followed one of three specific theory-based curricula. Children were matched on gender, intelligence quotient (IQ), and socioeconomic status. The average IQ for children in both groups when starting the study was 79. The IQ for children in the treatment group rose to 102 (control 83) after one year in the preschool and was 92 at age 10 (controls 85). As adults, children who participated in the preschool program have higher incomes, are more likely to have jobs, more likely to have completed high school, and have committed fewer crimes than those in the control group.[8]

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The Abecedarian Project followed four cohorts of children enrolled in full-time early care and education from ages 0-5 in Chapel Hill, North Carolina. Children had individualized educational programs and low teacher ratios. The curriculum focused on education as play in the curricular areas of social, emotional, and cognitive development, with a special emphasis on language skills. Children were followed through age 21. Children in the intervention group had higher IQs starting as toddlers through age 21, higher academic achievement in reading and math through young adulthood, were more likely to attend college, and were more likely to have their first child at a later age. Not only are the results of this program impressive for the young children, but mothers of intervention preschoolers were more likely to go further in school and have better employment than controls.[9]

The Head Start Impact Study was a large scale attempt to evaluate the Head Start national program that serves many low-income children. In the 2012-2013 academic year, 1,130,000 children were served by Head Start for at least some time during the year. Head Start serves mostly 3 and 4 year olds from low-income families.[10] The Head Start Impact Study included 4,667 newly entering 3 and 4 year olds. There were modest gains over the course of the year in cognitive and socio-emotional development; however,

findings generally did not persist beyond the Head Start year. This study highlights real world challenges of large scale implementation of early care and education. Compared to the smaller Abecedarian and Perry Preschool projects, the quality was less consistently high. In the Head Start Impact Study, 70% of children were in high quality programs, 60% with curriculum that emphasized language and math, and 60% of children had teachers with an associate's degree or bachelor's degree.[10]

The sum of evidence from these and other studies on formal early care education indicate that earlier child care (ages 0-2) has more short- and long-term impact on cognitive development and school performance. Furthermore, full-time child care, longer-term child care, low teacher ratios, high quality, specific curriculum emphasizing math and literacy, and higher teacher education all support school readiness and long-term academic success.

Quality of Care in North Carolina

Since 1999, North Carolina has used a star rating system to rate child care quality. All licensed child care programs received a star rating from 1-5 stars based on program standards and education standards. The program standards are rated using an observation scale [Early Childhood Environment Rating Scale (ECERS), Infant/Toddler Environment Rating Scale (ITERS), and Family Child Care Environment Rating Scale (FCCERS)]. These rating scales include observations of sufficient space, variety of play materials, clean and comfortable play area, interactions between adults and children, interactions between children, and interactions of children with activities and material. The education standards component of the star rating includes education and experience of lead administrators and the level of education and experience of classroom teachers.[11]

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The rating system was significantly revised in 2005. Since moving to a more rigorous system in 2005, most licensed facilities have improved in quality and are now licensed as 4 or 5 star centers or family child care homes (see Table 7.1).

Figure 7.1
North Carolina Child Care Program Star Ratings[11]

	Center (Number/%)	Home (Number/%)
*	85 (2%)	390 (16%)
**	37 (1%)	282 (11%)
***	946 (20%)	748 (30%)
****	1,153 (24%)	716 (29%)
*****	1,929 (41%)	326 (13%)
Other[b]	570 (12%)	12 (1%)
Total	4,720	2,474

Child care programs include licensed child care centers and family child care homes.[c]

Subsidies

Child care subsidies are administered through a local agency, often a department of social services. The subsidies are from a combination of state and federal funds and are administered based on a legislatively determined allocation formula. If a local agency has more eligible applicants than funds allow, the local agency can establish priorities for allocation of funding. Parents are allowed to use the child care subsidies to support their needs for child care in any arrangement that is most appropriate for their family, so long as the child care service provider accepts subsidies. Regulated care must be of 3, 4, or 5 star quality to receive child care subsidies. Child care subsidies are only available to families that meet situational and income criteria. Families must meet one or more of the following: parents working, looking for work, or in a job training program; children receiving child protective services or child welfare services; or children have an identified developmental need.[12]

b Other ratings include those which have probationary, provisional, religious, special, and temporary permits.

c Pat Hansen, MPH. Project Manager, Shape NC, The North Carolina Partnership for Children, Inc. Written (email) communication. January 18, 2013.

