



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

The North Carolina Department of Health and Human Services is seeking your input as a key stakeholder to an early draft of the North Carolina Early Childhood Action Plan. As you may be aware, the NC Department of Health and Human Services (DHHS) is spearheading the development of a **statewide North Carolina Early Childhood Action Plan**. The North Carolina Early Childhood Action Plan seeks to create a cohesive vision, set benchmarks for impact, and establish shared stakeholder accountability to achieving statewide goals for early childhood. The Action Plan is intended to galvanize departments, organizations, communities, individuals, and other entities from across the state to come together in support of improving early childhood outcomes.

The attached working draft of the Early Childhood Action Plan was created by a cross-agency team from DHHS, other state agency representatives, and several external content experts. The Action Plan builds on and borrows from the extensive work of the NC Pathways to Grade-Level Reading initiative led by the NC Early Childhood Foundation. You will also find the Early Childhood Action Plan Data Appendix that provides additional insight and transparency into the thinking that went into establishing goals.

It is important to note that the current draft does not yet include specific strategies to achieve the draft goals and metrics outlined in the Action Plan. Our intent is to first get feedback on goals and metrics and then begin to develop recommended interventions, policies and investments.

We welcome your input and ask that you send your feedback to [ECAP@dhhs.nc.gov](mailto:ECAP@dhhs.nc.gov) by 5PM on Monday, August 20. While your perspectives on any aspect of the draft will be appreciated, we especially hope for feedback on the following areas:

- Are there additional goals or metrics you think are critical to include as top priorities for the state? If so, please describe how the proposed goal is: 1) actionable, 2) impactful, and 3) measurable.
- For each goal, there are a set of proposed annual metrics. We believe that ultimately the metrics should be limited to three to five for each goal. Please comment on which metrics you would prioritize to keep.
- Are there other stakeholders you think need to be engaged in our next round of stakeholder feedback?
- What initial thoughts do you have about how your organization would like to actively engage in supporting the goals of the Early Childhood Action Plan?

If you have questions about the Early Childhood Action Plan, please feel free to reach out directly to Rebecca Planchard, Senior Early Childhood Policy Advisor for DHHS, at [rebecca.planchard@dhhs.nc.gov](mailto:rebecca.planchard@dhhs.nc.gov).

Thank you in advance for sharing your thinking with us, and for your continued support of North Carolina's young children and their families.

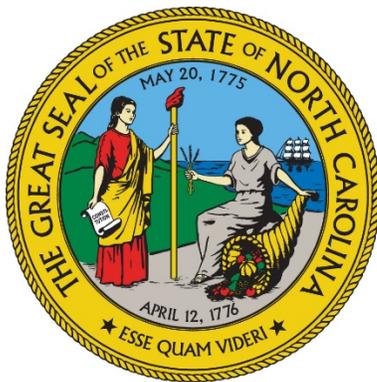
**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • OFFICE OF THE SECRETARY**

LOCATION: 101 Blair Drive, Adams Building, Raleigh, NC 27603  
MAILING ADDRESS: 2001 Mail Service Center, Raleigh, NC 27699-2000  
[www.ncdhhs.gov](http://www.ncdhhs.gov) • TEL: 919-855-4800

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# North Carolina Early Childhood Action Plan

*WORKING DRAFT*



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

**Last Updated: August 2018**

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- **GUIDING PRINCIPLES:** Our beliefs and commitments to be used throughout the development and implementation of the Early Childhood Action Plan
- **VISION:** A clear picture of the State of NC as a place where young children receive what they need to thrive, and broad aspirations for NC’s young children
- **2025 GOALS:** Measurable, child-level outcomes for young children by 2025
- **METRICS:** Ongoing measures of progress on outcomes for adults or service provisions that drive the child-level goals, reported annually
- **ACTIONS:** High-level intervention strategies
- **COMMITMENTS:** Investments or activities that show movement on the overall Action Plan
- **PROGRESS:** Annual dashboards or reports on metrics and goals

## Guiding Principles

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- 1. Brain and developmental science serve as the foundation for the Action Plan.**

Brains are built through children’s earliest experiences and through the environments around them. During a child’s first eight years, brain architecture is forming a foundation for all future learning, behavior and health. While positive experiences and environments can set up a child on a stronger life-long path, traumatic experiences or environments during those formative years can have long-lasting, detrimental impact.
- 2. Children and families are at the center of our work.**

