NEW YORK STATE OF OPPORTUNITY.

Council on Children and Families

NYS ECCS IMPACT

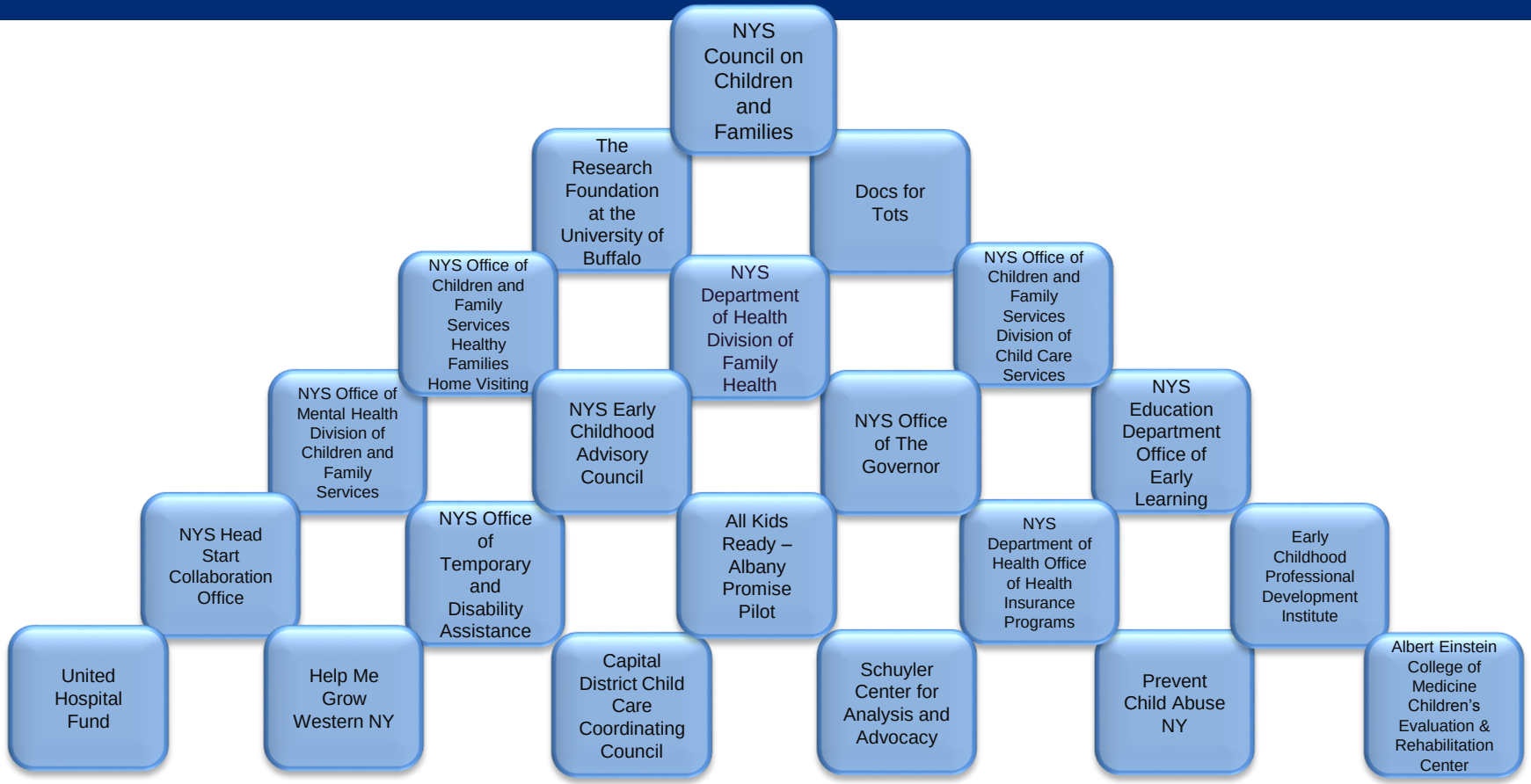
ECCS State Advisory Team (SAT) Quarterly Meeting

September 8, 2017

10am-11am

If you're having technical difficulties, please contact Ciearra Norwood 518-408-4107

This project is/was supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H25MC12970, Early Childhood Coordinated Systems, 100% HRSA funded. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.