In 2014, several changes were made to the subsidy eligibility requirements. The income limit for families with children 5 and under and children with special needs changed from 75% of the state median income (SMI) to 200% of the federal poverty guideline (FPG). For children ages 6-12, the maximum income limits changed from 75% of SMI to 133% of FPG.[13] In addition, beginning January 1, 2015, the child care subsidy eligibility requirements changed to include step-parents and non-parent relative caretakers (and non-parents' spouses and children, if applicable) in the accounting of the family "income unit" used to determine eligibility, if a child's parent does not live in the household.[d] These changes to the eligibility requirements have resulted in some children in relative care arrangements no longer being eligible for child care subsidies.[14]

There are currently approximately 398,000 children statewide (ages 0-11) who meet the eligibility requirements to receive subsidies.[15-17] However, available subsidies do not adequately meet the need. According to the Division of Child Development and Early Education's (DCDEE's) Subsidized Child Care Reimbursement System, in October 2014 (the last month for which data is available), 76,297 children in North Carolina received child care subsidies. There were an additional 29,806 children on the wait list.[18] Child care subsidies offer an opportunity for children who may be at risk for low school readiness to participate in high quality center-based care. Some counties have chosen to incentivize quality by offering higher subsidy rates to higher quality centers. One drawback to this approach is that it inevitably means there will be fewer subsidized child care slots without commensurate increase in resources. The Task Force concluded that the solution must focus on both increased quantity of care and better quality care. However, the Task Force emphasized that the ultimate goal is not to put more money into subsidies, but to improve families' financial independence, thereby decreasing the number of eligible families and children.

Child care subsidies offer an opportunity for children who may be at risk for low school readiness to participate in high quality center-based care.

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Workforce Development

A professional workforce is critical to the delivery of high quality child care. Credentials and ongoing training have been strongly associated with teacher quality and academic success in child care and early education. Training takes place in university and community college settings across the state. The quality star rating system incentivizes centers to encourage teachers to get ongoing education. However, only about half of child care teachers in North Carolina have a two or four year degree and many make minimum wage.[19] With low salaries and benefits, even for teachers with advanced degrees, it is hard for an individual teacher to justify ongoing education and investment in early childhood education as a profession.[20]

d North Carolina Session Law 2014-100.

The Child Care WAGE$ Project supports ongoing education, draws more highly-educated teachers to participating centers, and decreases teacher turnover by providing a salary supplement to teachers.

The North Carolina Child Care Services Association runs two important programs to support workforce development of teachers: T.E.A.C.H. Early Childhood Project and the Child Care WAGE$ Project. The Teacher Education and Compensation Helps (T.E.A.C.H.) Early Childhood Project is federally funded and provides a partial scholarship to child care teachers for college coursework in early education and provides a cash bonus upon completion. In return, the teacher commits to continued work in the field of early childhood education for 6-12 months depending on the scholarship. In 2011-2012, 3,831 teachers received T.E.A.C.H. scholarships.[21]

Funded by DCDEE, the Child Care WAGE$ Project supports ongoing education, draws more highly-educated teachers to participating centers, and decreases teacher turnover by providing a salary supplement to teachers based on ongoing education, center quality, and partnership with the local Smart Start. As a teacher advances his or her education, WAGE$ salary supplements increase.[22] Local Smart Start agencies are critical partners in these child care workforce development efforts.

In order to ensure higher quality and greater access to early child care and education for North Carolina's children, the Task Force recommends:

Recommendation 6.1: Ensure that Child Care Centers Provide a High Quality, Nurturing Environment (PRIORITY RECOMMENDATION)

Research shows that high quality early care and education is associated with better social-emotional development of children and less maltreatment. The Task Force on Essentials for Childhood strongly believes that the right answer is more AND better early care and education. The long-term goal in early care and education should be that all children from families who want early education can afford it and that it be of high quality. North Carolina should seek to maximize its investment in early care and education initiatives, and leverage federal and foundation resources to enhance the child care workforce and allow more children to attend high quality care and education programs.

a) The Division of Child Development and Early Education (DCDEE), in partnership with the Child Care Commission and the Department of Public Instruction Office of Early Learning, should continue to re-evaluate its quality star rating system and reimbursement system to identify high quality child care facilities based on updated evidence and best practices. As part of this work, DCDEE should revise the star rating system to include:

1) Criteria that consider the program's focus on learning to support children's social and emotional development, executive function, language skills, and health.