A child’s family is the most powerful influence on their development and the single biggest predictor of their social, emotional and educational success in later life. Multi-generational interventions are essential.
- 3. Our Action Plan builds upon existing strengths and partnerships.**

North Carolina has a rich history of success and innovation in early childhood. The Action Plan builds upon existing efforts and promotes diverse participation, cross-sector collaboration, and partnerships with families and organizations that have worked to improve child and family outcomes.
- 4. Our goals for North Carolina’s young children are ambitious and achievable.**

Child development is a dynamic, interactive process that is not predetermined; it occurs in the context of relationships, experiences, and environments. It is possible to build resilience and healthy development by creating positive and protective factors in young children’s lives.
- 5. Our focus is on all of North Carolina’s children reaching their full potential, recognizing that we must be intentional in order to eliminate disparities.**

North Carolina is committed to equity of opportunity for all children by confronting disparities through strategic commitments across the state. Child outcomes that vary disproportionately across race, ethnicity, socioeconomic status, physical and developmental ability, and geography, must be recognized in order to identify and implement strategic interventions.
- 6. Our Action Plan reflects our values of transparency, good stewardship, and accountability.**

Effective early childhood interventions can yield significant positive returns on investment (ROI) to individuals and to taxpayers through better outcomes in education, health, social behaviors, and employment. We will measure and report on the outcomes of our work and use data to continuously improve our efforts to ensure cost-effective strategies that result in the highest impact for children.



## Vision

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All North Carolina children get a healthy start and develop to their full potential in safe and nurturing families, schools and communities.

By 2025, all North Carolina young children from birth to age eight will be:

- 1) **Healthy:** Children are healthy at birth and thrive in environments that support their optimal health and well-being
- 2) **Safe and Nurtured:** Children grow confident, resilient and independent in safe, stable and nurturing families, schools and communities
- 3) **Learning and Ready to Succeed:** Children experience the conditions they need to build strong brain architecture and school readiness skills that support their success in school and life



## Goals and Metrics

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### Healthy

Children are healthy at birth and thrive in environments that support their optimal health and well-being

#### *Goal #1: Infant Mortality*

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By 2025, decrease the statewide infant mortality rate from 7.2 to 5.9 deaths per 1,000 live births

##### Infant Mortality Annual Metrics

1. Infant mortality rates for priority populations:
  - Black or African-American, non-Hispanic women
  - American Indian, non-Hispanic women
  - Women in Perinatal Health Region V (Southeastern region) and VI (Eastern region)
2. Percent of adults with health insurance, facilitating access to pre-conception and inter-conception care
3. Percent of pregnant women who receive on time prenatal care
4. Percent of pregnant women who smoke
5. Percent of pregnant women who drink alcohol
6. Percent of pregnant women who misuse prescription drugs and/or illegal substances
7. Birth rate of girls under the age of 19
8. Rate of intended versus unintended pregnancy
9. Rate of healthy intervals between pregnancies
10. Frequency of contraceptive care postpartum

#### *Goal #2: Healthy Birth Weight*

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By 2025, decrease the percentage of North Carolina infants born at a low birth weight from 9.2% to 8.2%

##### Healthy Birth Weight Annual Metrics

1. Infant mortality rates for priority populations:
  - Black or African-American, non-Hispanic women
  - American Indian, non-Hispanic women
  - Women in Perinatal Health Region V (Southeastern region)
2. Percent of adults with health insurance, facilitating access to pre-conception and inter-conception care
2. Percent of pregnant women who receive on time prenatal care



3. Percent of pregnant women who smoke
4. Percent of pregnant women who drink alcohol
5. Percent of pregnant women who misuse prescription drugs and/or illegal substances
6. Birth rate of girls under the age of 19
7. Rate of intended versus unintended pregnancy
8. Rate of healthy intervals between pregnancies
9. Frequency of contraceptive care postpartum

### Goal #3: Access to Preventive Health Services

By 2025, increase the annual percentage of North Carolina's young children enrolled in Medicaid who receive regular well-child visits

- For children ages 0 – 15 months, increase from 61.9% to 68.7%.
- For children ages 3 – 6 years, increase from 69.3% to 78.5%.

