

Table of Contents

	<u>Page</u>
i. Project Narrative	2
A. Introduction	3
B. Needs Assessment	3
C. Methodology	13
D. Work Plan	31
E. Resolution of Challenges	37
F. Evaluation and Technical Support Capacity	38
G. Organizational Information	40
ii. Program Specific Forms	42
iii. Attachments –Please refer to attachments.	
1- ECCS Evaluation Grid	
2- Staffing Plan and Job Descriptions for Key Personnel	
3- Biographical Sketches of Key Personnel	
4- Proposed Contracts	
5-1 Project Organizational Chart	
5-2 Logic Model	
6 - Annual Report (Not applicable to this grant application)	
7-1 thur 7-6 Other Relevant Documents	
o Letters of Support	

i. PROJECT NARRATIVE

As the original administrator and recipient of Early Childhood Comprehensive Systems (ECCS) funds, the North Dakota Department of Health (NDDoH) fully supports transfer of the North Dakota (ND) ECCS program to Prevent Child Abuse North Dakota (PCAND). NDDoH recognizes the close alignment between the ECCS program and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which PCAND administers in ND. In addition, PCAND has a long history of collaborative system development across the state; PCAND convenes the ND Home Visitation Coalition, which exists to expand home visiting services, as well as the Children's Justice Alliance, a cross-disciplinary group that works to improve the child protection system. PCAND is well situated to carry out the goals and objectives specified in the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) Catalog of Federal Domestic Assistance (CFDA) No. 93.110.

In 2003, the ND ECCS program established a work group, the Healthy North Dakota Early Childhood Alliance (HNDECA), which includes members from numerous early childhood affiliated agencies and organizations across the state. This diverse group of stakeholders engages in system development, provides integration activities, and utilizes a collective impact approach, in order to strengthen communities and improve the quality and availability of early childhood services at the state and local levels. PCAND has been a strong and active member of the HNDECA over the past five years. This unparalleled multi-agency, multi-level alliance continues to be of particular value, as the Governor's Early Childhood Advisory Council looks to HNDECA for guidance and information.

The ND ECCS program and its HNDECA will focus on Strategy 2: Coordination of the expansion of developmental screening activities in early care and education settings statewide by connecting pediatric and other child health leaders with child care health consultants to link training and referrals among medical homes, early intervention services, child care programs, and families. The ECCS program work plan for the period of August 1, 2013 through July 31, 2016 is intended to develop, implement, and improve upon numerous developmental screening projects and services that have been identified by HNDECA. The ECCS program will continue to (1) commit funding toward the development of an early childhood surveillance plan; (2) develop its procedure for data collection and analysis, creating a mechanism by which to share this data with HNDECA; and (3) provide the infrastructure for evidence-based decision-making; a more efficient service delivery system with a greater direct impact for those served.

The logic model that will guide our efforts is presented in Attachment 5-2. In brief, the focus of our initiative will be on creating and utilizing statewide networks to: a) expand developmental screening, b) engage early childhood health professionals, c) increase training, d) develop support systems, and e) create a statewide surveillance/monitoring system. These networks will generate strategies, tools, referral systems, training clearinghouses and programs, policies, and statewide data bases that will lead to better working relationship with health providers, community stakeholders and leaders, and policy makers to increase awareness of the need for developmental screening and associated training and referral systems. This expanded awareness should lead to increased infrastructure and capacity for developmental screenings and the training that is needed for both professionals and family members of the children served.

Additionally, a more effective referral system will be created to assist those in need. Ultimately, these changes will lead to improvements of children's health, reduction in children's health disparities, and a decrease in health care costs.

With an increased focus on surveillance and evaluation, the ECCS will place primary emphasis on serving all children birth to age three including minority children, children with disabilities, and children living in poverty. In summary, the ECCS program will coordinate expansion of developmental screening in early care and education settings statewide through system development; as such, the ECCS will link training, cooperation, and referrals among medical homes, early intervention services, child care programs, families, and pediatric and other child health leaders.

A. INTRODUCTION

Since 2003, the NDDoH has received an ECCS grant from HRSA to strengthen ND's early childhood system. The previous ECCS grant helped states establish and implement collaborations and partnerships that support families and communities as they, in turn, support the healthy development and school readiness of young children.

As the previous ECCS grant evolved, it was evident that support would be needed from multiple partners. The HNDECA was created to achieve the goals of this grant. HNDECA oversees the ECCS process to ensure implementation of federal guidelines and good stewardship of the planning funds. Comprised of approximately 85 program providers, stakeholders and parents; HNDECA facilitates enhanced communication, develops a shared knowledge base regarding ND early childhood programs, and identifies common goals and challenges for change.

It is through the HNDECA subcommittees that an ECCS work plan will be fully developed containing more detailed activities and strategies to ensure implementation success and focus on strategic planning, public relations, evaluation and sustainability. Subcommittee members build on existing strengths and integrate, rather than duplicate, current initiatives and services. HNDECA seeks to strengthen early childhood service collaborations and partnerships to support families and communities by leveraging local community assets, particularly human capital, with statewide resources.

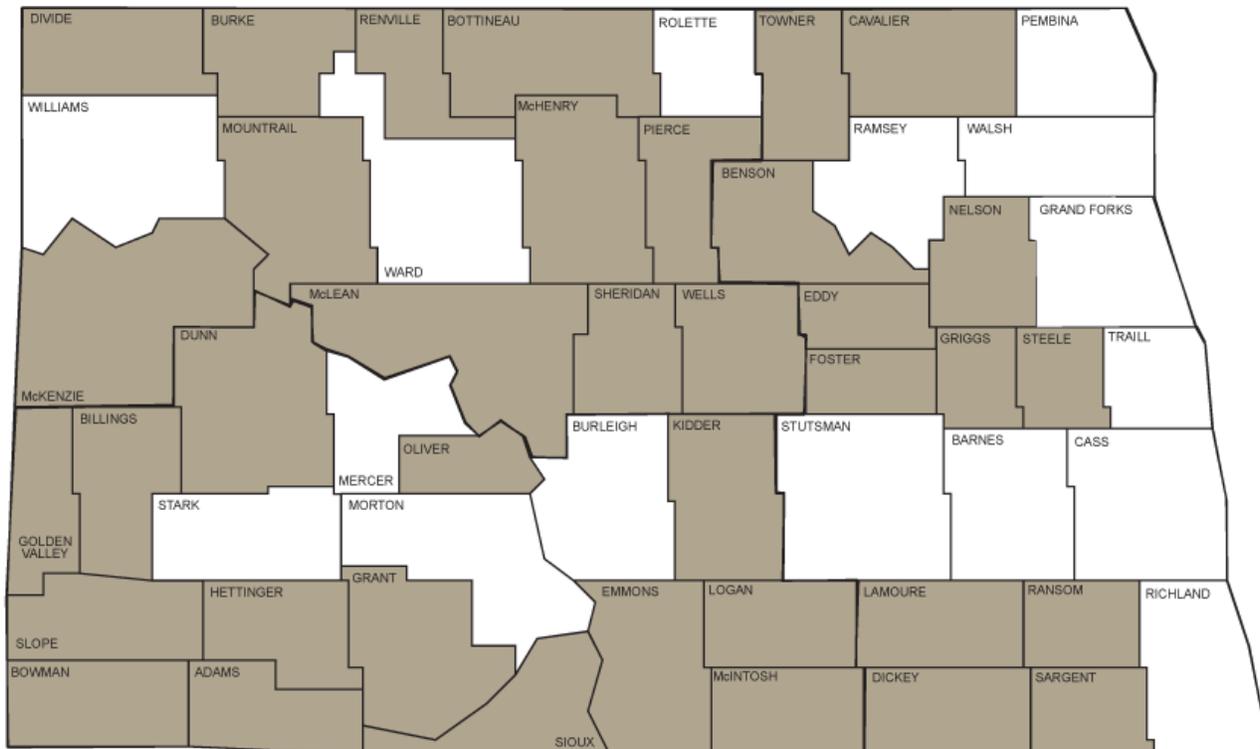
B. NEEDS ASSESSMENT

Background and Statement of Need

Geographic Distribution

ND is an agricultural state located in the geographic center of the United States between Montana and Minnesota, adjacent to the Canadian provinces of Saskatchewan and Manitoba. It is the 19th largest state by geographic size (70,698 square miles) and is divided into 53 counties spread over four distinct regions; the southwestern Great Plains (badlands), the northwest Missouri Coteau (plateau), the central Glaciated Plains, and the eastern border Red River Valley (US Census, 2012). The state's relatively small population base, 699,628 residents in 2012, and large geographic size pose an important challenge to providers with regard to delivering services to the children and families within the state. For example, the majority of ND counties (29) have fewer than 5,000 residents. Overall, the state's population density is 10 people per square mile with 70 percent of the counties in the state labeled "frontier" counties, defined as having a population density of six or fewer residents per square mile (US Census, 2010). Moreover, only 15 of the state's 357 incorporated places had a population base of at least 2,500 residents in 2010 which is typically viewed as urban (NDHFA, 2012). Because of the historical rural-to-urban movement of people in the state, slightly more than half (54.7%) of North Dakotans are classified as urban (US Census, 2011).

North Dakota Frontier Counties



03/11



Center for
Rural Health

The University of North Dakota
School of Medicine & Health Sciences

37 of 53 North Dakota Counties designated as Frontier
(less than seven persons per square mile)

Source: U.S. Census Bureau, 2010

Population Characteristics

The state population increased by 4.7 percent from 2000 to 2010 reaching 672,591 residents (US Census, 2010). However, energy development activity in western ND has significantly changed historical population trends within the state. The impact, which started in 2006, altered migration flows. More than half of the western counties in the state began experiencing population growth. From 2011 to 2012, North Dakota became the fastest growing state in the U.S. growing at 2.2 percent, three times the national average (US Census, 2012). Additionally, several high-growth micro areas in ND have emerged as among the fastest-growing in the nation (Williston-1st, Dickinson-3rd and Minot-39th) (US Census, 2013). Population estimates indicate that ND reached 699,628 in 2012 (US Census, 20102). Forecasts indicate that the population boom will continue into 2025 when the state's population is projected to reach nearly 842,000 (NDHFA, 2012).

The age profile within the state also has been very dynamic. For the first time since the early 1980s, the pre-school age population within the state is growing. After decades of decline, a sustained upswing in births began in ND starting in 2002 when there were 7,755 births recorded. By 2011 there were 9,234 births (NDDoH, 2012). This reversal parallels a significant upturn in the 25 to 44 age cohort which is the prime child bearing age category. It also reflects the prime working age category which grew in response to the state's robust economy. Population projections indicate that by 2025, the 0 to 24 population will increase by nearly 18 percent (NDHFA, 2012).

The racial and ethnic mix in ND is changing modestly. Over the past 20 years, the proportion of the state's population that is white declined from 96 percent to approximately 90 percent. ND has four American Indian reservations. American Indians comprise the largest minority group in the state, representing five percent of the state's population base and nearly 10 percent of the children in 2010 (NDHFA, 2012). More than 5,500 refugees have been resettled in ND from 1997 through 2012, a population representing 39 countries. Most of the refugees arriving in the state are resettled in four of the state's largest cities (Fargo, West Fargo, Grand Forks, and Bismarck) (LSSND, 2012).

Age distribution estimates indicate that approximately 6.6 percent of the ND population in 2011 was under five years of age and 22.1 percent was under 18 years of age (US Census, 2012b).

Socioeconomic Disparities-Economic Conditions

ND's robust economy has created an economic contradiction that highlights the challenges in socioeconomic disparities within the state. For example, the oil boom in the western part of the state combined with a strong agricultural economy has placed ND in the top two states for growth in Gross State Product (the leading indicator of a state's economy) among all states in the past four years (BEA, 2012) and per capita income growth in the past two years (BEA, 2013). Additionally, ND has consistently had among the lowest unemployment rates in the nation for the past several years (BLS, 2013). In contrast, an estimated 12.3 percent of residents in the state live in poverty (US Census, 2011).

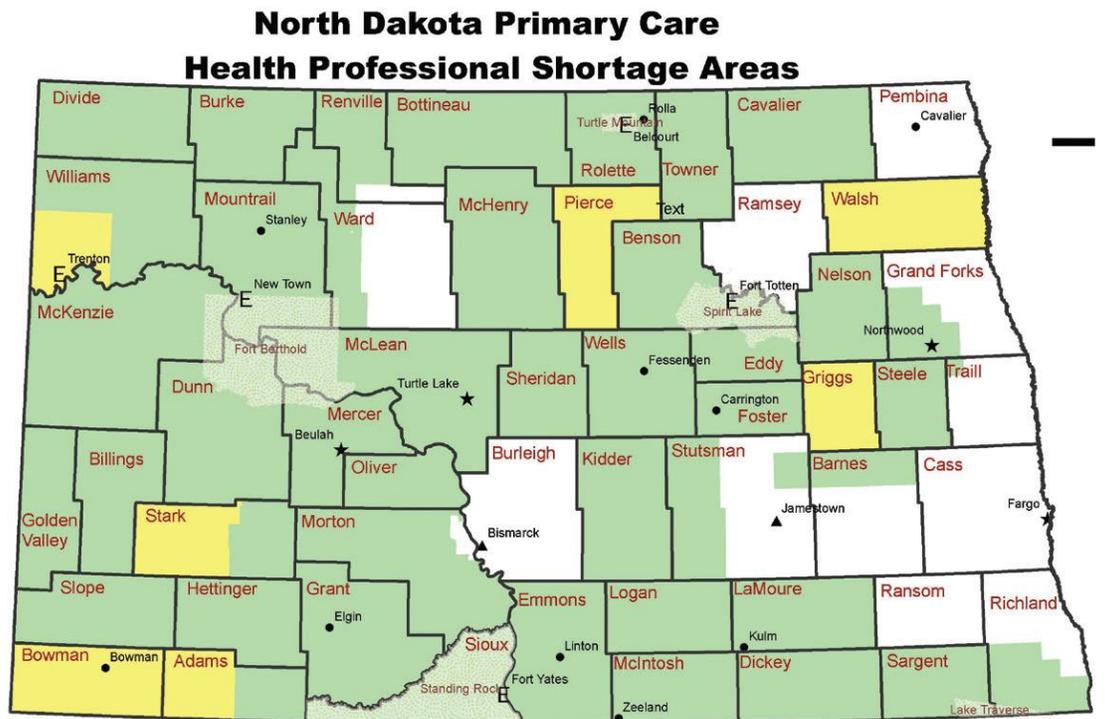
The disparity becomes more apparent when one narrows their focus to select groups, especially children. Nearly 18 percent of the children in the state under the age of five are impoverished.