2) **Quality measures focused on teacher/child interactions and teacher education and criteria on continuous quality improvement.**

b) **DCDEE should work with the North Carolina Rated License Assessment Project to revise its policies and procedures for implementation of rating scale assessments to reflect these criteria changes.**

c) **The North Carolina General Assembly (NCGA) should enhance child care subsidies by:**

1) **Adjusting subsidy funding to increase percentage of eligible children receiving subsidies per year by 1% points.**

2) **Increasing subsidies for infant and toddler care, expanding both the number of available child care slots as well as improving access to and affordability of higher quality care.**

3) **Allocating additional recurring funding for child care subsidies and, in conjunction with DCDEE and the Social Services Commission, examining eligibility requirements including household income, employment/education, and redetermination periods in order to ensure children's continuity of care and allow parents to remain in the workforce, weather family transitions, and increase families' economic security without jeopardizing short-term subsidy eligibility.**

4) **Excluding the income of a "non-parent relative caretaker" from the definition of the family income unit so that grandparents and other extended family members can continue to care for their children and support their learning opportunities.**

d) **DCDEE, in partnership with the North Carolina Department of Public Instruction, Office of Early Learning and community stakeholders including child care resource and referral agencies, community colleges, Head Start, Smart Start partnerships, and child care providers, should continue to work towards adequate wages and/or wage support, benefits (especially health insurance), education and training, and career advancement opportunities to continue to grow a high quality and well-trained early care and education work force. DCDEE and partner organizations should:**

1) **Continue ongoing evaluation of professional child care workforce development on a bi-annual basis, using the Child Care Services Association workforce study evaluation model. Evaluation should provide county-specific data.**

2) **Allocate sufficient funding for statewide WAGE$ salary supplementation for eligible child care workers and other workforce development programs. Funding should also support targeted resources and technical assistance for the workforce, in order to improve early education quality, as well as a continuous quality improvement frame.**

Primary Care Screening for Psychosocial Risk Factors and Protective Factors

Within a primary care setting, particularly in prenatal and pediatric care, there is great opportunity to enhance screening for psychosocial risk and protective factors and identify children and families at greater risk for child maltreatment and those who may need additional resources to help them establish safe, secure, and nurturing relationships and environments. Research has shown that identifying children and families at risk for child maltreatment through the pediatric setting can reduce the rate of additional maltreatment among these families.[23] Parents' physical, emotional, and social health; social circumstances; and child-rearing practices are essential determinants of child health and well-being. It is in the interest of supporting that health and well-being that children's medical homes are invested in screening for psychosocial risk and protective factors and facilitating referrals to services when appropriate.[24]

Research has shown that identifying children and families at risk for child maltreatment through the pediatric setting can reduce the rate of additional maltreatment among these families.

As approximately 13-20% of children and adolescents in the United States experience mental and behavioral health issues, pediatricians play an important role in addressing behavioral health issues.[25] In one North Carolina study, researchers found that pediatric residents identified at least one psychosocial concern in nearly 40% of their pediatric patients.[26] Screening can provide an entry into conversation with parents about family risk and protective factors, regardless of whether the screen is positive or negative. When a screening indicates risk, next steps can include more specific secondary screening, connection to a mental health provider, case management, referral to community based-services and supports, or co-management of the problem.[e]

Using psychosocial screening to identify those in need of behavioral health services, and integrating behavioral health into primary care can also reduce health care costs for families and payers.[27] In addition, establishing screening practices for families and children also presents an opportunity for health professionals to discuss child development and parenting skills, to identify family strengths, and to identify areas in which improved early care and education can be beneficial, particularly for at-risk children.[28] As of January 2015, brief behavioral and emotional screening procedures are reimbursable under Medicaid and the North Carolina Health Choice Health Insurance Program for Children.[29]

The Task Force examined existing psychosocial risk and protective factor screening structures and identified policy approaches to address the importance of psychosocial screenings to increase child and family well-being.