#### Access to Preventive Health Services Annual Metrics

1. Percent of children with health insurance
2. Rate of children with untreated tooth decay
3. Percent of children ages 19 – 35 months who are fully immunized
4. Percent of parents reporting that they have a regular place to take their children for medical care
5. Percentage of mothers engaging in any breastfeeding when child is 6 months of age
6. Rates of lead screenings before age 3

### Goal #4: Food Insecurity

By 2025, decrease the percentage of children living across North Carolina in food insecure homes from 20.9% to 17.5%

#### Food Insecurity Annual Metrics

1. Percent of eligible families enrolled in WIC
2. Percent of eligible families enrolled in SNAP
3. Rate of enrollment in Free and Reduced Lunch
4. Percent of families living in areas designated as food deserts according to the USDA Food Desert Atlas
5. Percent of families with regular access to healthy foods

## Safe and Nurtured

Children grow confident, resilient and independent in safe, stable and nurturing families, schools and communities

### Goal #5: Child Abuse and Neglect

By 2025, decrease the rate of children in North Carolina who are victims of maltreatment

- For children ages 0 – 3, reduce from 20.12 to 18.11 per 1,000 children
- For children ages 0 – 5, reduce from 18.23 to 16.41 per 1,000 children

#### Child Abuse and Neglect Annual Metrics

1. Rate of births to mothers with at least a 12<sup>th</sup> grade education
2. Percent of working families with access to the Family Medical Leave Act
3. Percent of working families with access to Paid Family Leave
4. Rate of mothers screened for depression at well-child visits,
5. Among mothers who positively identified with depression: percent referred to and receive services for depression\*
6. Percent of parents with access to mental health, domestic violence and substance abuse services
7. Percent of parents who misuse alcohol, prescription drugs, and/or other illegal substances

\*In Data Development: The Department of Health and Human Services is seeking recommendations on reliable and accurate data sources available to track progress toward this goal, and additional ongoing metrics.

### Goal #6: Time to Permanency for Children in Foster Care

Part 1) By 2025, decrease by 10% the number of days it takes for children in the foster care system to be either reunified with their family, placed under guardianship, or another adult is given custody.

- For children aged 0 – 3, decrease the median number of days from 371 to 334
- For children aged 0 – 5, decrease the median number of days from 372 days to 335 days

Part 2) By 2025, decrease by 10% the number of days it takes for a child in the foster care system to be placed into adoption.

- For children aged 0 – 3, decrease the median number of days from 822 to 740



- For children aged 0 – 5, decrease the median number of days from 853 to 768

#### Time to Permanency for Children in Foster Care Annual Metrics

1. Percent of working families with access to the Family Medical Leave Act
2. Percent of working families with access to Paid Family Leave
3. Availability and utilization of reunification funds and services
4. Frequency rates of case reviews, permanency/court hearings and child and family team meetings
5. Frequency rates of face-to-face visitation between birth parents and their children in foster care
6. Frequency and quality of shared parenting between birth parents and foster parents
7. Adherence to visit/screening schedules (physical health/immunizations, dental health, mental/behavioral health, and developmental) for infants and toddlers

#### Goal #7: Social Emotional Well-Being and Resilience

*By 2025, increase measures of social and emotional well-being and resilience of young children by \_\_\_\_%\**

#### Social Emotional Well-being and Resilience Annual Metrics

1. Rate of children screened for social-emotional development support
2. Among children who identify positively for social-emotional development needs, rate of children who are referred to and receive services\*
3. Rate of families engaged in evidence-based family resilience support programs\*

\*In Data Development: The Department of Health and Human Services is seeking recommendations on reliable and accurate data sources available to track progress toward this goal, and additional ongoing metrics.

## Learning and Ready to Succeed

Children experience the conditions they need to build strong brain architecture and school readiness skills that support their success in school and life

### Goal #8: Early Development

*By 2025, increase the percentage of children across North Carolina who demonstrate on track developmental skills.\**

#### Early Development Annual Metrics

1. Percentage of children who demonstrate on-track language skills at 24, 36, and 48 months\*
2. Rate of children screened for developmental delay at well-child visits
3. Among those children who identify positive for a developmental delay, rate referred to and receive services\*
4. Percentage of parents who regularly read with their children
5. Average number of books in a family home with children

\*In Data Development: The Department of Health and Human Services is seeking recommendations on reliable and accurate data sources available to track progress toward this goal, and additional ongoing metrics.