One in four of ND's American Indians live in poverty including nearly half of American Indian children under the age of 18. Over 38 percent of children living in single-parent families within the state are below the poverty threshold. This increases to nearly 45 percent for children living with single mothers (US Census, 2011). Statewide, approximately one-third of children (32%) enrolled in school received free and reduced-fee school lunches (NDDPI, 2012). A comparison of the cost of living between the eastern (i.e., Fargo-Moorhead metro area) and western (i.e., Minot micro area) parts of the state indicates that costs for the western region are much higher for categories of housing, transportation, and goods and services (C2RE, 2010).

While most North Dakotans have some form of health insurance, many residents are without coverage. According to the Census Bureau's Small Area Health Insurance Estimates program, 6.1 percent of ND's youth did not have health insurance coverage in 2010 (i.e., 9,514 children ages 0 to 18). In 17 of 53 ND counties, at least 10 percent of children did not have health insurance in 2010. Of all uninsured children living in ND, the vast majority have working parents (80 percent). The majority of uninsured children (58 percent) live in low-income families (i.e. incomes up to 200 percent of the federal poverty level) (ND KIDS COUNT, 2013).

ND Health Professional Shortage Areas and Resources

Access to important medical services is limited in ND largely due to its low population density. The small population base and great geographic area to be served makes access to health services very expensive. Eighty-one percent of counties in ND are designated by the federal government as a primary care Health Professional Shortage Area (HPSA). Shortages of mental health providers are also a concern, with 89% of counties designated as a Mental Health Professional Shortage Area. In oral health, 32% of the counties are designated as dental HPSAs (CRH, 2012).



Findings from the MIECHV Needs Assessment

2010 MIECHV needs assessment

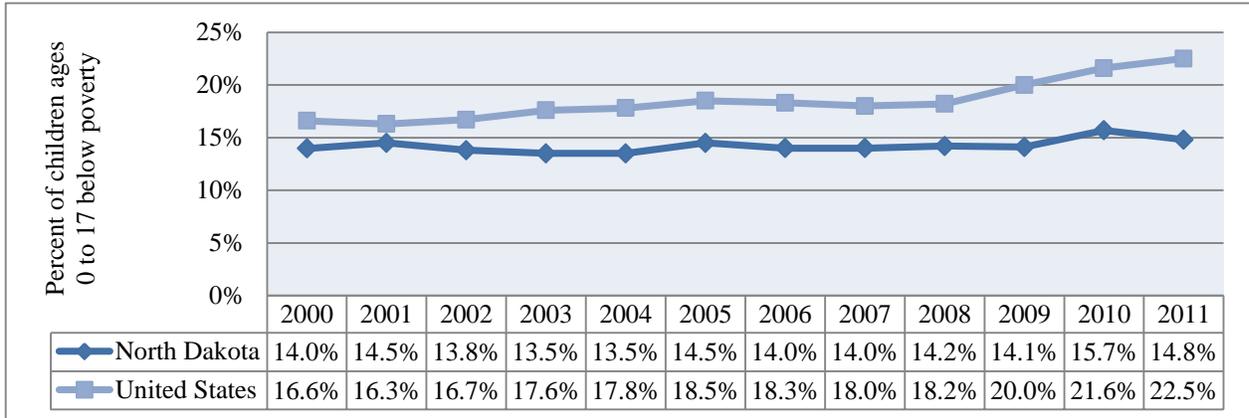
The MIECHV needs assessment for ND was conducted in late summer of 2010. It provides an overview of key performance indicators that were useful in identifying communities in greatest need of a home visiting program in ND. Moreover, it was used in designing a strategy to prioritize both communities of need and which type of home visiting program would be most useful in ND. The rural nature of the state limited the amount and type of data that could be explored. As a result, counties and regions were used in the analysis. This was necessary to avoid issues of confidentiality or data instability due to small numbers.

Since the focus of this ECCS grant is on infants and young children, we limited our review to those performance indicators that best offer context to the needs of this specific age group. The data were updated including trend lines where possible to provide the most current outlook. Attention was given to two main themes. First, larger macro dimensions are explored such as economic issues (i.e., children in poverty) and safety (i.e., children needing services for abuse and neglect). Second, we present findings regarding birth outcomes (i.e., preterm births and low weight births), issues of mortality (i.e., neonatal deaths), developmental screening, and child care. The regional analysis consisted of groups of counties and coincides with the eight planning region boundaries established by the state of ND for the purposes of standardizing areas being served by state agencies.

Economic Conditions

As noted earlier, ND's economy has notable contradictions. For example, child poverty rates in the state are relatively high and vary widely throughout the state. Statewide, the percent of children ages 0 to 17 living in poverty changed little from 14.0 percent in 2000 to 14.8 percent in 2011 (SAIPE, 2011). During this same time period, per capita income of residents in ND rose from \$25,592 or 38th in the nation to \$45,747 or 9th in the nation (BEA, 2013). The most severe pockets of child poverty in the state are on the American Indian reservations. Approximately 38 percent of residents in Sioux County, which is part of the Standing Rock Reservation, were impoverished in 2008 – the 12th highest poverty rate in the nation (when ranked among all counties nationwide). In fact, Sioux, Benson, and Rolette counties (all reservation counties) have consistently had 23 percent or more of their population living in poverty since at least 1970.

Percent of children ages 0 to 17 impoverished in ND and the United States, 2000 to 2011



Source: U.S. Census Bureau, 2000 Decennial Census and Small Area Income and Poverty Estimates

Young children in ND are at greater risk of poverty. Current data indicate that 18.7 percent of ND children ages 0 to 4 live in families with incomes below poverty. This proportion increases to 59.1 percent for American Indian children ages 0 to 4 living in ND (US Census, 2011).

Another outcome measure that demonstrates the economic needs of children in ND is Temporary Assistance for Needy Families (TANF). The TANF program operating in ND provided assistance to 6,145 children ages 0 to 19 in 2012, which is 4 percent of all children statewide. This proportion has decreased by approximately 3 percentage points since 1998. In the reservation counties of Benson, Rolette, and Sioux, nearly one-third of all children receive TANF (NDDHS, 2012).

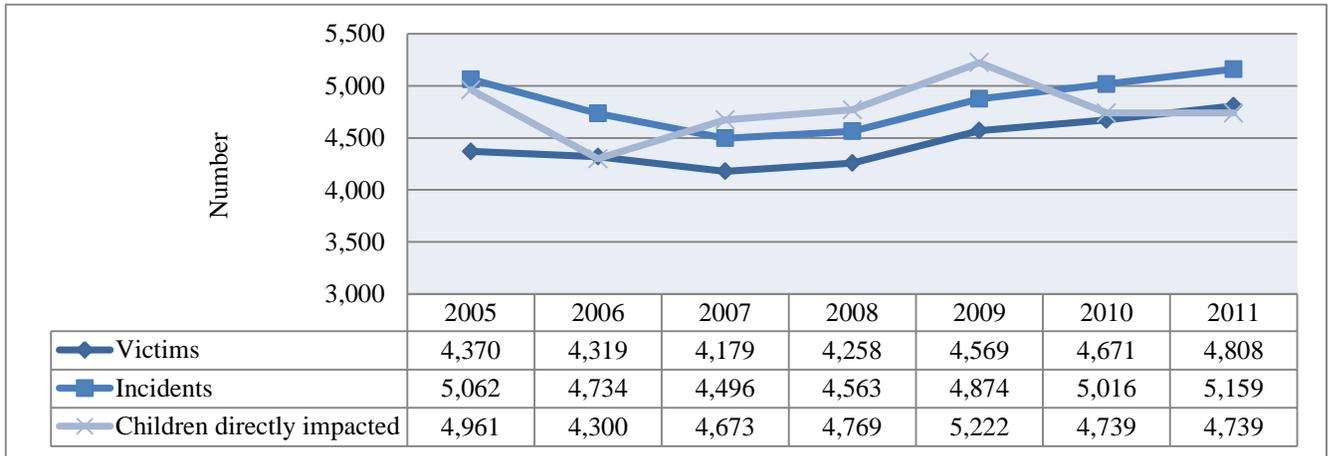
Finally, the proportion of children without health insurance remains a concern. Data from the National Survey of Children’s Health (NSCH) indicate that 9.9 percent of the state’s children under the age of 6 were without insurance at some point in 2012 (NSCH, 2012). A smaller proportion of children with special health care needs were uninsured with 9.6 percent in 2006 and 7.5 percent in 2010 (NS-CSHCN, 2010).

Child Maltreatment

In 2011, there were 6,900 children suspected of being abused or neglected in ND, which is an 8 percent increase (501 children) in one year. Eleven of ND’s 53 counties reported increases of at least 20 percent from 2010 to 2011. In 2011, there were 1,442 victims of child abuse and neglect in cases where it was determined that services were required (KCDC, 2013). Younger children are at greater risk of being a (suspected) victim of child abuse and neglect. In 2010, nearly one-fourth of suspected victims in ND were under the age of 4 (27 percent) (NDDHS, 2011).

The impact on ND children from domestic violence also is of concern. At least 4,739 children in ND were directly impacted by incidents of domestic violence in 2011.

Domestic violence victims, incidents, and children directly impacted, ND, 2005-2011



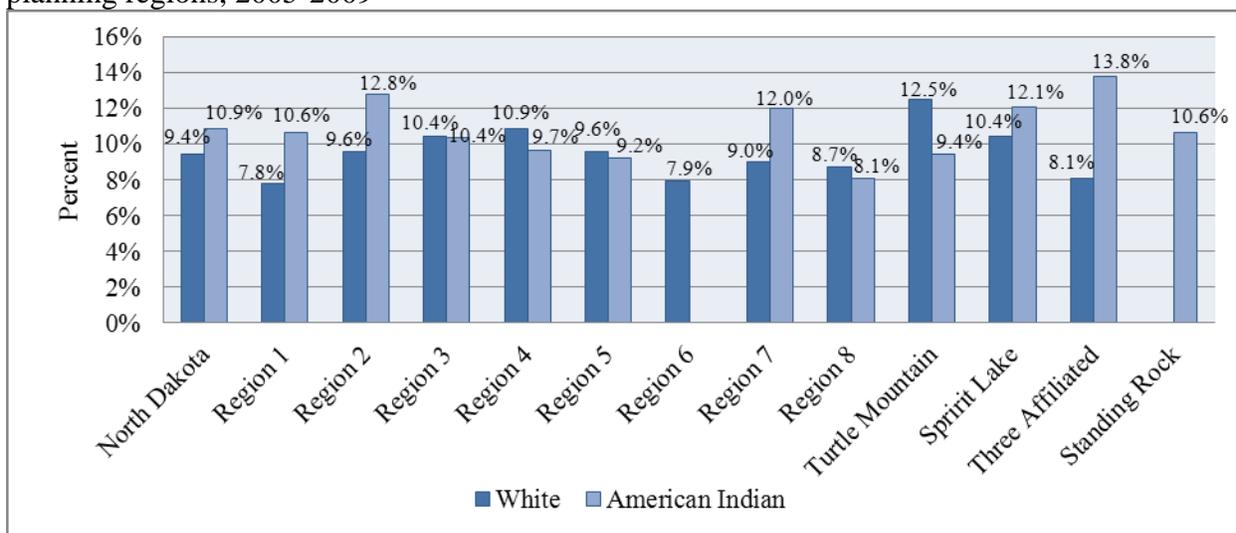
Source: North Dakota Council on Abused Women's Services

Birth outcomes

A review of birth outcomes reinforces the pattern of differential needs within the state. Using aggregated data from 2005-2009, 10 percent of live births in the state were preterm (4,164). This proportion is relatively unchanged from 2000-2004. Infants born to American Indian mothers have a greater risk of being born preterm in ND. According to data from 2005-2009, 11 percent of live births to American Indian mothers in ND were preterm compared to 9 percent of live births to white mothers. In the Three Affiliated tribal area, 14 percent of live births to American Indian mothers were preterm in 2005-2009.

The pattern for low weight births in the state was similar to that of preterm births. According to aggregated data for 2005-2009, 7 percent of live births in ND were low birth weight (2,850 births). This proportion remained unchanged from 2000-2004. Overall, infants born to American Indian mothers have a greater risk of being born with a low birth weight in ND. According to data from 2005-2009, 7 percent of live births to American Indian mothers in ND were low birth weight compared to 6 percent of live births to white mothers.