Examples of Screening in Practice

Originally launched in 1990 by the Maternal and Child Health Bureau of the Health Resources and Services Administration, Bright Futures is a comprehensive

e Earls, M. Leading pediatric consultant, Community Care of North Carolina. Written (email) communication.January 24, 2015.

set of evidence-based guidelines and toolkits developed by pediatricians and child development experts. The guidelines are designed for use from the prenatal period through age 21, in order to improve health care quality and outcomes for children.[30] Bright Futures encourages a community approach to health and acknowledges the importance of healthy parents, families, and environments in promoting healthy children.[31]

The Bright Futures model encourages pediatricians to use several screening tools during their child health visits. These tools include developmental screenings for children, maternal depression screening, and pediatric behavioral and psychological assessments.[30] The Bright Futures guidelines recommend screening mothers for depression at baby's 1, 2, and 6 month visits. The Affordable Care Act mandates that all private insurance plans (except for those that are considered "grandfathered plans") must provide coverage of the Bright Futures clinical preventive services for infants, children, and adolescents without any cost sharing. Bright Futures also encourages the routine application of these screenings, use of anticipatory guidance to approach safety and health issues, and the establishment of a medical home for children and families, in order to promote continual, high-quality preventive care and integration with other services.[32]

Bright Futures encourages a community approach to health and acknowledges the importance of healthy parents, families, and environments in promoting healthy children.

The Safe Environment for Every Kid (SEEK) parent screening questionnaire is one of many screening tools used by Bright Futures to identify families at risk for child maltreatment or other problems. It asks parents and caregivers about general home safety practices and several common family stressors, including financial problems, child's behavioral problems, parental depression or mental illness, substance abuse, and domestic violence.[33] The questionnaire is a component of a larger comprehensive model of pediatric primary care. The SEEK model also utilizes expanded health professional training, motivational interviewing, additional parent engagement, integrated behavioral and mental health care, and direct services to children and families in need of additional help. Additional screening tools include the Kemper-Kelleher screen, which includes questions about the parents' childhood experiences with risk factors, as well as current experience with depression, substance abuse, and social support systems. The Survey of Wellbeing of Young Children (SWYC) includes questions about substance use (including tobacco), food availability, depression, and domestic violence. The Edinburgh screen is used to identify postpartum depression.[f] The Strengthening Families approach also provides a potential tool for protective factor screening; this tool asks parents about their feelings toward child care responsibilities and challenges, as well as their general outlook on parenting and life events.

Launched in 2011, Community Care of North Carolina's (CCNC) pregnancy medical home model provides a useful example of psychosocial risk factor

f Earls, M. Leading pediatric consultant, Community Care of North Carolina. Written (email) communication. January 24, 2015.

screening in an obstetric care setting. The CCNC pregnancy medical home is a partnership between the Division of Medical Assistance (DMA), Division of Public Health (DPH), CCNC, and other state maternity providers. The program provides case management to Medicaid recipients with medical or psychosocial risks to their pregnancy. Women are served by case management during their pregnancy and afterwards until 60 days postpartum. The pregnancy medical home consists of an obstetrician or primary care provider who works with a care manager (nurse or social worker) to coordinate the patient's care. The project's primary goals are to improve birth outcomes, increase quality of maternity care, and reduce costs of health care in the Medicaid population through healthier babies. Over 1,600 providers in 380 practices participate in the CCNC pregnancy medical home.[34]

CCNC's pregnancy medical home model provides case management to Medicaid recipients with medical or psychosocial risks to their pregnancy.

Work is also being done with the CCNC pregnancy medical home to develop systems for routine communication between the obstetric care managers and care managers with Care Coordination for Children (CCNC's population health management program for at-risk infants and children) regarding infants at risk of toxic stress due to maternal risk factors (depression, substance use, domestic violence, homelessness), as well as communication with the infant's medical home.[35] Sharing patient information between providers, while keeping within the confines of privacy laws, can improve the quality of care for patients as well as reduce unnecessary costs.