### Goal #9: Kindergarten Readiness

*By 2025, increase the percentage of children across North Carolina who enter kindergarten developmentally on track, according to the Kindergarten Entry Assessment.\**

\*In Data Development: Kindergarten Entry Assessment (KEA) data is collected statewide by the Department of Public Instruction (DPI). The assessment process includes five domains for child development: approaches to learning, language development and communication, cognitive development, emotional and social development, and health and physical development. DPI is in the process of developing state and county level reporting on this assessment.

#### Kindergarten Readiness Annual Metrics

1. Among children under age 6 attending licensed care, percent of children who are in high quality centers and homes
2. Percent of eligible children under age 6 receiving child care subsidy
3. Among children under age 6 attending licensed care and receive subsidy, percent of children who are in high quality centers and homes



4. Percent of early childhood teachers with post-secondary early childhood education, by degree
5. Percent of early childhood administrators and principals with post-secondary early childhood education, by degree
6. Percent of teachers working with priority populations who receive training or coaching for their work (i.e., English Language Learners, children with disabilities)
7. Percent of teachers who receive professional development on children's mental health, including trauma
8. Rate of children expelled from early care and education settings
9. Percent of families paying 10% or less of their household income on childcare
10. Percent of eligible four-year-olds attending NC Pre-K programs
11. Percent of children who are attending an early care program, and have not changed early care and learning programs within the year
12. Percent of children with access to early care and education programs in their native language

### Goal #10: Third Grade Reading Proficiency

By 2025, increase the percentage of children achieving reading proficiency across the state from 58% to 64% according to NC DPI Performance Data on third grade reading EOGs, and from 39% to 43% according to the fourth grade National Assessment of Education Progress.

#### Third Grade Reading Proficiency Annual Metrics

1. Reading proficiency for priority populations:
  - Black or African-American, non-Hispanic
  - American Indian, non-Hispanic
  - Hispanic
2. Increase in percentage of Kindergarten students reading or exhibiting pre-literacy behaviors at or above grade level by the end of the year according to mCLASS 3D assessment, administered by DPI
3. Increase in percentage of 1<sup>st</sup> grade students reading at or above grade level by the end of the year according to mCLASS 3D assessment, administered by DPI
4. Increase in percentage of 2<sup>nd</sup> grade students reading at or above grade level by the end of the year according to mCLASS 3D assessment, administered by DPI

## Data Appendix

### *What is the Data Appendix?*

The Early Childhood Action Plan Data Appendix is presented as a guiding document to be read in conjunction with the Action Plan. It offers more insight into the creation of the 2025 goals, and will hopefully serve to answer questions that may remain after reading the Early Childhood Action Plan.

**Goals in the process of data development and additional research, and details regarding metrics are not yet included in this appendix.**

### *How were the Early Childhood Action Plan goals and draft metrics developed?*

A consultant and DHHS policy advisor have served as project directors in the creation of the Action Plan. The Action Plan content was drafted through a series of working groups and targeted engagement with experts and stakeholders. The Early Childhood Action Team working group, composed of senior DHHS leadership, drafted the vision and guiding principles of the plan. Another body, known as the Data Work Group, regularly convened from the fall of 2017 through the spring of 2018 to explore what data sources would guide the Action Plan. A separate working group of inter-division leaders met to draft the metrics that follow each goal.