Percent of total live births that are less than 37 weeks gestation by race in ND's statistical planning regions, 2005-2009



Rates of deaths from birth defects, respiratory distress syndrome (RDS), and maternal pregnancy complications are higher in ND than the national average. There was an average of 154.8 infant deaths per 100,000 live births in ND due to birth defects from 2003-2005 compared to 136.5 in the United States overall. There were 28.5 deaths per 100,000 live births due to RDS compared to 20.9 nationally.

Developmental screening

The need for developmental screening in ND remains high. Survey data from 2011/12 based on parent feedback indicate that 19.9 percent of ND children ages 4 months to 5 years are at moderate or high risk for developmental or behavioral problems compared to 26.2 percent nationally (NSCH).

The rate of developmental screening conducted in the state is below national averages. In 2007, only 17.6 percent of the children ages 10 months to 5 years in ND who had at least one health care visit in the past 12 months had standardized developmental and behavioral screening (SDBS) conducted during their health care visit; nationally, 19.5 percent had screening conducted (NSCH).

Early intervention

ND's efforts in early childhood intervention show promise but need improvement. For example, the percent of children in the state ages 19 to 35 months who have received a full schedule of age-appropriate immunizations is relatively high. In 2005, 78.8 percent of children were fully immunized, however that proportion dropped to 76.0 percent in 2010 (ND KIDS COUNT). The 2011/12 data from the NSCH indicate that 85 percent of children ages 0 to 5 had at least one preventive medical care visit during the year. Findings from this survey point out that 19.9 percent of children ages 0 to 5 are at a moderate or high risk of developmental, behavioral or social delays which is a decrease of 2.8 percentage points from 2007.

In 2011, 13,123 ND children were enrolled in special education (14 percent of total public school enrollment). Statewide, 31 percent of students enrolled in special education had a specific learning disability, 25 percent had speech impairment, 6 percent were emotionally disturbed, 6 percent had an intellectual disability, and 6 percent had autism. Among children ages 3-5, 14 percent (1,804) were enrolled in special education in public schools, a proportion up slightly from 2009 (13%).

Reduction and remediation of toxic stress/trauma

Stress in children's lives comes from a variety of sources. A leading cause for young children is an adverse economic situation such as poverty or economic strains impacting their parents or caregivers such as unemployment or low wages. Similarly, stress typically results from maltreatment or the perceptions of impending maltreatment. Stress may also be individually derived such as an inability to adapt due to social, emotional, or cognitive issues. General outcome indicators for these typical stressors have been discussed above. A more generalized measure of the overall level of stress or trauma of children within the state can be derived from reports of family well-being. For example, data from the 2011/12 NSCH indicate that 7.7 percent of ND children ages 0 to 5 were reported to have two or more adverse family experiences.

Child care

The state's high labor force engagement by both men and women create an environment for potential high demand for child care. This is illustrated by the state's very low unemployment rates, very high rates of multiple-job holding (9 percent and third highest ranking in the nation), and very high rates of mothers in the workforce (77.5 percent, second highest in the nation). In 2010, approximately 73 percent of the state's young children lived in families where all the parents in the household were working (i.e., children potentially needing child care), which is the fourth largest proportion in the nation. Additionally, the number of children ages 0 to 5 in the state who need child care (i.e., have working parents) grew by 14 percent from 2000 to 2010. The statewide licensed capacity for child care only meets the needs of 37 percent of children ages 0 to 14 whose parents are working. For 20 counties throughout the state, licensed spaces are available for less than 20 percent of children whose parents are working. Population projections indicate that the number of children ages 0 to 14 in the state with all parents in the workforce will reach 99,000 children by 2015. This represents an increase of 9 percent from 2010 to 2015. This will contribute to an already strained child care system within the state.

The workforce within the child care system also will be strained. Approximately 4,800 North Dakotans in 2010 earned their living caring for and educating children in licensed early childhood settings. Estimates indicate that, by 2025, this workforce will need to expand by an additional 1,500 workers. The primary source of training for this crucial sector is ND's Child Care Resource and Referral (CCR&R) program. Their records indicate that 11,563 individuals completed training in the past year. Statewide, 38 out of 47 child care centers with budgets of \$500,000 or less were not nationally accredited and the vast majority of non-accredited centers stated they were not in the process of becoming nationally accredited.

Head Start Program's Key Areas of Need or Concern

A review of the various ND Head Start Program needs assessments revealed two key areas of need or concern pertinent to MIECHV a statewide Home Visiting Program. These two areas include health services and social/emotional issues. We will briefly highlight each of these two key areas.

Health Services

A common concern raised in the Head Start Program's needs assessments was the rise in childhood obesity and the need for more emphasis on issues such as nutrition, healthy weight, and exercise. Many of the programs have organized nutrition committees, implemented physical activity initiatives, and engaged families, caregivers, and communities in dialogues regarding nutrition and exercise. In addition, they have organized family support coordinator programs to monitor growth charts and other tools that assess healthy lifestyles. This is a significant issue area that should be considered with regard to potential emphasis areas in home visiting programs.

Social/Emotional Issues

A second common issue raised in the various Head Start Program needs assessments centered on social/emotional issues and disabilities among children. Head Start programs are reporting a growing number of children identified with disabilities. Similarly, program staff is reporting an increasing need for training in dealing with the social/emotional needs of children. In some cases, programs are exploring the Nurtured Heart Approach, Conscious Discipline initiatives or Education Specialist/Mentor Coaches as possible solutions. These initiatives and observations are indicative of a potential issue that should be explored. Data from the ND Department of Public Instruction indicates that, in 2009, 14 percent of students ages 3 to 21 enrolled in public schools were enrolled in special education. This is up from 13 percent in 2000 and 11 percent in 1995.

High Priority Unmet Needs

Developmental screening of children is a significantly underutilized preventative service in ND. Only about one of five children in the state was screened for developmental, behavioral and social delays in 2011 using a standardized screening tool. The dynamic population changes in the state combined with the pockets of underserved American Indian children on reservations makes this issue even more significant. The network of health service providers in much of western ND has been severely strained due to rapid population growth as a result of energy development activity. Complicating the issue is the rural nature of this region which limits access to health professionals. Similarly, the poor economic conditions on the reservations combined with service delivery challenges on reservations create significant strains on early childhood health care systems. As noted earlier, a major barrier to addressing the problem is the sparsely populated nature of ND. A key to resolving the issue is the creation and effective utilization of networks and partnerships that leverage local community assets, particularly human capital, with statewide resources. Fortunately, the past accomplishments of ND's ECCS program which established an early childhood infrastructure through the HNDECA network has positioned the state well to undertake such a challenge.

C. METHODOLOGY

In this section, the overall goals of the project and the listed specific objectives that respond to the stated need and purpose for this project are identified. The section is divided into five parts. Part A will be a general discussion of the methodological approach. It will outline the general goals and objectives of the project and highlight the strategies that will be used to accomplish the tasks. The Part B will focus on collaboration including a review of existing ECCS efforts and planned methods for multi-agency coordination. The Part C will discuss continuous quality improvement (CQI). The Part D will address information dissemination strategies. The Part E will center on sustainability of the project.

a. Methodological Approach

The project will center on five major goals and eleven objectives to accomplish those goals. These are discussed in detail in the project work plan.

Goal 1: Expand activities that increase developmental screening and associated training within early care and education in North Dakota and increase needed referrals when needed among medical homes, early intervention services, child care programs, and families.

- Objective A: Expand the Ages and Stages Questionnaire (ASQ) online system for easy access to a reliable screening tool for parents, caregivers and professionals.
- Objective B: Expand developmental screening activities in early care and education settings.
- Objective C: Increase cooperation to appropriately refer children and families.

Goal 2: Engage pediatric providers, child care health consultants, infant mental health consultants, home visitors, and child health professionals in developing strategies to improve linkages and referrals.

- Objective A: Create linkages to statewide networks of key health providers groups to influence professional strategies regarding screening and referrals.
- Objective B: Expand statewide networks that establish and promote policies and guidelines for early childhood screening and referrals.

Goal 3: Design approaches that utilize and promote training to early care and education professionals that focus on a) the importance of human development during infancy and early childhood, and b) early childhood developmental and behavioral screening.

- Objective A: Create clearinghouse for training opportunities.
- Objective B: Design training programs for key stakeholder groups.
- Objective C: Develop statewide mental health training.

Goal 4: Outline necessary system enhancements, work flow, financing structures and policy changes necessary to support the strategy.

- Objective A: Enhance community level policy environments.
- Objective B: Enhance capacity of child services.

Goal 5: Design approaches for capturing and documenting developmental and behavioral health screening and referral activities across early care and education, health, and early intervention systems that will be integrated into existing state data collection systems.

- Objective A: Integrate early childhood programs into State Longitudinal Data System.

Screening

The expansion of developmental screening efforts will be accomplished in a variety of ways. First, innovative efforts currently being piloted will be expanded. For example, the Children's Consultation Network (CCN), a network of mental health professionals located in the Fargo/Moorhead area whose mission is to provide social-emotional screening and therapeutic consultation services for children and caregivers, will continue its efforts in assessing the value of using handheld electronic screening tools for on-site mental health screening. Two evidence-based screening tools will be used: Ages and Stages - Social Emotional (ASQ-SE) tool for ages 6 to 60 months and the Pediatric Symptom Checklist. Each parent/guardian arriving at the pilot site clinics, with a child between the ages of 6 to 60 months, will be offered the parent friendly, electronic screening tool to complete while waiting to see their physician. The results of the screening tool will be immediately computed for review of child score vs. cut off score by the pediatrician during the appointment. Children with elevated scores, indicating social-emotional difficulties, will have access to a timely referral to an Early Childhood professional for further evaluation and face-to-face consultation. Children with elevated scores indicating social emotional warning signs will be then referred to appropriate community based resources. Second, local public health offices and their satellite units will be provided the ASQ-SE developmental screening toolkit for use in screening of their clients. Similar to the pilot clinics, pediatricians will review the scores and referrals will be made through the referral network. Third, in coordination with the ND Quality Rating and Improvement System (QRIS), an on-line version of the ASQ-SE will be made available for a much broader audience of parents, caregivers, and professionals. Guidelines for the management, promotion, and evaluation of this effort will be accomplished through the grant period. Finally, ND's Right Track program will be expanded. This program is managed through the North Dakota Department of Human Services (NDDHS) and provides in-home developmental screening using consultants.

Training

A variety of training activities and approaches also will be used throughout the project. First, the CNN will be coordinating training associated with the screening pilot project clinics. They will provide outreach activities to communities regarding children's mental health through various methods including a training series, fairs, school conferences, a web site, and collaborative partners. Second, North Dakota's CCR&R will assist in training activities through their Easy-to-Learn online training program which is delivered through a partnership with Minnesota. This program offers the learner interactive feedback with professionals. Third, training efforts will be targeted to key health provider groups. For example, one initiative will target the state's medical school to an effort to enhance training to medical students. This will be accomplished through a partnership with faculty within the medical school. Similarly, a collaborative statewide network of pediatricians, family practice physicians, and other child health care professionals will be organized to engage them in determining best training practices and solutions to more effective developmental screening. Finally, a network of families and caregivers will be organized to gain

insight into training needs from the caregivers' perspective. Initial efforts have started with the North Dakota Federation of Families for Children's Mental Health (NDFFCMH). The NDFFCMH is a parent-run organization focused on the needs of children and youth with emotional, behavioral or mental disorders and their families. They provide support, advocacy, and educational training for families regarding children's mental health. Their training and education incorporates social and emotional warning signs that are developmentally appropriate along with screening information and how to access services.

Referrals

The strategy for enhancing developmental referrals is through a more effective referral network. Pilot projects aimed at assessing the current children's mental health system in the state have concluded that one of the best ways to improve the system is to provide doctors, teachers, professionals and caregivers with easier access to resources through a comprehensive community children's mental health services guide. For example, a successful pilot project in the Fargo/Moorhead area was created through Children's Mental Health Summit in 2006. Health professionals in the region joined together to evaluate the children's mental health system within the region and identify ways to improve it. One result was the joint collaboration of this health professional to create a comprehensive resources guide which detailed children's mental health services in the region. The guide contains information about what services each agency provides areas they address, insurance they accept and other contact information. Through this grant, the collaborative process of bringing health professional together to examine children's mental health services will expand to create a statewide referral network.

Surveillance and Data Tracking

The ECCS program has established epidemiology support for the program's work plan through the Center for Social Research (CSR). See Attachment 4-1. An epidemiologist will coordinate surveillance functions as well as oversee the systematic collection of data. Additionally, the epidemiologist will assist in the analysis and reporting of data; tracking of trends; and identifying gaps and disparities in data and programmatic activities. The epidemiologist will lead the development and implementation of a statewide data surveillance plan system and is responsible for the development of reports and other communications regarding survey findings derived from the data surveillance plan. The epidemiologist will provide technical assistance and consultation to the ECCS program and HNDECA members on the use of early childhood data.