The Assuring Better Child Health and Development (ABCD) Program, launched in 2000 and initially sponsored by the Commonwealth Fund and the National Academy for State Health Policy, is a quality improvement initiative that has successfully developed and maintained a system of implementation for developmental and autism screenings within pediatric care. ABCD works through the CCNC network and utilizes a state advisory group made up of representatives from key agencies and convened by the Office of Rural and Health and Community Care.[28,36] ABCD is also supported by some local Smart Start partnerships and has received additional Race to the Top funding since 2012, allowing it to expand statewide. The Race to the Top expansion project is led by the North Carolina Partnership for Children and implemented regionally in close collaboration between CCNC, Smart Start local partnerships, and early intervention agencies.[g] North Carolina was found to be successful in implementation of screening practices, with 90% of primary care practices implementing screening procedures, and 85% of Early and Periodic Screening, Diagnosis, and Treatment claims including age-appropriate developmental screening.[37]

While ABCD's original focus was on developmental screening for children, lessons learned from the success of the project have been applied to increase

g Oberleithner, A. Health and family support program officer, Smart Start. Written (email) communication. August 24, 2014.

psychosocial screening as well. Successful components of the ABCD model include the use of care managers, application of data collection and evaluation techniques to inform quality improvement, integrating screening and surveillance into the office workflow, and identifying community supports and referral partners for additional behavioral health needs (including Head Start, home nurse visiting programs, community mental health services, and family support groups).[37] ABCD aims for practices to help parents learn more about developmental milestones and age-appropriate behavior, which can benefit all families, not just those families identified as needing additional services.

Integrated Care

An inherent challenge in the expansion of screening for psychosocial factors within the primary care setting is a potential lack of behavioral and mental health services for those patients identified as high risk. Communities may lack the resources to provide adequate services, or stigmatization of mental illness or substance abuse may decrease patients' willingness to seek out or participate in services. Behavioral and mental health services may also be cost-prohibitive for many families. Integrating behavioral and mental health with primary care has been associated with improved quality, improved outcomes, improved patient and provider satisfaction, and decreased cost.[38] The quality and consistency of treatment in primary care settings, and the integration with referral specialty services for behavioral health care, are essential to improved behavioral health treatment for children and families.

Integrating behavioral and mental health with primary care has been associated with improved quality, improved outcomes, improved patient and provider satisfaction, and decreased cost.

Integrated care refers to either the delivery of behavioral and mental health and substance abuse services in a primary care context, or the delivery of primary care in behavioral health care settings (sometimes referred to as reverse integration or reverse co-location). The Task Force recommendations around integrated care generally apply to integrating behavioral health care into pediatric, family medicine, and obstetric primary care settings.

The American Academy of Pediatrics has recently called for increased access to mental and behavioral health services for children, specifically through integrating mental and behavioral health services into the pediatric setting.[39] In a fully integrated system, the relationship with the provider is continuous (as with primary care), although the episodes may be time limited. For example, a patient in a primary care setting may have episodic depression during times of stress, and may occasionally need care by a behavioral health specialist. The behavioral health specialist in the integrated setting has an ongoing relationship. Because pediatric health providers often have strong, ongoing relationships with children and families, there is an opportunity to use the fundamental skills of these providers to identify and address children's and families' mental and behavioral health needs.[39]

Common strategies of high quality, successfully integrated care include: active management by a primary care clinician, collaboration with a mental health professional, adherence monitoring, treatment response assessment using a

symptom checklist, active support for patient self-management skills, and integrated treatment lasting at least 16 weeks.[40] Mental and behavioral health treatment for children and adolescents may include interventions such as cognitive behavioral therapy, case management, home-based interventions, and other family-focused treatments, which have been shown to be particularly effective.[39]

In the pediatric setting, integrated care may help prevent lost costs due to absenteeism of parents with children in need of mental health services.

Such integrated care has also proven cost effective. Because the management of behavioral health conditions accounts for as much as half of the time of primary care clinicians, integrated care can ensure that the right provider cares for the right condition at the right time. A meta-analysis of 57 studies showed an average cost savings of 20% with integrated care.[27] In the pediatric setting, integrated care may have the additional advantage of helping prevent lost costs due to absenteeism of parents with children in need of mental health services.[39] Close collaboration or full integration can still take place even if there are few behavioral health specialists available in a community. This can occur through the use of available part-time behavioral health specialists, consultations with behavioral health providers, or the use of tele-behavioral health.

The current discussion around Medicaid reform in North Carolina represents an opportunity to invest in integrated care in our state. Specifically, the Governor's proposed plan for Medicaid reform recognizes both the improved quality and potential for cost savings with integrated care. Accountable Care Organizations can choose to invest in primary care-behavioral health integration as a means of improving health outcomes and lowering overall health care costs.[41] However, there is currently no requirement for integrated care. As the Medicaid reform proposal is reviewed by the North Carolina General Assembly and implemented, partners involved in primary care such as Community Care of North Carolina and experts in integrated care such as the North Carolina Center of Excellence for Integrated Care should work with policymakers and DMA to best support the delivery of integrated care and the technical challenges of such integration in pediatric and obstetric practices.