## Infant Mortality

<b>2025 Goal</b>	By 2025, decrease the statewide infant mortality rate from 7.2 to 5.9 deaths per 1,000 live births
<b>Definitions</b>	<i>Infant Mortality Rate:</i> Number of infant (aged under 1 year) deaths per 1,000 live births.
<b>Rationale</b>	<p>Infant mortality is widely used as a measure of population health, as well as the health and well-being of children and families across the world. It is not only a measure of the risk of infant death, but also used more broadly as a crude indicator of community health status, poverty and socioeconomic status levels in a community, and availability and quality of health services (AMCHP). Of great importance in assessing population health with infant mortality are the disparities in infant mortality, which is most prominent between African-American and white infants.</p> <p>North Carolina’s infant mortality rate (7.2% in 2016) <a href="#">ranks among the highest in the US</a> and there are significant disparities by race. The five leading causes of infant mortality in NC are preterm birth/low birth weight, birth defects, Sudden Unexpected Infant Death (SUID)*, maternal complications of pregnancy/ labor/delivery, and other perinatal conditions.</p> <p>*Sudden Unexpected Infant Death includes Sudden Infant Death Syndrome (SIDS), accidental suffocation/strangulation in sleep environment, and other unknown causes of infant death.</p>
<b>Priority Populations</b> <i>Groups of North Carolinians that have a disproportionate risk associated with this goal</i>	<ul style="list-style-type: none"> <li>• Black, Non-Hispanic Women</li> <li>• American Indian, Non-Hispanic Women</li> <li>• Women in Perinatal Health Region V (Southeastern region) &amp; VI (Eastern region)</li> </ul>
<b>Data Sources</b>	<ol style="list-style-type: none"> <li>1) North Carolina State Center for Health Statistics, 2016 NC Resident Birth and Death Certificate data.</li> <li>2) Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS), National Vital Statistics System.</li> </ol>

## Healthy Birth Weight

<b>2025 Goal</b>	By 2025, decrease the percentage of North Carolina infants born at a low birth weight from 9.2% to 8.2%
<b>Definitions</b>	<i>Birth weight:</i> the weight of the newborn measured immediately after birth. Birth weight of less than 5.5 lbs., or 2500 grams, is considered low birth weight. A low birth weight infant can be born too small, too early, or both.
<b>Rationale</b>	<p>In 2016, <a href="#">9.2% of births in NC were low birth weight</a>, while the US average was 8.2%. This places North Carolina among the ten worst states in the nation for this measure. Compared to infants of normal weight, low birth weight infants may be more at risk for many health problems. According to the <a href="#">Center for Disease Control</a>, some babies born with a low birth weight may become sick in the first six days of life or develop infections. Other babies may even suffer from longer-term problems such as delayed motor and social development or learning disabilities.</p> <p>Over the course of the last decade, the NC low birthweight rate has remained unchanged and has increased 5 percent since 1997 when the rate was 8.8%. We determined that setting our target at the best performing state (Alaska at 5.9%) was too aspirational and not achievable by 2025. We set our target at meeting the current national average; which will improve our low birthweight rate by 10 percentage points.</p>
<b>Priority Populations</b> <i>Groups of North Carolinians that have a disproportionate risk associated with this goal</i>	<ul style="list-style-type: none"> <li>• Black, Non-Hispanic Women</li> <li>• American Indian, Non-Hispanic Women</li> <li>• Women in Perinatal Health Region V (Southeastern region)</li> </ul>
<b>Data Sources</b>	<ol style="list-style-type: none"> <li>1) North Carolina State Center for Health Statistics, 2016 NC Resident Birth Certificate data.</li> <li>2) Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS), National Vital Statistics System.</li> </ol>

## Access to Preventive Health Services

<p><b>2025 Goal</b></p>	<p>By 2025, increase the annual percentage of North Carolina’s young children enrolled in Medicaid who receive regular well-child visits</p> <ul style="list-style-type: none"> <li>• For children ages 0 – 15 months, increase from 61.9% to 68.7%.</li> <li>• For children ages 3 – 6 years, increase from 69.3% to 78.5%.</li> </ul>
<p><b>Definitions</b></p>	<p>The required components of a well-child visit are:</p> <ul style="list-style-type: none"> <li>• Comprehensive health and developmental history that assesses for both physical and mental health</li> <li>• Comprehensive, unclothed physical examination</li> <li>• Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices</li> <li>• Laboratory testing (including blood lead screening appropriate for age and risk factors)</li> <li>• Health education and anticipatory guidance for both the child and caregiver</li> </ul>
<p><b>Rationale</b></p>	<p>Well-child visits provide an opportunity for providers to influence health and development of young children and are a critical opportunity for screening. Well child visits allow health care providers to carefully monitor and foster a child’s overall health and development, support parents as they care for their child, provide anticipatory guidance, provide preventive care, and identify and address health concerns early.</p> <p>Rates of well-child visits for children under 15 months and enrolled in Medicaid have increased from 56.4% in Calendar Year (CY) 2015 to 61.9% in CY2016. The CY national 2016 Quality Compass Medicaid HMO 75<sup>th</sup> Percentile Benchmark is 68.7%. Medicaid Managed Care Plans will be accountable for achieving the 75<sup>th</sup> percentile benchmark as part of the Quality Strategy for Medicaid Managed Care. We set our goal at 68.7% (the 75<sup>th</sup> percentile) because it is achievable and will be consistent with the Quality Strategy as part of Medicaid Managed Care.</p> <p>Rates of well-child visits for children ages 3-6 years and enrolled in Medicaid have increased from 68.9% in CY2015 to 69.3% in CY2016. The CY national 2016 Quality Compass Medicaid HMO 75<sup>th</sup> Percentile Benchmark is 78.5%. Medicaid Managed Care Plans will</p>