A second component to the surveillance and data tracking system is the partnership with the new State Longitudinal Data System (SLDS). North Dakota's SLDS was initially formed in 2007 through statewide legislation (ND Century Code Section 15.1-02-18). The overall purpose of the SLDS is to leverage stakeholders and partners of education, training, and employment programs for the purpose of research and evaluation of programs in order to improve outcomes. The system is housed in the state's Information Technology Department (ITD). ITD has established a Early Childhood subcommittee as an advisory group as the project works towards gathering early childhood data. Currently, five HNDECA members make up this early childhood advisory: the ECCS program director, the State Head Start Collaboration Office director, a representative from the Department of Public Instruction, a representative from the NDDHS Early Childhood Services, and the PCAND director. ITD is currently finishing its Phase I efforts and moving into Phase II which includes incorporating additional Pre-K/early childhood data. Since the SLDS is

a longitudinal data set and incorporates a vast array of data on individuals (e.g., enrollment records, educational performance, program participation), it has the ability to examine the long-term impacts of early childhood events and activities. Thus, this effort offers significant promise for objectively exploring the value of early interventions.

Capacity Building and Policy Changes

Capacity building and policy development will be accomplished by leveraging the extensive network of 85 program providers and stakeholder groups HNDECA. The alliance facilitates enhanced communications, develops a shared knowledge base regarding the state's early childhood programs, and identifies common goals and challenges for change. Its core mission is to provide leadership by planning, developing and implementing collaboration and partnerships to support families and communities in their development of children. The past efforts of HNDECA in capacity building and policy changes are outlined in the following discussion of collaboration.

b. Collaboration

The organizational structure in ND for early childhood development built through previous ECCS efforts is the HNDECA. Its governance structure is currently built around six main committees. A Leadership Committee oversees the overarching Stakeholder Committee (see matrix on page 24) and subcommittees which function as the main working groups.

The ECCS Program Director will continue to assist with coordinating subcommittee meetings which center on each of the goals to be accomplished. In order to facilitate the work of HNDECA, each subcommittee has selected a chairperson or co-chairpersons to lead the group. These chairpersons serve as a lead contact to coordinate activities with the ECCS Program Director between meetings and to provide routine reports to the Leadership Committee.

The HNDECA Leadership Committee is a statewide leadership team that was established to assure the effectiveness of the system planning and implementation effort. The Leadership Committee consists of representation of three NDDoH program directors: Title V Maternal and Child Health (MCH) Director, ECCS Coordinator, and Children's Special Health Services; the MIECHV Director; CCR&R Director; community member with a Doctorate in Early Childhood; and program directors from the NDDHS, which include Early Childhood Services, Child Care Administration, Head Start State Collaboration Office, Medicaid, Children's Mental Health and Substance Abuse, Child Care Assistance, Children's Trust Fund, and Child Fatality Review Panel. Other representatives include ND KIDS COUNT, Family Voices of North Dakota, NDSU Parent Resource Centers, and the NDFFCMH, United Tribes Technical College, the American Association of Pediatricians (AAP) and families.

The HNDECA Leadership Committee has identified a need to continue enhancing partnerships statewide with a key focus on leveraging existing resources and creating collaboration among programs to reduce fragmentation of policies. Upon receipt of project funding and in collaboration with the ND Chapter of the American Academy of Pediatricians (AAP), a search for a pediatrician to serve on the HNDECA Leadership Committee will be conducted. The Leadership Committee participants continually review and discuss the need for clearer outcomes

and indicators as well as better collection, reporting and use of data sources. Participants want to be sure that all of their efforts are clearly understood by the group and that all are working toward the same broad goals. They strive to be sure that the process is effective and that the outcomes and indicators will provide the federal funding source with the documentation needed to illustrate progress and success.

ECCS SYSTEMS DEVELOPMENT EFFORTS

The ECCS grant's new primary focus is to coordinate the expansion of developmental screening activities in early care and education settings statewide. To accomplish this, the program must elaborate on established collaborations and partnerships that support providers, professionals, families and communities as they, in turn, support implementation and continuity in statewide developmental screening. For the past ten years, ECCS funding has afforded ND the opportunity to engage in strategic planning and partnership building required to develop a comprehensive early childhood system. HNDECA stakeholders will continue to convene regularly for the purpose of fulfilling the ECCS grant work plan initiatives through the grant period. HNDECA partners will look back on accomplishments and redefine priorities to develop a comprehensive road map for further program implementation.

Not only has the ECCS program taken action to develop a systems building plan, it has taken the extra step of ensuring that the plan also involves consensus building. In simple terms, consensus refers to agreement on some decision by all members of a group, rather than a majority or a select group of representatives. The consensus process is what a group goes through to reach this agreement. The assumptions, methods, and results are very different from traditional parliamentary procedure or majority voting methods.

In the traditional political/legal processes, one side wins and one side loses. Some issues come back time and again, or an issue may be so contentious that it is simply never resolved. By contrast, a public policy consensus dialogue is framed and agreements developed in a mutually beneficial way ensuring that no issue is "off limits" and that all essential stakeholders are on board.

Acting according to consensus guidelines enables a group to take advantage of all group members' ideas. By combining their thoughts, people can often create a higher-quality decision than a vote decision or a decision by a single individual. Further, consensus decisions can be better than vote decisions because voting can actively undermine the decision. People are more likely to implement decisions they accept, and consensus makes acceptance more likely.

Specific to HNDECA, members are provided with guidance (written and verbal) regarding the proposed goals and products of each meeting to help the participants be clear about their stake in the meeting. During the meeting, ECCS staff provides facilitation and problem solving and assures a level playing field for all participants and that the agreed upon ground rules for discussion are followed.

Following each meeting, ECCS staff develops a written record (summary) that reflects the discussion held and the agreements reached. Unlike traditional meeting "minutes", the summary

is a product of the work of the group rather than any individual effort. This approach ensures that single voices are heard but group decisions are made and that process is what is recorded in the summary.

ECCS PROGRAM FUNDING INITIATIVES:

In this section, the past efforts of our partners are described as they worked towards the development of systems building through moving forward on their individual work plan, goals and objectives. It is important to realize the work that has been done through HNDECA because it has laid the foundation for the future of the ECCS program as we developed this application. The work has provided the groundwork for the expansion of statewide developmental screening activities. Through the work of HNDECA, strong partnerships have been established which have helped to begin the systems building process in North Dakota. HNDECA has grown to over 85 partners representing state, local, public and private entities, along with family advocates and community members. Given the rural nature and small population of ND, committee work can sometimes be a challenge. However, active participation in HNDECA along with the increase in partnerships has shown a commitment to early childhood and has been valuable in the implementation of the ECCS work plan.

As a result of continued ECCS program implementation, seven contracts supporting implementation of the HNDECA work plan goals during 2012-2013 were awarded. HNDECA stakeholders developed a Request for Funds and a scoring mechanism was designed to score each applicant on the following criteria: Statement of Need, Collaboration Efforts, Evaluation, and Budget. The scope of work for the seven HNDECA projects for funds awarded is as follows:

- ***Lakes and Prairies Community Action Partnership*** developed a plan and implemented a Classroom Assessment Scoring System (CLASS) Coaches in ND for the purpose of improving CLASS scores within early childhood classrooms in ND. The coaching program is a partnership between the teacher and a trained consultant that provides relevant, interactive, and ongoing feedback. The CLASS is a tool for observing and assessing the qualities of interactions among teachers/caregivers and children in early childhood settings. It measures the emotional, organizational, and instructional supports provided by teachers/caregivers that are known from research to contribute to children's social development and academic achievement. The tool is used to assess interactions between teachers/caregivers and children for a variety of purpose, including professional development, monitoring and evaluation, and research.

The CLASS focuses on the quality of classroom interactional processes, rather than on the content of the physical environment, available materials, or the specific curriculum. The physical environment (including materials) and curriculum matter in the context of how teachers put them to use in their interactions with children.

In ND, the CLASS is being used in Head Start programs and in the emerging Quality Recognition and Information System (QRIS) as a monitoring and measurement tool. QRIS includes preschool, child care and Head Start settings and includes categories and

measurements for Family Involvement, Learning Environment, Health and Safety, Professional Development, Curriculum, and Program Administration, many of which parallel the focus areas of HNDECA. Therefore, it is important to develop an adequate infrastructure of trained personnel who can reliably use the tool for assessment purposes, but also to coach teachers and caregivers to improve their practices as defined by the CLASS.

Participants invited included professionals from the early care and education field within ND. These professionals may be affiliated with child care centers, preschools, CCR&R programs, and Head Start programs throughout ND.

- ***Minot State University*** project provided a Care Coordination and Health Benefits Counseling training. The ND Center for Persons with Disabilities (NDCPD) at Minot State University developed the Care Coordination and Health Benefits Counseling training as a part of the ND Integrated Services grant. The Care Coordination and Health Benefits Counseling training was designed to assist families, parents, consumers and health professionals with navigating the complex health insurance system. There are five web-based modules that teach participants about health benefits counseling, care coordination, medical home, healthy transitions and state and local resources. The training was provided to state level staff (Children's Special Health Services (CSHS) and Family Health Division for the NDDoH, 977-KIDS Now staff in the NDDHS, etc.), family organization staff (Family Voices, Pathfinder, Experience Parents, etc.) and county social service staff that administer the CSHS program. This project provided the funding for 25 individuals to participate in the training.
- ***North Dakota Child Care Resource and Referral*** project developed a companion piece for the Early Learning Guidelines, birth to age 3. The committees of HNDECA continue to spread the word about ND's Early Learning Guidelines (research-based, measurable descriptions of the things young children are expected to know and be able to do at each age and stage of development). In 2011, ND adapted and printed a parent/provider companion piece to Early Learning Guidelines for ages 3-5 from a resource available in the state of Montana. ECCS grant dollars braided with stakeholder funding allowed for two printings of the document. The document has been widely distributed and well received based on stakeholder feedback. It helps families and child care providers understand how a child is growing and learning and helps them plan activities and use family/caregiving routines to support child growth and development.

The years from birth to three are critical years for the development of foundational skills that can lead to life-long success. ECCS recently provided funding to CCR&R to develop a companion document for birth to three year old. This companion document will help families and child care providers develop a better understanding of infant and toddler development, include a simple developmental checklist, and provide some strategies they can use to enhance children's development. It encourages natural setting assessment practices that are carried out during everyday learning and play experiences. The companion document stresses that children develop in the same general pattern but at

different rates, and skills grow from simple to complex, and encourages readers to explore and adapt activities as appropriate for each child's needs.

Future updates/revisions and reprints will be necessary to continue educating all parents of young children and child care providers about how children develop and learn, making our state's citizens more in tune to child development and when to be concerned.

- ***Lutheran Social Services of North Dakota*** project developed five Public Service Announcements (PSA) for radio broadcast aimed toward educating the general public about key factors they need to consider as they evaluate their current or future child care arrangements. The five PSAs included messages regarding safety, mental health, nutrition/physical activity, early learning and child care best practices. The concept of this project was to educate and inform parents and providers regarding quality child care and all the aspects they should consider when looking for a child care provider. If we were able to gain parents attention to the importance of these issues, then parents would perhaps discuss these with the providers and providers might change their policies regarding parents' concerns and needs.

The HNDECA stakeholders can see the impact of this type of education for parents in many areas of child care, including developmental screening. If parents are informed and educated they will talk about developmental screenings to the child care provider, their pediatrician, and anyone who has the opportunity to provide this service. If parents drive the issue about the importance of screening, it removes the stigma surrounding child development issues.

- ***Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*** is a set of guiding principles developed by the AAP for use in pediatric well-child visits from the prenatal period to age 21. The Bright Futures guidelines address the care of all children and adolescents to include children and youth with special health-care needs and children from families of diverse cultural and ethnic backgrounds. The NDDoH's Title V and ECCS programs, in collaboration with the NDDHS, provided an educational training based on the AAP Bright Futures guidelines in November 2012. This training provided materials and education on how to provide uniformity in the preventive care children in ND receive. The target audience for this training was local public health, Head Start, Early Head Start, Health Tracks and Medical Home pilot sites. In attendance were 107 participants, who mainly consisted of nurses and social workers, as well as some physicians.

In conjunction with a development screening tool, Bright Futures can enhance health promotion and monitor children for physical and behavioral problems. Age appropriate anticipatory guidance can be used to help facilitate discussion and concerns parents may have regarding their child. Bright Futures recommendations and guidance coincide with the key developmental periods in children.

A core value of Bright Futures is their commitment to health promotion and disease prevention. Bright Futures recommends states develop a community resource guide to be

used as a means of linking community members with health and education professionals. ND already has a directory which connects families to existing programs, resources and contact information regarding the services available to children, women and families - [A Connection Directory for Families and Agencies](#). This directory is currently being revised and the updated directory will be available July 2013. ECCS program staff and HNDECA stakeholders continuously promote the use of the Connection Directory in early care and education, schools and healthcare agencies.

As an overarching construct for our work moving forward, Bright Futures will continue to be a source of best practice guidance.

- **North Dakota State University Extension Services** conducted full day Nurtured Heart Approach (NHA) workshops in seven regional sites throughout ND during the spring and early summer of 2012. Five more workshops are scheduled for the spring and early summer of 2013. The NHA workshop provides a set of strategies that builds richer relationships between adults and children.

Many parents and professionals report increasingly difficult and challenging child behaviors. Based on the interest of programs such as Nurturing Hearts, it is apparent they are looking for information to improve their skills in addressing intense child behaviors that will result in improved behaviors at home, in school, and in public. The NHA, developed by Howard Glasser, M.A., is a way to deliver social emotional curriculum with messages of value, competence, respect and belonging. This approach represents transformational change in how parents and those who care for children nurture, support, and communicate with them. Through using the NHA, parents and others move from being “behavior police”, reacting intensely to unwanted behavior, to growing good behaviors by becoming “success mentors” in the lives of children. Research from a study of 41 five-week NHA courses conducted over two years indicates that parents experience beneficial changes in their role in dealing with emotional and behavior problems of their children. Parents trained in NHA significantly increased positive attention to their child and decreased negative exchanges (e.g., yelling, scolding) relative to a control group (Joel Hektner 2013). Crucial concepts of the NHA and communication skills specific to the approach are taught in overview sessions and 5-week NHA parenting classes.