The Task Force recommends:

Recommendation 6.2: Enhance Care and Reimbursement Standards to Promote Children and Families' Mental Health (PRIORITY RECOMMENDATION)

a) Community Care of North Carolina (CCNC), should work with the North Carolina Division of Public Health (DPH), the Division of Medical Assistance (DMA), the North Carolina Pediatric Society, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), the North Carolina Medical Society, and the North Carolina Academy of

Family Physicians, to establish guidelines for primary care clinicians for expanded screening of families with children for psychosocial risk factors and family protective factors, using Bright Futures as a model. Guidelines should be applicable to all populations, regardless of payer. Expanded screening guidelines should include/address:

1) **Increased referrals, when appropriate, to existing mental health and social services, and improve care coordination and information sharing among health care (primary care and mental health) and social service providers.**

2) **Ongoing evaluation by DMA, including frequency of and intervals between implementation, quality of existing mental health and social services, and receipt of referred services.**

3) **Evaluation of payment policies to incentivize universal screening and services provided (prenatal, postnatal, children, new parents). DMA should explore the establishment of incentive structure for primary care providers who reach expected goals for screening (i.e. percentage of parents screened), assessment, referral, and treatment protocol for children and families, as well as development of a data collection process by which to track services and outcomes.**

4) **CCNC should ensure transfer of patient information from psychosocial risk screening done as part of pregnancy medical home to infants' pediatric medical provider and other medical services.**

b) **DMH/DD/SAS, DMA, the North Carolina Foundation for Advanced Health Programs, CCNC, North Carolina Pediatric Society, and the North Carolina Academy of Family Physicians should support current work to increase integrated behavioral health care under Medicaid reform. DMA and DMH/DD/SAS should build in methods to facilitate and establish integrated behavioral health within their practices (i.e. onsite mental health providers, social workers, etc.).**

Ensuring Economic Opportunity and Security for North Carolina's Families

There is a well-documented link between poverty and health outcomes. Poor children fare worse in almost every indicator of health, including birth outcomes, access to care, health-risk behaviors, and mortality. Through the recent recession, more than 160,000 children in North Carolina entered poverty for a total of more than half a million children in poverty.[42,43] In 2013, the percentage of poor children increased from 19.5% of the child population in 2007 to 24.9%—nearly one in every four children.[42] Poverty and financial stress have a negative impact on children's cognitive development, impair their

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ability to learn, and can contribute to behavioral, social, emotional, and health problems later in life. Poverty has also been associated with greater risk for child maltreatment, particularly neglect.[44,45] The risks posed by poverty are greatest among children who experience poverty during their earliest developmental years (before age 5), as well as those who experience persistent and deep poverty.[43,46] In contrast, increased household income during early childhood has been positively associated with better health outcomes, as well as higher wages and increased work hours once the child reaches adulthood.[47] Working to ensure economic opportunity and financial security for North Carolina's families and children is an investment that will reap great rewards.

Tax Policy

Over the last several years, as our nation and state has suffered the negative impact of a years-long recession, policymakers' focus has turned to exploring ways to achieve fiscal balance and advance economic opportunity for North Carolina. In 2013, the North Carolina General Assembly adopted several tax policy reforms. These reforms included a shift to a flat rate personal income tax of 5.75%.[48,49] The child tax credit was also changed from $100 per child for adjusted gross income under $60,000 to a progressive rate of $100 per child for adjusted gross income over $40,000 and $125 per child for adjusted gross income under $40,000.[50,51] The child tax credit was eliminated for households earning above $100,000.[51]

On both sides of the aisle, policymakers claim their policies will have the greatest benefit for the state, but broad, non-partisan analysis is necessary to understand the full scope of impact, particularly on low-income families.

The 2013 tax reform also removed the state earned income tax credit (EITC) for North Carolina's families. The state EITC was a small tax credit, on average $116 per year, for working low to moderate income families. Nearly one million families received the state EITC in 2011. The EITC was available to families earning between $38,000-$52,000 per year (based on marital status and number of children), with the greatest benefits to families earning between $10,000-$22,000 per year.[52] For very low-wage workers, the credit expanded with higher income, with the aim of encouraging greater work hours. The EITC is most often temporary assistance, with most recipients no longer eligible after one to two years, or after they have increased work hours and/or wages.