	<p>be accountable for achieving the 75<sup>th</sup> percentile benchmark as part of the Quality Strategy for Medicaid Managed Care. We set our goal at 78.5% (the 75<sup>th</sup> percentile) will be consistent with the Quality Strategy as part of Medicaid Managed Care. This will be ambitious, but we believe it is achievable with the resources of Medicaid Managed Care to foster the improvement.</p>
<p><b>Priority Populations</b> <i>Groups of North Carolinians that have a disproportionate risk associated with this goal</i></p>	<p>N/A</p>
<p><b>Data Sources</b></p>	<ol style="list-style-type: none"> <li>1) NC Medicaid,</li> <li>2) Care Analyzer Medicaid HEDIS data</li> </ol>

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## Food Insecurity

<b>2025 Goal</b>	By 2025, decrease the percentage of children living across North Carolina in food insecure homes from 20.9% to 17.5%
<b>Definitions</b>	<p><i>Low food security:</i> Reports of reduced quality, variety, or desirability of diet.</p> <p><i>Very low food security:</i> Reports of multiple indications of disrupted eating patterns and reduced food intake</p> <p>Source: <a href="#">USDA</a></p>
<b>Rationale</b>	<p>Food insecurity among children is associated with negative health, social, and academic outcomes. Multiple reports indicate that North Carolina’s families face food insecurity at higher rates than much of the country. The most recent <a href="#">USDA report</a> on overall food insecurity across the country ranks NC as the 10<sup>th</sup> state. While the USDA does not have a current report that includes rankings for households with children, they do have a report based on slightly older data. In <a href="#">this analysis</a>, NC is ranked #8 for households with children. Feeding America <a href="#">reports</a> that approximately 1 in 5 children in NC live in food insecure households, with that rate rising in some counties to more than 1 in 3. Feeding America <a href="#">ranks</a> NC as #11 in the country for percent of children with food insecurity.</p> <p>The percent of children living in food insecure homes on NC has been declining over the last several years, however NC continues to rank in the top quartile of states for percent of children living in food insecure homes. We determined that setting our target at the best performing state (North Dakota at 9.4%) seemed too aspirational and not achievable by 2025. We set our target at the <a href="#">current national rate</a>, 17.5%.</p>
<b>Priority Populations</b> <i>Groups of North Carolinians that have a disproportionate risk associated with this goal</i>	<ul style="list-style-type: none"> <li>Counties with highest rates of children living in food insecure households (Scotland County with 30.6% and North Hampton with 30.2% as well as several counties with rates between 25% - 29%).</li> </ul> <p>See <a href="#">Feeding America</a> for more details</p>
<b>Data Sources</b>	<ol style="list-style-type: none"> <li>1) USDA</li> <li>2) Feeding America</li> </ol>