In 2009, a group of community partners in Cass County began developing a comprehensive plan to implement NHA training and classes throughout the county. Response to NHA has been very positive and word of its use has been spreading across the region and state. A total of 41 NHA programs have been conducted in the region during a two year period. In addition to direct parent education, the NHA is also being embedded in agencies and schools throughout the region. Multiple agencies have been integral partners in the collaborative planning, implementation and future sustainability of the local NHA project in Cass County. Many have worked together to bring training to the community over the past three years and there has been an amazing amount of community resources committed to this work in terms of collaboration, providing community facilities for training, and promotional activities. A common thread of commitment from the HNDECA partners runs through the listing that follows:

NDSU Extension – Cass County has provided vision and leadership to the local NHA Community Collaboration Project. NDSU Extension Administration has been incredibly supportive of this work with both small doses of funding and by conducting evaluation activities to assess NHA’s vision and resulting outcomes. Although NHA is not yet a recognized evidence based practice, evaluative research of programs in the Midwest is accumulating compelling evidence that demonstrate its efficacy. NDSU Human Development Family Science faculty, Dr. Joel Hektner, is the project researcher in this evaluative effort.

Several year ago, PATH ND embedded NHA in their work. They have multiple NHA Advanced Trainers throughout the state positioned to support local NHA work in their regions. PATH ND has provided personalized treatment foster care and family-based services for children and families throughout the state of North Dakota since 1994. During this time, PATH ND has pioneered the treatment foster care concept and has built a reputation for quality and leadership in the foster care field.

Cass County Social Services has 18 staff trained in NHA. They are currently using and integrating NHA in their work with families.

NDDHS – Southeast Human Service Center has one NHA Advanced Trainer on staff. They are one of three research sites should the research proposal to National Institute of Mental Health submitted by Dr. Joel Hektner be accepted.

United Way of Cass-Clay has placed their vision and focus on building community capacity and increasing high school graduation rates. United Way has been an important supporter, financially and with their program focus, vision and leadership in the community. They continue to be a strong supporter of the ECCS program and have extended their continued support of the ECCS program for the upcoming grant period of 2013-16.

Fargo, West Fargo, and Moorhead school districts have provided financial support to the NHA project from the beginning. Currently, West Fargo Public Schools have two active NHA Advanced Trainers educating internally and in the community. Fargo Public Schools is currently supporting over 35 staff to attend a Nurturing the Heart of Autism professional development workshop.

South Eastern North Dakota Community Action Association (SENDCAA) Head Start in Fargo has trained all of their staff (teachers, paraprofessionals, cooks, bus driver, etc.) in NHA. They are embedding the approach into their work with children and families. They also have two active NHA Advanced Trainers on staff, training both internally and throughout the community.

Children's Consultation Network has been a collaborative partner. Two of their staff are NHA Advanced Trainers. They integrate NHA in their mental health work with families.

Additional agencies serving on the NHA Collaborative Team and supporting the community wide work included CCR&R, Clay County Collaborative, Fargo Cass Public Health, The Village Family Service Center, YWCA Shelter, Prairie Public TV, ND Autism Center, Red River Children's Advocacy Center, ND Autism Society, and Red River Valley Asperger-Autism Network.

These HNDECA partners feel this coordinated education effort will develop and strengthen the ND Parent Education Network's capacity to deliver and sustain NHA education statewide.

- ***Children's Consultation Network*** utilized ECCS program funds to create a plan to develop and expand services to CCR&R child health consultants across ND. These services included (1) survey child health consultants at the five ND CCR&Rs to identify the needs of child care providers, (2) provide "Eager to Learn" trainings/consultation to the CCR&R consultants; (3) provide resources to CCR&R consultants and providers on how to handle typical behaviors presented in child care; (4) provide direct consultation services; and (5) market materials which promote education on early childhood development and mental health.

It is important to note that the ECCS Program Director represents the program and its stakeholders on numerous coalitions and advisory boards in order to keep a pulse on any and all opportunities of braiding work plan activities and funding. Key insight gained from participating in these activities along with the important networking and relationship building opportunities of membership on the boards and in the coalitions improves the ECCS program's to strengthen and advance its focus on developmental screening. Some of the coalitions and advisory boards that the ECCS program director attends are:

- MCH Title V Core Team Committee
- Healthy ND Advisory Board
- Ronald McDonald Care Mobile Advisory Committee
- ND Home Visiting Coalition
- ND Social Emotional Development Alliance
- ND Oral Health Coalition and the Access Subcommittee
- Region VII Children's Services Coalition
- NDDoH Physical Activity in Child Care Advisory Committee
- ND Coordinated School Health Interagency Workgroup
- ND Head Start Collaboration Office – Early Childhood Health Committee
- ND Economic Security and Prosperity Alliance
- ND Early Childhood Learning Committee (Governor's Early Learning Council)
- ND Early Childhood Longitudinal Data Committee

ECCS PROGRAM COORDINATION:

The following matrix identifies current service integration activities existing within ND regarding early childhood intervention and the status and capabilities of those services. These are the partners that comprise HNDECA and represent their programs and work collaboratively for the efforts of ECCS and many other opportunities to braid funding for early childhood development. They lead state policy development that supports programs or services that focus on mitigating toxic stress, expanding developmental screening, and strengthening systems for improved child care quality and child care health consultation in infancy and early childhood in ND. The matrix may not be inclusive of all entities, but is meant to illustrate the foundation the ECCS has built over the previous years and that it continues to attract partners around the state.

Integration Partner Name and Category of Service	Partner Level S = Statewide MS = Multi-State N = National R = Regional in ND DL = District/Local	Contributions							
		Communication Network Access	HNDECA Member	Consultation	Data Analysis	Epidemiology	Evaluation	Training/Education	Visibility (credibility)
Head Start: (Education) Beulah & Hazen West River Head Start Dickinson Public Schools – Community Action Head Start Early Childhood Center Early Explorer Head Start & Early Head Start Minot Public School District – Head Start & Early Head Start South Eastern ND Community Action Agency SENDCAA Head Start - Fargo Spirit Lake 0-5 Head Start Program Standing Rock 0-5 Head Start Three Affiliated Tribes Head Start – New Town	R DL	X	X	X	X			X	X
Child Care Resource & Referral: (Child Care & Training) First Children’s Finance CCR&R Grand Forks, ND Lakes & Prairies Community Action Partnership Lutheran Social Services (Fargo & Moorhead)	S R	X	X	X				X	X
Coalition: (Advocacy) Governor’s Early Childhood Education Council Children’s Services Coalition – Region 7 Family Voices of North Dakota Federation of Families for Children’s Mental Health Healthy Families – Home Visitation Mental Health America of North Dakota North Dakota Council on Abused Women’s Services Prevent Child Abuse North Dakota North Dakota Home Visiting Coalition United Way of Cass-Clay	S MS	X	X		X		X	X	X

<p>North Dakota State Agencies: (Government)</p> <p>Department of Commerce – Community Services Block Grant Program Economic Development & Finance Division</p> <p>Insurance Department – Health Insurance Counseling</p> <p>Department of Health – MCH Title V Children’s Special Health Services Division of Family Health Field Medical Officer Oral Health Program</p> <p>Department of Human Services – Child Care Assistance Child Support Enforcement Children & Family Services Disability Services Division Early Childhood Services (state child care licensing) Medicaid & Healthy Steps Eligibility Mental Health & Substance Abuse (Children’s Mental Health Program) Part C Early Intervention Public Information State Children’s Health Insurance Program (SCHIP) Health Tracks Screening & Services Tribal Liaison</p> <p>Department of Public Instruction – Community Learning Homeless Project Office of Special Education School Approval and Accreditation Healthy and Safe Schools</p>	S	X	X	X	X	X	X	X	X
<p>District Health Units: (Public Health)</p> <p>Bismarck/Burleigh Public Health Unit Dickey County District Health Unit Cavalier District Health District Central Valley Health Unit City County Health Department Custer Health Emmons County Public Health Fargo Cass Public Health First District Health Foster County Health Department Grand Forks Public Health Department Kidder County District Health Unit Lake Region District Health Unit LaMoure County Public Health Department McIntosh District Health Unit Nelson/Griggs District Health Pembina County Health Department Ransom County Public Health Department Richland County Health Department Rolette County Public Health District Sargent County District Health Unit Southwestern District Health Unit Steele County Public Health Department Towner County Public Health District Traill District Health Unit Upper Missouri District Health Unit Walsh County Health Department Wells County District Health Unit</p>	DL	X	X	X	X			X	X
<p>Special Services (Education)</p> <p>Anne Carlson Center Minot Air Force Base</p>	DL		X					X	X
<p>County Social Services: (Government)</p> <p>Burleigh County Griggs County Mountrail County Trail County</p>	DL	X	X	X	X				X

Tribal Government: (Government) Indian Health Services Spirit Lake Employment & Training Spirit Lake Nation Standing Rock Nation United Tribes Technical College	R	X	X	X					X
Associations (Health & Human Services) North Dakota Community Action Association	S	X	X	X					X
Higher Education (Colleges/University) North Dakota Center for Persons with Disabilities Minot State University – Early Childhood Special Education Medical Home Pilot Project North Dakota State University – Center for Child Development North Dakota KIDS COUNT Program Barnes County Extension Services Cooperative Extension Service University of Mary – Division of Education University of North Dakota – School of Medicine & Health Services – Center for Rural Health United Tribes Technical College	S	X	X	X	X	X	X	X	X
Media (Information/Technology) Prairie Public Broadcasting	S	X							X
Medical Professional Association North Dakota American Academy of Pediatrics	S	X	X	X	X			X	X
Community Health Care Association of the Dakotas (Community Health Centers)	MS	X	X						X

ECCS PROGRAM DEVELOPMENT:

The next step in our long term planning efforts will be to hold a strategic planning meeting for all HNDECA stakeholders in the fall of 2013. This meeting will offer an opportunity to provide updates, report facts and findings regarding both epidemiological data gathering and discuss the analysis of those findings. This strategic planning meeting will then provide stakeholders an opportunity to negotiate the roles they will play over the next three years in advancing the objectives and activities within the ECCS work plan submitted with this grant. In addition, strategies for evaluating success will be discussed with HNDECA stakeholders including the indicators and processes that will be used for each objective. The stakeholders and lead pediatrician will also define their new roles within the Early Care/Education, Public Health/Health Care Providers, and Policy/Systems/Professional Development committees to address the work plan activities as the ECCS program focuses on statewide developmental screening issues.

The continuous epidemiologic data collection and evaluation process will ensure HNDECA stakeholders have an accurate pulse on early childhood issues in ND that are made available by ECCS grant funds.

THE ROLE OF FAMILY MEMBERS:

Families are active in HNDECA and its subcommittees. There are family participants on each of the HNDECA subcommittees and input from this group has been invaluable. Families have empowered each subcommittee to view each system as a support to families, instead of just as a stand-alone system. The family participants will continue to be involved as we proceed with the ECCS state plan. In addition, most of the members of HNDECA are parents themselves and,

thus, may be asked to give information and opinions through that lens to help create broad and diverse dialogue.

In 2010, a new project solicited the help of families statewide to share their stories of success regarding early childhood programs and organizations throughout the state of ND.

The goal of this project is to connect with local legislators and share the value of early childhood programming in ND through stories and experiences. Families were asked to highlight a positive experience they had with a state, local or community program (i.e., their local Head Start, Family Voices of North Dakota or CCR&R program). Family stories are a powerful way to develop relationships among parents, professionals and policy makers. Their stories reveal the details and the impact of systems on the daily lives of families and children. They help people connect and they connect us to our work and to each other in meaningful ways. They deepen our understanding of individual and shared experiences. And it is our hope that they will spur change in systems that seem unnecessarily difficult to understand.

A folder was assembled for the families that contained a photo frame greeting card, including the matching stationary and envelope. A cover letter explained the purpose of the project, the importance of them sharing their success stories and thanked them for participating. A “how to” document outlined the letter writing process and provided suggestions of what to include in their story and reminded them not to solicit or lobby for certain legislation or to ask for money. The project was to inform legislators that current programs and services in their legislative districts were being utilized and parents/children/families were gaining success from these programs. Our intent was to be informative and demonstrate the value of children’s programs and services during the deliberations of the 2011 legislative session. The purpose of personalizing messages to legislators is to reinforce the fact that they are involved members of their home districts and have influence or impact on the very programs and services that affect the residents of their district. The folder also contained an information release form, a map of legislative districts and a listing of legislators by district.

Approximately 256 packets were distributed by HNDECA stakeholders. Stakeholders included:

- CCR&R
- Family Voices of ND
- Healthy Families
- Fargo/Cass Public Health
- Head Start Agencies
- ND Department of Health – Children’s Special Health Services
- Morton County Social Services
- NDSU Extension
- NDSU – Gearing Up For Kindergarten
- NDDHS – Early Childhood Services
- Early Intervention

The stakeholder groups served as a liaison with the families to distribute and collect the letters, cards with a photo attached, and release forms. The stakeholder liaisons were to review the

letters for accuracy of information (names of organizations, services provided, etc.) and to rule out any letters of advocacy.