It remains unclear what affect these policies have had or will have on the economic security of North Carolina's families and children. On both sides of the aisle, policymakers claim their policies will have the greatest benefit for the state, but broad, non-partisan analysis is necessary to understand the full scope of impact, particularly on low-income families.

Higher Education and Workforce Development

Developing and maintaining a strong workforce is important in ensuring economic security for North Carolina's families. The Task Force examined programs which aim to assist individuals as well as businesses in developing skills and training necessary for job growth and workforce strength.

The North Carolina Community College System (NCCCS), a statewide network of 58 community colleges, is heavily involved with workforce development within their respective communities. SuccessNC is a planning initiative of NCCCS that aims to increase the percentage of students who transfer, complete credentials, or remain continuously enrolled from a six-year baseline of 45% in 2004 to 59% in 2014. SuccessNC has multiple components, including Career and College Promise pathways, which offers dual enrollment programs for high school students wishing to earn college transfer credit and technical education certification.[53] NCCCS also works with the North Carolina Department of Public Instruction (DPI) to administer the North Carolina High School to Community College Articulation Agreement, which provides opportunities for students to receive community college credit for proficiency in high school courses in the same subject.[53]

NCCCS works directly with business and industry to develop career training and job readiness programs tailored specifically to the businesses' workforce needs.

NCCCS works directly with business and industry to develop career training and job readiness programs tailored specifically to the businesses' workforce needs. Through the Customized Training Program, NCCCS focuses on job growth and productivity for local businesses. The program provides community college representatives who collaborate directly with local businesses to determine and coordinate the kinds of assistance they need. Offered services include training needs assessment, curriculum design and development, orientation development, and lab and computer training.[54] NCCCS also administers the Small Business Center Network, which provides resources and assistance for small business owners and employees, including business development, marketing, bookkeeping and taxes, and assistance with networking.[55] To this end, federal grant money has recently been allocated toward linking community colleges directly with business and industry associations and expanding on-the-job training through apprentice programs.[56]

Other innovative programs aimed at increasing college attendance and promoting economic security are also being implemented across the state. DPI, in partnership with North Carolina New Schools, the State Board of Education, North Carolina Independent Colleges and Universities, NCCCS, and the University of North Carolina, has invested in the early college high school initiative since 2004. The early high school college initiative establishes high school programs on the campuses of two- or four-year colleges, and allows high school students to simultaneously complete their high school education while also earning two years of transferable college credit or an associate's degree.[57] Many of the early college programs also partner with local employers to provide specified training, internships, and other exposure to career development.[58,59]

Many early college programs partner with local employers to provide specified training, internships, and other exposure to career development.

As of the 2013-2014 school year, there were 77 early college high school programs in North Carolina, serving more than 15,000 students, and with a combined graduation rate of 96.2%.[58] This program provides support for students during what is typically the most difficult part of a college program, particularly for low-income students, and also provides these two years tuition-free, helping

low-income students and others who are underrepresented in higher education gain a foothold in the education system and expand their future economic opportunities.[58] In November 2014, North Carolina New Schools received a $20 million federal Department of Education grant to expand their work on the early college initiatives. After raising matching funds in order to finalize the grant funding, North Carolina New Schools will be able to expand early college work by creating new stand-alone schools, applying strategies in traditional high schools, and working with other states to promote the early college model.[59]

The Task Force recommends:

Recommendation 6.3: Ensure Economic Security for Children and Families (PRIORITY RECOMMENDATION)

The North Carolina General Assembly (NCGA) should commission a non-partisan economic analysis of the impact of current North Carolina state tax policy on children and families, including impact on economic security, take home pay, and employment rates. This analysis could be conducted by the North Carolina Center for Public Policy Research, the Fiscal Research Division of the NCGA, or a similar non-partisan policy analysis firm. The NCGA should use findings from this analysis to inform future policies to address economic opportunity and security for families and children.

Recommendation 6.4: Enhance Career Training and Education Opportunities to Promote Economic Security for Families

The North Carolina Community College System and local education agencies should work with local industry to enhance career training opportunities consistent with the needs of local industry. These programs should apply best practices from apprenticeship models, job certification programs, and early college integrated programs.

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