## Child Abuse and Neglect

<p><b>2025 Goal</b></p>	<p>By 2025, decrease the rate of children in North Carolina who are victims of maltreatment</p> <ul style="list-style-type: none"> <li>• For children ages 0 – 3, reduce from 20.12 to 18.11 per 1,000 children</li> <li>• For children ages 0 – 5, reduce from 18.23 to 16.41 per 1,000 children</li> </ul>
<p><b>Definitions</b></p>	<p><i>Child maltreatment:</i> all types of abuse and neglect of a child under the age of 18 by a parent, guardian, custodian or caregiver. <a href="#">North Carolina law identifies</a> three types of maltreatment: Abuse, Neglect and Dependency.</p>
<p><b>Rationale</b></p>	<p>In early childhood, major adversity (including conditions like extreme poverty, neglect, abuse, or severe maternal depression) can weaken the architecture of the developing brain and permanently set the body’s stress response system on high alert resulting in long-term consequences for learning, behavior, and both physical and mental health. This is especially true when children do not have the benefit of caring adults with capacity to buffer children from the effects of unrelenting or toxic stress. (See more from <a href="#">Harvard’s Center on the Developing Child</a> on this topic.)</p> <p>A recent <a href="#">Child Trends report</a> explains that child maltreatment is influenced by a number of factors, including poor knowledge of child development, substance abuse, other forms of domestic violence, and mental illness. In addition, while maltreatment occurs in families at all economic levels, abuse, and especially neglect are more common in low income families.</p> <p>Young children are more likely than older children to be victims of child maltreatment. According to the NC Division of Social Services In North Carolina, 127,788 children were reported as being maltreated in SFY 2017 with children age 0 – 5 comprising a disproportionate number of those reports at 39.78%, or 50,835 children. Furthermore, at the end of January 2018, children age 0 – 5 also comprised the majority of the 10,242 of the children served by the foster care program at 3,887 or 37.95% .</p> <p>In order to set our 2025 goals, we considered the current NC rates and the national rate. According to <a href="#">US DHHS</a>, the national rates of maltreatment for federal fiscal year 2016 for children ages 0 – 3 is 14.48 per 1,000 and for children ages 0 – 5 is 12.97 per 1,000. We</p>

	then calculated a resonant and seemingly achievable reduction of 20% from the current rate. The targets listed above represent a 20% decline by 2025 from North Carolina’s baseline performance for state fiscal year of 2016 – 17.
<b>Priority Populations</b> <i>Groups of North Carolinians that have a disproportionate risk associated with this goal</i>	<ul style="list-style-type: none"> <li>• African American or Black</li> <li>• American Indian</li> <li>• Low income and extremely low-income families</li> </ul>
<b>Data Sources</b>	<ol style="list-style-type: none"> <li>1) Central Registry and NC FAST</li> <li>2) US DHHS</li> </ol>

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## Time to Permanency for Children in Foster Care

<p><b>2025 Goal</b></p>	<p>Part 1) By 2025, decrease by 10% the number of days it takes for children in the foster care system to be either reunified with their family, placed under guardianship, or another adult is given custody.</p> <ul style="list-style-type: none"> <li>• For children aged 0 – 3, decrease the median number of days from 371 to 334</li> <li>• For children aged 0 – 5, decrease the median number of days from 372 days to 335 days</li> </ul> <p>Part 2) By 2025, decrease by 10% the number of days it takes for a child in the foster care system to be placed into adoption.</p> <ul style="list-style-type: none"> <li>• For children aged 0 – 3, decrease the median number of days from 822 to 740</li> <li>• For children aged 0 – 5, decrease the median number of days from 853 to 768</li> </ul>
<p><b>Definitions</b></p>	<p><i>Foster care placement:</i> Temporary substitute care provided to a child who must be separated from his or her own parents or caretakers when the parents or caretakers are unable or unwilling to provide adequate protection and care.</p> <p><i>Permanence:</i> For children and youth in the custody and placement responsibility of the county department of social services, permanence occurs when the child has a lasting, nurturing legally secure relationship with at least one adult that is characterized by mutual commitment.</p> <p><i>Legally secure placement:</i> A placement in which the direct caregiver has the legal authority to make parental decisions on behalf of the child.</p>
<p><b>Rationale</b></p>	<p>Young children need safe, permanent homes with nurturing and secure attachments to adults for healthy growth and development. For children who must be placed in foster care, the stress of being removed from the home and placed in out-of-home care can aggravate the original insult of the maltreatment and prolong the prolonged activation of the child’s stress response system, which impacts the child’s developing brain. <a href="#">A recent study</a> suggests that trauma-informed approaches to removing children from home and placing them in foster care can reduce the amount of reoccurring maltreatment, reduce time to permanency, limit the number of</p>