Cards and letters were delivered to the ND Legislative Assembly on Wednesday, January 19th, 2011. The legislature had been in session for two and one-half weeks. There are 47 Senators and 26 (55 percent) received at least one card and letter. Of the 94 members of the House of Representatives, 49 (52 percent) received at least one card and letter. Many legislators received multiple cards and legislators from different programs and organizations. Legislators in 29 of the 53 county districts received cards and letters. This effort engaged a new cadre of early childhood professionals and parents in the work of educating legislators about the importance of the service array. Further, it produced a platform for advocates to build meaningful relationship with legislators.

Stakeholder participants were excited about the project and felt that it would connect constituents to legislators. Families gained confidence and power in the ability to share their successes. This project was repeated during the 2013 legislative session. However, it is too early to gather and interpret data to understand the impact or effects of their efforts to bring education and recognition of community organizations and their programs to their constituents and their families.

PARTNERSHIP MOU'S:

During the upcoming ECCS grant period, PCAND will be working with these organizations to secure necessary MOU's and will provide the progress in this effort in the program's annual progress reports. In the interim, as the ECCS program transitions from the NDDoH to PCAND, MOU's that have been previously established are still recognized by the NDDoH. In 2003, a multi-agency Memorandum of Agreement (MOA) was established between the NDDHS, NDDoH, and the Primary Care Office/Primary Care Association. This agreement defined the responsibilities of parties with respect to people receiving Title XIX (Medicaid), Title V (Maternal Child Health and CSHS), Title X (Family Planning), Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), North Dakota Head Start State Collaboration Office, Diabetes Prevention and Control Program, Right Track Program, Immunization Program and Birth Review Program services. The MOA states that the Division of Vital Records will compile and share data with other entities. Partners have identified the need to routinely review this MOA and provide updates. A copy of the MOA is available upon request.

c. Plan for Continuous Quality Improvement Process (CQI)

CQI leadership and personnel:

Specific accountability for CQI will be held by the Project Administrator and the Center for Social Research. The ECCS program staff and the CSR will assume responsibility for the overall design and maintenance of the CQI system. As the senior CQI leadership, they will together ensure:

- coordination between all CQI levels,
- calibration of data,

- early and relevant feedback to all project and CQI teams,
- and, completion of federal reporting duties.

Mezzo and Macro CQI groups

CQI efforts will be driven at two primary levels for the project. Macro level work impacts the entire scope of the project and mezzo level work will be specific to a various topic specific committees. The HNDECA will serve as the macro level team while the Early Care/Education, Public Health/Health Care Providers, and Policy/Systems/Professional Development committees of HNDECA act at the mezzo level. Micro level work is accomplished within agencies which will provide representation to the mezzo level teams. As project related work from various agencies is completed, it will be reported out to the appropriate mezzo level team. This team will complete a review and analysis and make suggestions back to the various agencies about process. CQI data will also be forwarded to HNDECA which will work with all teams to derive CQI projects, complete reviews and create feedback ongoing.

CQI maintenance: The ND ECCS believes that the quality of process is critical to achievement of excellent outcomes and that shortfalls in progress are most often attributable to issues within the process rather than issues with the individuals involved. As such, the goal of the ECCS is the reduction of unwanted variance in the process of achieving outcomes. CQI will be the responsibility of all project staff, and training will be provided to all team members to ensure their capacity to fulfill their role in the system. Project committees within the ECCS will be independently tracked to identify progress and evaluate effectiveness. Feedback, analysis and reporting tools will be developed by the committees as needed.

Administration schedule and reporting: The CQI design will include a cycle of planning, acting, and reviewing. The planning phase (currently in process) involves identification of specific standards of program delivery; process indicators; outcome measures of programs; and coordination both of collection efforts and of communication among program partners, families, communities, and stakeholders. The action portion of the cycle (to begin after receipt of award and proceed through the duration of the project) involves provision of services, including collection of data, as described in the work plans. The review process (to begin within the first month of service and recur throughout the project) entails analysis of completed work and identification of strategies for improvement.

CQI priorities and relevant subjects: CQI priorities will be (1) to continue to gain system completeness through the three stages of CQI; (2) to put data to effective use such that participant families receive increasingly high quality services; and (3) to integrate the core data necessary for improving and developing statewide systems to support screening. Relevant subjects of CQI include screening delivery, referral systems, supervision and management of these systems, universal screening and coordinated intake, and interface in the early childhood system.

d. Plan To Disseminate Information

Information from the various components of the project will be disseminated in a variety of ways. First, as in the past, progress on the activities will continue to be shared with HNDECA through meetings and via the ECCS website. Further dissemination will occur as HNDECA members report progress to their respective networks creating a cascading effect. Second, the development of a communications strategy for various activities is built into the work plan. Included in this strategy is the design of factsheets, multimedia presentations, and marketing approaches aimed at effectively reaching a broad audience of child health professionals, caregivers, educators, child advocates, and child care providers. Third, program progress will be consistently provided to state agencies (e.g., NDDoH, NDDHS, North Dakota Head Start State Collaboration Office) through HNDECA partners. Finally, community leaders and key policy makers will be informed of progress through briefing notes and factsheets that will be designed for key stakeholders.

e. Sustainability

To assure program sustainability and collaboration, the ECCS program has positioned itself to be the primary gathering and analyzing entity for early childhood program data, with the help of the HNDECA stakeholders. Each is supportive in providing data and information pertinent to our efforts. The ECCS program can continue to provide this vital role in the state of ND to all those who are in need of such data regarding early childhood issues.

The work of ECCS is about partnering to establish sustainable systems. Model screening projects conducted in ND through medical provider systems have shown sustainability once in place. Hospitals especially seem responsive to the concept of expanded screening on mental health issues. The most significant challenge to sustainability is insuring availability of referral systems and service providers. Sustainability efforts will target two key areas: screening/referral and service providers. ECCS and HNDECA will focus on large medical systems in the state to systematize the screening and referral process and maintain them within their existing structures. Working with insurance providers and state agencies, ECCS hopes to encourage participation as a “normal” activity health care provider practicing with young families.

The establishment of service provider training networks and post screening service systems is a state and local, private, and public partnership issue. The ECCS will work at the state agency level to encourage policy initiatives that support investment in system sustainability. At the local level, the ECCS and HNDECA will support community efforts to identify funding sources to sustain provider systems. The ECCS project will aggressively seek supplemental state and private funding to support the work plan in subsequent years.

D. WORK PLAN

The following describes the objectives used to achieve each of the activities proposed in the ECCS Strategy #2 Work Plan and outlined in the previous Methodology section. Please note that this work plan ties to the North Dakota ECCS Logic Model 2013-2016 which is available in Attachment 5-2.

The ECCS project has routinely updated the federally approved State Early Childhood Plan to reflect new technologies and emergence of new funding and partnership opportunities as well as legislative policy changes affecting the implementation of the plan. All changes made to the plan are done by consensus and are thoroughly reviewed and discussed with stakeholders. While the core functions and priorities of the plan remain generally stable, the plan is flexible enough to meet the ever-changing landscape.

Relative to the program infrastructure, ECCS staff includes the Project Director and Project Assistant, both of whom are employed by PCAND. It is important to note that while PCAND is a new applicant for ECCS funding, the former ECCS Project Director retired from the NDDoH and was recently hired by PCAND to retain the continuity of the program. Necessary adjustments in the staff will be reviewed as part of the evaluation process. The ECCS Project Director will continue to receive professional staff support from contractors detailed in Attachments 4-1, 4-2, and 4-3. A lead pediatrician for the project will be identified immediately following project award. This key position will spearhead ongoing screening system efforts and coordinate with staff and partners to accomplish the scope of work. HNDECA and the ND Home Visiting Coalition represent the stakeholder group, convened by the ECCS staff that has taken the responsibility for developing and implementing the statewide plan for early childhood services delineated below.

Work Plan		
Early Child Comprehensive System (ECCS)		
Strategy		
ND will coordinate the expansion of developmental screening activities in early care and education settings statewide by connecting pediatric and other child health leaders with child care health consultants to link training and referrals among medical homes, early intervention services, child care programs and families.		
Target Population: Children birth to age 3		
Goal 1: Expand activities that increase developmental screening and associated training within early care and education in North Dakota and increase needed referrals among medical homes, early intervention services, child care programs, and families.		
Objective A: Expand Ages and Stages Questionnaire (ASQ) online system for easy access to a reliable screening tool for parents, caregivers and professionals.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
In cooperation with HNDECA leadership team, identify lead pediatrician.	November 2013	ECCS
Determine promotion, evaluation and system maintenance strategies.	August 2014	CCN, CCR&R, ECCS,

Implement the online ASQ Enterprise version along with technical support.	July 2015	CCN, CCR&R, ECCS,
Increase availability of Right Tracks in ND.	July 2015	CCR&R, ECCS, HS
Outcome Indicators: # of users of online system, # of children enrolled in Right Tracks		
Context: This builds on the work underway between the CCN and CCR&R to grant access to online screening by those who complete a training course.		
Objective B: Expand developmental screening activities in early care and education settings.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Create a partnership with the ND Quality Rating and Improvement System (QRIS) to provide guidance to QRIS participants on how to successfully meet the criteria to provide screening information to enrolled families.	July 2014	ECCS, QRIS
Assist child care programs with integrating screening procedures into standard programming, including routine conversations with families about developmental milestones and the value of early detection.	July 2015	CCN, CCR&R, ECCS
Promote the value of developmental screening to child care programs (i.e., PSA's), including how to have conversations with parents regarding child development concerns.	July 2015	CCN, CCR&R, ECCS
Generate multimedia materials to use on website(s) and other social media providing access to examples of conversations for both families and child care teachers/providers to help them learn how to bring up concerns and refer a child for further screening.	July 2015	CCN, CCR&R, ECCS
Outcome Indicators: # of enrolled families, # of child care programs assisted, # of materials distributed, # of website users		
Context: This builds on the current ECCS program that has collaborated with its HNDECA partners on projects regarding developmental screening.		
Objective C: Increase cooperation to appropriately refer children and families.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Purchase the Ages and Stages – Social Emotional Questionnaire (ASQ-SE) developmental screening toolkit for Local Public Health and their satellite units statewide to be utilized with families involving children birth to age 3.	July 2014	LPH(SU)

Provide a continuous series of comprehensive online trainings using the Eager to Learn Platform.	July 2016	CCN, CCR&R, ECCS
Outcome Indicators: # of toolkits distributed, # of training sessions, # of health professionals using online training		
Context: Eager to Learn course will include mid-level information on early childhood mental health including strategies that professionals can convey in consultative relationships on topics such as adequate sleep, inconsolable crying, aggression, separation anxiety, toileting issues, and more. Using and scoring the ASQ-SE will also be covered. <ul style="list-style-type: none"> ○ How to communicate with families ○ How to interact with referral systems 		
Goal 2: Develop strategies to improve linkages and referrals in pediatric providers, child care health consultants, infant mental health consultants, home visitors, and child health professionals		
Objective A: Create linkages to statewide networks of key health provider groups to influence professional strategies regarding screening and referrals.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Collaborate with the University of North Dakota's medical school to include ongoing education to medical students regarding developmental screening, trauma and mental health issues, and to educate on screening tools, and referral and treatment options statewide.	July 2014	Dr. Robert Beattie, ECCS, HNDECA
Develop a collaboration to integrate physical and mental well-being into clinics through the consistent use of developmental screening tools by pediatricians and family practice physicians statewide.	July 2015	Dr. Reed Sulik, ECCS, HNDECA
Engage and inform professionals in a statewide system of care regarding linkages and referrals to trained professionals for children in need of treatment regarding developmental delays or trauma. (i.e., Connection Directory).	July 2016	CCN, CCR&R, HNDECA, HVC
Create partnerships with developmental pediatricians, early intervention services for infants/toddlers, and special education services to determine appropriate follow-up activities after screening.	July 2016	CCN, CCR&R, HNDECA, HVC
Outcome Indicators: # of medical students exposed, # of health professionals using screening, # of health professionals linked to network, curriculum change at medical school		
Context: This capitalizes on the current relationship (quarterly meetings) of CCR&R child care health consultants with the ND Academy of Pediatrics to promote early developmental screening and to share information to build a strong referral system.		
Objective B: Expand statewide networks that establish and promote policies and guidelines for early childhood screening and referrals.		

Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Develop Birth to 3 Early Learning Guidelines.	July 2014	CCR&R, CCN, HNDECA
Implement voluntary Early Learning Guidelines.	July 2015	CCR&R, CCN, HNDECA
Explore funding opportunities for a quality rating and improvement system.	July 2016	ECCS
Expand the scope and capacity of family support agencies, organizations and departments in ND.	Through July 2016	CCN, CCR&R, ECCS
Outcome Indicators: funding support, implementation of guidelines, % increase of capacity		
Context: This capitalizes on current efforts of early childhood screening and referrals that are continuously being carried out by WIC, MOPS, PRC, Head Start, CCR&R, and NDSU Extension.		
Goal 3: Design approaches that utilize and promote training to early care and education professionals that focus on a) the importance of human development during infancy and early childhood, and b) early childhood developmental and behavioral screening.		
Objective A: Create clearinghouse for training opportunities.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Promote the early childhood Growing Futures Training Registry as the central clearinghouse for training opportunities.	July 2014	CCN, CCR&R, ECCS
Outcome Indicators: # of promotional materials, # of registry users		
Context: This builds on the current partnership between CCR&R and Growing Futures.		
Objective B: Design training programs for key stakeholder groups.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Continue to deliver training to child care professionals on strategies to address early childhood mental health topics.	Through July 2016	HVC, HNDECA, QRIS

Provide statewide training on the use and scoring of the ASQ-SE toolkit.	July 2014	CCN, HNDECA, LPH,
Create and provide a statewide training for child care and home visiting providers to educate participants on trauma.	July 2015	CCN, CCR&R, HNDECA, HVC
Continually collaborate with HNDECA partners to identify training and promote training to early care and education professionals who serve young children.	Through July 2016	HNDECA
Outcome Indicators: # of training sessions, # of individuals trained, # of toolkits distributed, distribution of professionals trained		
Context: Training has been started with the NDFFCMH which provides training for families regarding children’s mental health and incorporates social and emotional warning signs that are developmentally appropriate, screening information and how to access services.		
Objective C: Develop statewide mental health training.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Assist in providing statewide mental health related training.	July 2016	CCN, HNDECA, LPH
Assist in the development of a mental health professionals’ network to provide training and technical assistance using culturally relevant approaches.	July 2016	CCR&R, CCN, ECCS, HNDECA
Outcome Indicators: # of training sessions, # of individuals trained, # of individuals in network		
Context: This builds on HNDECA’s current process of securing time on the ND School Counselors Association (NDSCA) meeting to discuss training of school counselors to do screenings.		
Goal 4: Outline necessary system enhancements, work flow, financing structures and policy changes necessary to support the strategy.		
Objective A: Create new policies for communities.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Research the development of the formula for caseload standards.	July 2014	ECCS, HNDECA, QRIS

Research the development of a policy that requires new regulatory staff to attend new licensor training within the first year of employment and continue education in early care and education on an annual basis.	July 2015	ECCS, HNDECA, QRIS
Add a peer review-based quality assurance system to county and regional staff.	July 2016	QRIS
Outcome Indicators: feedback on policies, implementation of quality assurance system		
Context: Already in practice regulatory staff attends new licensor training and receives continuing education. Also, the County Social Service Directors have had some early discussion regarding caseload standards, although no agreements have been reached.		
Objective B: Enhance capacity of child services.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Explore funding opportunities to build infrastructure to support medical homes in ND.	July 2014	ECCS
Develop a plan to provide sustainable education, training outreach and enrollment activities for childcare providers.	July 2014	CCR&R, CCN, HNDECA
Enhance in-home services by avoiding duplication and assuring that home visiting is intentional and family-centered.	July 2015	QRIS
Outcome Indicators: amount of funding support for medical homes, plan development, reduction in duplication of services		
Context: CSHS has a contract with the ND chapter of the AAP for a ND Medical Home Initiative. Funding has been used to support infrastructure development in the form of an AAP Medical Home Liaison position which serves to facilitate the different medical home pilot programs.		
Goal 5: Design approaches for capturing and documenting developmental and behavioral health screening and referral activities across early child care and education, health, and early intervention systems that will be integrated into existing state data collection systems.		
Objective A: Integrate early childhood programs into State Longitudinal Data System.		
Key Activities	Target Completion Date	Responsible Groups (Partners)* see glossary
Provide support and collaborate with the ND ITD regarding the statewide longitudinal data project.	Through July 2016	ECCS, HNDECA
Support contract funding to the program epidemiologist to engage in collaborative efforts with the statewide longitudinal data project.	Through July 2016	ECCS, HNDECA
Outcome Indicators: # of programs entered into SLDS, funding support		

Context: This builds on the relationship already established with the ND ITD.

E. RESOLUTION OF CHALLENGES

Many opportunities and challenges will be addressed during implementation of the ECCS state plan. The development of HNDECA has been an opportunity for program providers and stakeholders to communicate effectively, develop a shared knowledge about early childhood programs in ND, and identify common challenges and goals for change. ECCS will continue to develop infrastructure designed to implement a collaborative program. As we move forward with the systems building process, turf issues are fading and new relationships have been formed. Through these partnerships, HNDECA members have found success in their work. This was accomplished by effectively integrating work plan activities such that different partners could see how their efforts dovetailed with others creating a synergy that motivated collaboration.

The lack of quality assurance systems and data regarding what constitutes quality services within each of the components has been a challenge. The ECCS Leadership Committee developed outcomes and indicators in February 2006, which will be used to track the progress of the goals and action steps in the HNDECA strategic plan. HNDECA partners such as ND KIDS COUNT have shared data and this information has been used to guide program decisions and set priorities within the implementation of the state plan. For example, the KIDS COUNT program worked closely with CCR&R on generating objective, evidence-based data that examined the ND QRIS, the future need for early child care, and child care dismissals. This has been a starting point; as HNDECA moves through the implementation phase, it will examine the need for specific data resources that will need to be developed to effectively evaluate the plan.

HNDECA has formulated a plan with multiple stakeholders to integrate services and resources, reduce the duplication of services, and to coordinate funding sources. Careful consideration has been given as to what resources would be needed to implement each action step. HNDECA clearly recognizes the need to shift resources from crisis services to prevention. The continued implementation of this plan will motivate and challenge early childhood programs to evaluate activities and collaboration efforts to improve services for the good of ND's children and families.

The AAP will play an important role in educating and enhancing ND pediatrician's knowledge of social emotional screening practices. There is hesitancy on the part of some providers to introduce new practices that use new tools or technologies and require new structures. The model programs operating in the state have demonstrated that these discomforts soon dissipate with training and experience. This seems to be our largest challenge and it is anticipated where most of the time and effort for the first year of the project will be spent.

The most significant challenge for HNDECA is financing the development of a comprehensive early childhood system. HNDECA has formulated a plan with multiple stakeholders to integrate services and resources, reduce the duplication of services, and to coordinate funding sources. Although ND does struggle with a number of programs unaccustomed to combining or sharing resources, HNDECA partners continue to make headway in these collaboration efforts. Two

examples illustrate this progress. First, a collaborative funding effort among the NDDoH Title V, ECCS, and the NDDHS was brokered to distribute the Bright Futures early learning guidelines. A similar funding collaborative was created among CCR&R, Head Start, ECCS, and the NDDHS to develop the state's Early Learning Guidelines.

HNDECA is exploring ways to continue to build relationships and seek sources of funding to sustain the systems building work in ND. The Leadership Committee has identified the need to develop a matrix related to current and potential HNDECA partners and resources. This will aid HNDECA in strengthening partnerships and utilizing resources in a wise manner to benefit early childhood efforts in our state. Through this process, the Leadership Committee will review the ND Services for Children and Families document that includes information related to the actual, budgeted, and recommended expenditures for children and family programs in the state.

HNDECA continues to explore other funding options by reviewing and sharing grant announcements with partners to support the systems building effort. Partners have been reviewing potential funding options from grantors such as the Dakota Medical Foundation, the Otto Bremer Foundation, and from other private funders such as Blue Cross Blue Shield of North Dakota. Advocates for early childhood have also pursued legislative efforts to support early childhood funding. Legislation during the 2013 session related to programs and funding for early childhood issues such as full-day and pre-kindergarten programs, child care health consultation, early childhood professional development, parent resource centers, Medicaid buy-in, home visitation and the State Children's Health Insurance Program (SCHIP). By seeking additional funding and strengthening relationships with HNDECA partners, North Dakota will continue to unify and strengthen its early childhood system that promotes positive development and improved health of all children.

The HNDECA Leadership Committee will continue to explore policy projects and other ways to support children and families in our state. Family supporters have been active during the legislative sessions and will continue to advocate for the needs of families and children during the interim by providing information to bring about community awareness regarding early childhood. As a commitment to action, letters of support for the ND ECCS program were received and can be viewed as Attachments 7-1 through 7-6.

Children in ND face a variety of challenges to overcome that relate to their health, education, and social welfare. By establishing comprehensive service systems, families receive support during their children's first years of life. This will affect what type of learner their children will be and who they will become. The implementation of the ND ECCS state plan will support families and communities in their development of children that are healthy and ready to learn at school entry.

F. EVALUATION AND TECHNICAL SUPPORT CAPACITY

Multiple partners share data with HNDECA including ND KIDS COUNT, Medicaid, CCR&R, the ND Head Start State Collaboration Office, the ND Department of Public Instruction, and the NDDoH. The ECCS project director currently works with other Title V staff to examine state and federal performance measures relating to maternal and child health, including epidemiologists from different sections within the NDDoH. We anticipate this relationship will

continue uninterrupted. Additionally, the ECCS program will contract with Dr. Richard Rathge, who is the Director of the Center for Social Research at ND State University, to assist with the data collection, analysis, and evaluation components of the project. He has extensive experience in the area of survey and evaluation research, with a special focus on children. He has training in Maternal and Child Health Epidemiology sponsored by Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) and the Centers for Disease Control and Prevention (CDC). Additionally, he has served as the Executive Director of the ND KIDS COUNT program for more than a decade (www.ndkidscount.org). This program is responsible for monitoring and documenting the health and well-being of ND's children. He has evaluated numerous programs related to children including various youth health needs assessments for hospitals, communities and counties, statewide child abuse and neglect programs, special child needs programs, and early infant care programs. His research background is extensive and includes evaluation research studies sponsored by National Cancer Institute, the CDC, and various state agencies. Dr. Rathge served as ND's State Demographer for over 30 years and is a professor in the departments of Sociology and Agribusiness and Applied Economics at ND State University. Dr. Rathge was the lead evaluation researcher for the North Dakota State Head Start Collaboration Office and ND's Maternal and Child Health 2011-2015 Title V Needs Assessment and Affordable Care Act (ACA) MIECHV Program Needs Assessment.

In addition, the ECCS Program Director will work with the Center for Social Research at ND State University to review data as it relates to the ECCS state plan. HNDECA subcommittees will further examine outcomes, indicators and data in this upcoming year.

A surveillance system will be developed to track and monitor performance on all benchmark measures outlined on page 44. These benchmarks align with the six MIECHV benchmarks and will be used to provide context for evaluating the success of the program. The data will be reported on a flow basis with one-third of the indicators reported in the first year, two-thirds of the indicators reported the second year, and all measures reported in the last year of the grant cycle. This system will be created in an Excel worksheet to expedite both data entry and analysis. The units of analysis will not be consistent because of confidentiality and data stability issues due to small numbers; therefore, multiple worksheets will be used based on the level of geography in which the data are available. For example, data regarding school readiness, family economic self-sufficiency, and coordination of services will be available at the county level while maternal and newborn health, child injuries/abuse, and crime and domestic violence will be at the regional level. This approach will provide an opportunity to cross-tabulate the data by characteristics when appropriate. Exploration will occur to see if there are urban versus rural differentials, or if counties with high proportions of minorities perform differently than those with low proportions of minorities. In brief, we will perform epidemiological analyses where appropriate.

The evaluation of the work plan will be consistent with the ND ECCS Logic Model 2013-2016 in Attachment 5-2 and conducted in two basic stages. A detailed evaluation grid is available in Attachment 1. The first stage will focus on process evaluation strategies and activities. This stage will be continuous in that an assessment of the effort (i.e., resources including staff), activities, and appropriateness of the products and/or services will be examined continuously

throughout the grant cycle. The evaluation of effort and activities will be based largely on reports, interviews, and discussions from network subcommittees, interviews, and notes from meetings with partners, conference calls, and surveys. The appropriate questions and discussion will surface as the activities unfold throughout the year. A periodic assessment will be conducted to insure appropriate feedback is collected and necessary course corrections instituted. The second stage will center on evaluation activities related to the surveillance system and outcome measures from the work plan. Data collection and analysis within the surveillance system and work plan activities also will be continuous and align with the availability of the data. Since much of the data collected through state agencies is made available at different time periods, the summative evaluation process also will be fluid in that an assessment of the success of each indicator will occur at different time periods. However, all HNDECA members will have access to the surveillance system data so they can continuously monitor the activities and outcomes of the various indicators. Moreover, network members will have the opportunity to request epidemiological analyses to assist them in their work activities. An overall comprehensive evaluation will be completed for the final report. There are no specific barriers anticipated with regard to implementing the program performance evaluation.

G. ORGANIZATIONAL INFORMATION

As of August 1, 2013, assuming the ECCS program is awarded funding; it will transition to be located within PCAND. It is important to note that since its inception, ECCS was originally located within the NDDoH under the direction of the MCH Title V Director. Because the new grant opportunity places emphasis on infancy and early childhood birth to age 3, broadens and enhances the efforts of the MIECHV program, and requires reporting on statewide data that aligns with the six MIECHV benchmarks, it was determined that PCAND would be better suited to administer the ECCS grant given that PCAND is ND's MIECHV grantee. Hence, the NDDoH feels that PCAND is better strategically aligned to carry out the goals, objectives, and reporting for this new grant opportunity. The NDDoH is fully supporting a grant application being submitted from PCAND.

PCAND was established in 1978 in Bismarck, ND and is committed to a safe and nurturing environment, free from abuse and neglect for all children. The agency is focused on creating community-based prevention efforts through the implementation of community development strategies including advocacy, public awareness, technical assistance, and networking services. Located in Bismarck, the agency employs six staff with three ongoing contractor positions. PCAND provides community based services at the Turtle Mountain Band of Chippewa Reservation, the Spirit Lake Reservation, in Williston, and in Devils Lake. Major projects include the MIECHV project, the ND Home Visitation Coalition, Child Abuse Prevention Month, Children's Justice Alliance, Period of Purple Crying, Nurturing Healthy Sexual Development, and Authentic Voices. Funding sources include the HRSA, NDDHS, NDDoH, private foundations, and private donations. This year PCAND will reach over 400,000 ND residents with the Partnering to Build Strong Families prevention message.