	<p>placements, increase use of supportive services and increase parent-child contact.</p> <p>The 2025 goals represent a 10% reduction in the median days to the two types of permanency. As there are no national numbers on this measure, the previous five state fiscal years were considered. The most recent state fiscal year, 2016 – 17, was not the highest among those, nor the lowest. The 10% target represented a number lower than the lowest years, while remaining achievable based on current rates. Additionally, the target for reunification, guardianship, and custody, represents a number of days that is below another federal timely permanency measure.</p> <p>Choosing the median number of days to permanence offers a straightforward measure that makes permanence and different segments of a placement episode easy to compare. The courts, for example, compare the number of days from removal to permanence to number of days from the initial adoption petition to permanence as a measure of timeliness. The use of a median rather than an average is important because with the use of an exit cohort, the number of days to permanency can vary more dramatically for children who enter at a younger age, causing the average for those younger age groups to be much higher. Median scores are much less susceptible to fluctuations based on a small number of outliers.</p>
<p><b>Priority Populations</b> <i>Groups of North Carolinians that have a disproportionate risk associated with this goal</i></p>	<ul style="list-style-type: none"> <li>• African American or Black</li> <li>• American Indian</li> </ul>
<p><b>Data Sources</b></p>	<p>1) Child Placement and Payment System (CPPS) and NC FAST</p>

## Third Grade Reading Proficiency

<p><b>2025 Goal</b></p>	<p>By 2025, increase the percentage of children achieving reading proficiency across the state from 58% to 64% according to NC DPI Performance Data on third grade reading EOGs, and from 39% to 43% according to the fourth grade National Assessment of Education Progress.</p>
<p><b>Definitions</b></p>	<p><i>Reading Proficiency:</i></p> <ul style="list-style-type: none"> <li>• The NC End-of-Grade tests are scored on five performance levels, with Level 1 being the lowest and Level 5 the highest. Students scoring at or above Level 3 are considered to be proficient.</li> <li>• The National Assessment of Educational Progress (NAEP) provides another measure of reading proficiency based on a sample of students in each state. Scores are grouped into three performance levels; basic, proficient and advanced. Students scoring at or above proficient are considered to be proficient. The National Assessment of Educational Progress (NAEP) reading assessment is given every 2 years to students at grades 4 and 8, and approximately every 4 years at grade 12.</li> </ul>
<p><b>Rationale</b></p>	<p>A broad and ongoing array of research continues to demonstrate that reading proficiency by the end of third grade matters. Children who read proficiently by the end of third grade are more likely to succeed academically, graduate from high school ready for college and careers, and become successful, productive adults. <a href="#">A recent report</a> from the NC Early Childhood Foundation underscores the importance of looking at these data for subgroups of the population since there are significant disparities in reading proficiency by race, ethnicity and whether or not a student is an English language learner or not.</p> <p>The percentage of NC fourth graders rating proficient on the NAEP in 2017 was 39%, which places NC in the top third of the nation. Over the last decade, the percentage of NC fourth graders scoring proficient has steadily increased, moving from below the national average to above. 2025 is seven years away; in the past seven years, NC has improved its percent proficient by about 15%. We are utilizing the NAEP as a proxy for third grade reading proficiency levels, as it is a nationally normed assessment, although it is given in fourth grade and not third.</p>

	<p>In terms of setting the 2025 goal, aiming to match the state in the nation with the highest proficiency (Massachusetts at 51%) would represent more than a 30% improvement in seven years. Instead, we set our 2025 goal at the best state in the region, Virginia at 43%, which would be about a 10% improvement.</p> <p>Using the same 10% improvement impact for the NC third grade reading EOG would mean a target of 64% proficient on the state test.</p>
<p><b>Priority Populations</b> <i>Groups of North Carolinians that have a disproportionate risk associated with this goal</i></p>	<ul style="list-style-type: none"> <li>• African-American or Black</li> <li>• American Indian</li> <li>• Hispanic</li> <li>• Limited English Proficient</li> <li>• Economically Disadvantaged</li> </ul>
<p><b>Data Sources</b></p>	<ol style="list-style-type: none"> <li>1) NAEP</li> <li>2) Third Grade Reading EOG</li> </ol>

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