PCAND has extensive experience with designing and implementing statewide systems development efforts that engage multi-disciplinary groups to create significant change in communities:

- MIECHV funding was received in September of 2012 to serve Ramsey and Rolette Counties and to address statewide early childhood systems development. The project convenes a stakeholders group to support the effective coordination of services and identify areas for potential policy and service delivery growth.
- Through Child Abuse Prevention Month activities, PCAND identifies, organizes, and funds local prevention efforts during the spring of each year focusing on April for the statewide campaign. For 2013, 40 of ND's 53 counties partnered with this project. Parents, children, and professionals receive training, information, and technical assistance about preventing abuse and neglect at the community level.
- The Period of Purple Crying (PPC) targets all ND hospitals with birthing centers to create awareness and provide training to new parents on traumatic brain injury or shaken baby syndrome. PCAND supplies each birthing center in the state technical assistance on delivery of the PPC materials. Parents receive information about child development, managing parental stress, selecting appropriate caregivers, and preventing shaken baby syndrome injuries.
- Children's Justice Alliance convenes a group of 50 law enforcement, child welfare, and child advocacy professionals from across ND to identify challenges and potential improvements to the child protection systems.
- The ND Home Visitation Coalition was initiated with funding from the NDDoH and is facilitated by PCAND. This group represents 23 agencies providing home visitation services throughout the state. The Coalition is organized to create public awareness, professional networking, and advocacy for home visitation services.

PCAND has partnered with the Standing Rock, Three Affiliated, Spirit Lake and Turtle Mountain tribes in ND and has solid experience in working with tribal authorities to establish services and systems that enhance the lives of Native people. PCAND currently has active projects at all reservations - two that have been in existence for over two years. The Office for the Elimination of Health Disparities within the NDDoH has been a valuable resource in Tribal territories and PCAND continues to involve them as advisors with the ECCS project. PCAND has engaged the Native American Training Institute in Bismarck to provide support to its staff and various project partners on the nuances of cultural diversity experienced in ND, and will continue to access them for this project. Additionally, PCAND has built sound relationships with Tribal Health, Indian Health Services, and Tribal Colleges around the state that will augment the work of this project.

In the eastern half of the state, refugee populations continue to increase and establish local communities. Many partner agencies are working directly with these individuals to create networks of services tuned to meet the specific needs of these groups. For this project, PCAND will rely heavily on these partner networks to extend services and systems to refugees.

ND partners are confident PCAND will continue to build on the already existing early childhood partnerships that have been established and will no doubt form new partnerships to improve the quality and availability of early childhood services at both the state and local levels.

In order to bring continuity, program knowledge and experience, the current ECCS program director, Cheryl Masset-Martz, has agreed to continue in that capacity with the transition to

PCAND. She holds an Associate of Science degree in Business Management and a Bachelor of Science in University Studies with emphasis in Benefit Administration from ND State University. She has 30 years of state government service. She is proficient in program administration, leadership and team building, accounting and budgeting related to grant and contract monitoring, and facilitating the development and implementation of work plans by the various HNDECA committees. On a monthly basis, she reviews the budget reports from the accounting office to monitor program expenditures and represents the ECCS program on a number of coalitions and committees. See Attachments 2 and 3 for the job description and biographical sketch.

The ECCS program will also be supported by a .15 full time equivalent administrative assistant. This role includes providing support for the HNDECA, its subcommittees and chairpersons, and maintaining the alliance list serves. The position assists the ECCS program director with contracts, databases, mailings, and program back-up. See Attachments 2 for the job description.

As Executive Director, Tim Hathaway, brings 25 years of experience in Early Childhood Services and 15 years of administrative experience to this project. His leadership with the MIECHV project has demonstrated ability to administer federal project successfully. See Attachment 3 for the biographical sketch.

The limited ECCS program staff is able to carry out core functions of the program, but is constrained in expanding programs to fully meet the early childhood needs in the state. Activities of the ECCS program staff focus on core program functions of needs assessment, policy development, and quality assurance. Due to the constraints of program funding, there is limited ability to add positions and therefore the program relies on contractors to carry out specific program tasks. The ECCS program currently has a contractor, the Center for Social Research (CSR), secured regarding epidemiology and evaluation services. As described in Section F, CSR, lead by Dr. Rathge's knowledge and experience with North Dakota data resources, is a very valuable attribute to HNDECA. He also has numerous similar contracts with a number of early childhood partners which gives him the ability to associate multiple programs and assist in the blending of goals, objects, and funding. Because CSR also has access to many staff and student resources, the ECCS program is able to reap tremendous value for the dollars spent towards these two program services.

Without the continuum of director, the ECCS program would have little to no continuity or program history. It is with much certainty that we can say that the progress and success of the ECCS is attributed to continuity and program knowledge and experience which has kept the HNDECA stakeholders and partners involved with the ECCS program through the growth of this program. In addition, consensus-based meetings have bridged partner relationships where none had previously existed, and strengthened those that had.

d. Program Specific Forms

**Benchmarks
Early Child Comprehensive System (ECCS)**

Strategy

We will report on statewide data that aligns with the six MIECHV benchmarks. Each benchmark area has specific indicators that directly correlate with the benchmark area. At the end of year one, we will report on two benchmark areas. Each year thereafter, we will report on two additional benchmarks. Therefore, at the end of year three, we will report on all six benchmarks.

MIECHV Benchmark 1: Improved maternal and newborn health

Indicator(s)	Completion Date
Percentage of infants born premature	July 2014
Rate of deaths from birth defects, respiratory distress and maternal pregnancy complications	July 2014
Percent of infants born with a low birth rate	July 2014

MIECHV Benchmark 2: Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits

Indicator(s)	Completion Date
Rate of substantiated child abuse and neglect among children birth to age 3	July 2014
Childhood deaths due to external causes, by cause and age	July 2014
Children suspected of being abused or neglected	July 2014

MIECHV Benchmark 3: Improvements in school readiness and achievement

Indicator	Completion Date
Percentage of children who received developmental screening and did not need follow up or referral	July 2015
Percent of children enrolled in special education	July 2015
Percent of 3- and 4-year-olds enrolled in preschool	July 2015

MIECHV Benchmark 4: Reduction in crime or domestic violence (ND has chosen domestic violence)

Indicator	Completion Date
Percentage of families which screen positive for domestic violence and are referred	July 2015
Domestic violence victims, incidents, and children directly impacted	July 2015
Incidents of domestic violence that were reported to crisis intervention centers	July 2015

MIECHV Benchmark 5: Improvements in family economic self sufficiency	
Indicator	Completion Date
Percentage of children in poverty (i.e., living in households with incomes below the federal poverty level)	July 2016
Median household income	July 2016
Individuals below the federal poverty level	July 2016
MIECHV Benchmark 6: Improvements in coordination and referrals for other community resources and supports	
Indicator	Completion Date
Measured coordination with documented referrals between child care programs, medical homes, and early intervention service providers	July 2016
Children ages 10 months to age 5 in North Dakota who had at least one health care visit in the past 12 months and had standardized developmental and behavioral screening (SDBS) conducted during their health care visit	July 2016
Children under age 6 without health insurance, by detailed age	July 2016

Acronyms

AAP – American Academy of Pediatrics
 ACA – Assessment and Affordable Care Act
 ASQ –SE – Ages and Stages – Social Emotional
 BECEP – Bismarck Early Childhood Education Program
 CCN – Children’s Consultation Network
 CCR&R – Child Care Resource and Referral
 CDC – Center for Disease Control and Prevention
 CFDA – Catalog of Federal Domestic Assistance
 CSHS – Children’s Special Health Services
 CLASS – Classroom Assessment Scoring System
 CQI – Continuous Quality Improvement
 CQI – Continuous Quality Improvement
 ECCS – Early Childhood Comprehensive System
 FPL – Federal Poverty Level
 FTE – Full Time Equivalent
 HNDECA – Healthy North Dakota Early Childhood Alliance
 HPSA – Health Professions Shortage Area
 HRSA – Health Resources and Service Administration
 HRSA – U.S. Department of Health and Human Services Health Resources and Service Administration
 HS – North Dakota Head Start program

HVC – North Dakota Home Visiting Coalition members
ITD – North Dakota Information Technology Department
LPH(SU) – Local public health and their (satellite units)
MCH – Maternal and Child Health
MCHB – Maternal and Child Health Bureau
MIECHV - Maternal, Infant, and Early Childhood Home Visiting
MOA – Memorandum of Agreement
MOPS – Mothers of Preschoolers
NDCPD – North Dakota Center for Persons with Disabilities
NDDHS – North Dakota Department of Human Services
NDDoH – North Dakota Department of Health
NDFFCMH – North Dakota Federation of Families for Children’s Mental Health
NHA – Nurtured Heart Approach
NSCH – National Survey of Children’s Health
PATH ND – Program focused on treatment foster care and family-based services
PCAND – Prevent Child Abuse North Dakota
PPC – Period of Purple Crying
PRC – Parent Resource Centers
QRIS – North Dakota Quality Rating and Improvement System
RDS – respiratory distress syndrome
S.M.A.R.T. – Self-Monitoring, Analysis, and Reporting Technology
SAHIE – Census Bureau’s Small Area Health Insurance Estimates
SCHIP – State Children’s Insurance Program
SDBS – Standardized Developmental and Behavioral Screening

SENDCAA – SouthEastern ND Community Action Agency
SLDS – State Longitudinal Data System
TANF – Temporary Assistance for Needy Families
WIC – Women Infants and Children program

CITATIONS

BEA, 2012. U.S. Bureau of Economic Analysis, Gross Domestic Product by State, <http://www.bea.gov/>, June 2012.

BEA, 2013. U.S. Bureau of Economic Analysis, State Personal Income 2012, <http://www.bea.gov/>, March 2013.

BLS, 2013. U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, Unemployment Rates for States, <http://www.bls.gov/>, February 2013.

C2ER, 2012. The Council for Community and Economic Research (C2ER), Arlington, VA, ACCRA Cost of Living Index, Annual Average 2010, obtained from the U.S. Census Bureau’s 2012 Statistical Abstract, Table 728, <http://www.census.gov/compendia/statab/>.

CRH, 2012. The University of North Dakota School of Medicine & Health Sciences, Center for Rural Health, ND Health Professional Shortage Areas, <http://ruralhealth.und.edu/maps/>, January 2012.

LSSND, 2012. Lutheran Social Services of ND, New American Services, March 2012.

Joel Hektner, 2013. Effectiveness of the Nurtured Heart Approach parent training program. Poster presentation, NDSU College of Human Development and Education Showcase, April 17. http://www.ndus.edu/hdfs/faculty_staff/joel_hektner/

KCDC, 2013. The Annie E. Casey Foundation, KIDS COUNT Data Center, <http://datacenter.kidscount.org/>. Data obtained in April 2013.

NDDOH, 2012. North Dakota Department of Health, Vital Records, North Dakota Resident Vital Event Summary Data 1997-2011, <http://ndhealth.gov/vital/pubs.htm>, June 2012.

NDHFA, 2012. Center for Social Research at North Dakota State University, 2012 North Dakota Statewide Housing Needs Assessment: Housing Forecast, <http://www.ndhfa.org>, September 2012.

NDDHS, 2011. North Dakota Department of Human Services, FFY 2010 Children and Family Services Statistical Bulletin, <http://www.nd.gov/dhs/info/pubs/family.html>, June 2011.

NDDHS, 2012. North Dakota Department of Human Services, Unduplicated Counts of Cases and Recipients by County of Physical Residence for TANF, SNAP, Medicaid, LIHEAP, and CCAP, <http://www.nd.gov/dhs/info/pubs/help.html>.

NDDPI 2012. North Dakota Department of Public Instruction, Child Nutrition & Food Distribution, Free and Reduced Price Lunch Eligibility Data, <http://www.dpi.state.nd.us/child/rebs/index.shtm#NDFR>, October 2012.

NDKC, 2013. North Dakota KIDS COUNT at North Dakota State University, Insights on Children, Health Insurance Coverage Status for Children in North Dakota, <http://www.ndkidscount.org/publications.html>, March 2013.

NSCH, 2012. 2011-2012 National Survey of Children's Health, <http://www.childhealthdata.org>.

NS-CSHCN, 2010. 2005-06 and 2009-10 National Survey of Children with Special Health Care Needs, <http://www.childhealthdata.org>.

US Census 2011. U.S. Census Bureau, 2007-2011 American Community Survey 5-Year Estimates, <http://factfinder2.census.gov>, December 2011.

US Census, 2012. U.S. Census Bureau, Population Division, Table 1. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2012 (NST-EST2012-01), <http://www.census.gov/popest/>, December 2012.

US Census, 2012b. U.S. Census Bureau, Population Division, Table 3. Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for North Dakota: April 1, 2010 to July 1, 2011 (SC-EST2011-03-38), <http://www.census.gov/popest/>, May 2012.

US Census 2013. U.S. Census Bureau, Population Division, Table 6. Estimates of Population Change for Micropolitan Statistical Areas and Rankings: July 1, 2011 to July 1, 2012 (CBSA-EST2012-06), <http://www.census.gov/popest/>, March 2013.