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Today's Agenda

- Introductions
- Meeting Schedule
- New ECCS Western NY Lead
- Drivers, Indicators and Measures
- Place based Community Updates
- PARTNER Tool
- Survey Monkey
- Challenges & Improvements
- Plans for Year 2

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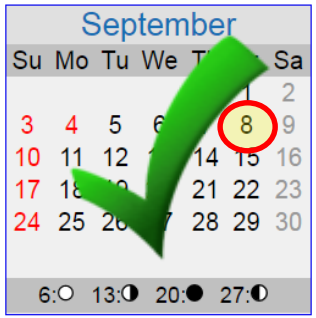
SAT Year 2 Meeting Schedule



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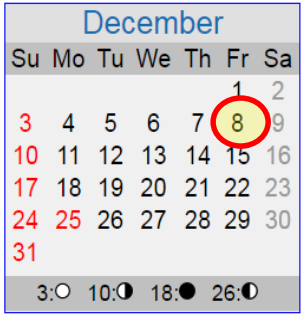
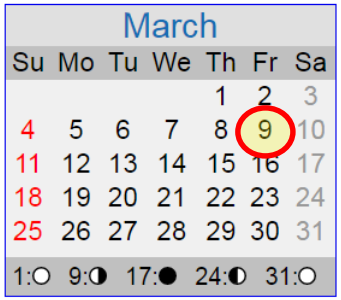
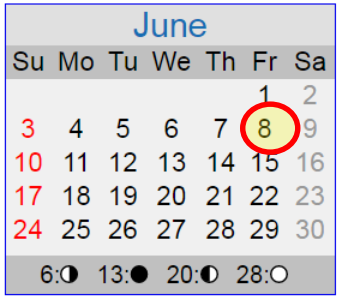


December 8, 2017



March 9, 2018



June 8, 2018

Always the 2nd Friday of the month

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New Western NY ECCS CoIIN Leads

The SUNY Research Foundation at the University of Buffalo Jacobs School of Medicine

Dr. Dennis Kuo, Division Chief of General Pediatrics at the University of Buffalo Jacobs School of Medicine and the Medical Director of Primary Care Services at Women and Children's Hospital of Buffalo

Dr. Anna Hays, Clinical Assistant Professor, the University of Buffalo Jacobs School of Medicine

SUNY RF The Research Foundation for The State University of New York

University at Buffalo The State University of New York

WOMEN & CHILDREN'S HOSPITAL OF BUFFALO A Kaleida Health Facility

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Diagram: ECCS CoIIN

ECCS Federal CoIIN Partnership
Health Resources and Services Administration Maternal and Child Health Bureau (HRSA)
National Institute for Children's Health Quality (NICHQ)
Zero to Three (ZTT)
Applied Engineering Management Corporation (AEM)

ECCS State CoIIN Team
The NYS Council on Children and Families (lead agency)
Capital District Child Care Coordinating Council
Docs for Tots
NYS Early Childhood Advisory Council
NYS Early Childhood Professional Development Institute
NYS Education Department, Office of Early Learning
NYS Department of Health, Division of Family Health
NYS Department of Health Office of Health Insurance Programs
NYS Office of the Governor
NYS Head Start Collaboration Office
NYS Learn the Signs Act Early Ambassador at Rose Kennedy CERC at Montefiore
NYS Office of Children and Family Services, Health Families NY Home Visiting Program
NYS Office of Children and Family Services, Division of Child Care Services
NYS Office of Mental Health, Healthy Steps Program, Division of Children and Family Services
NYS Office of Mental Health, Division of Children and Family Services
NYS Office of Temporary and Disability Assistance
Prevent Child Abuse NY
The Research Foundation at the University of Buffalo
Schuyler Center for Analysis and Advocacy
United Hospital Fund

Local CoIIN Team
Nassau County, NY
Place-Based Community
Docs for Tots (lead)
Child Care Council of Nassau
Choice For All
Economic Opportunity Commission of Nassau County
Family Partners
Hofstra University
Long Island FQHC
Mental Health Association of Nassau
Molloy College
Nassau BOCES
Nassau County Department of Health
Northshore Family Guidance
Northwell Health
Visiting Nurse Service of New York

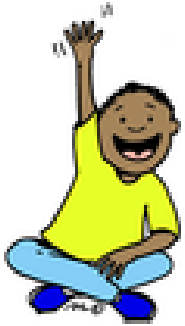
Local CoIIN Team
Western NY
Place-Based Community
2-1-1 Western NY
Buffalo Prenatal-Perinatal Network
Catholic Charities
Child & Adolescent Treatment Services
The Child Care Resource Network
Early Childhood Direction Center - Kaleida Health
Erie County Department of Social Services
Erie County Medical Center
Erie-Niagara Birth to 8 Coalition
Every Person Influences Children (EPIC)
Family and Children Services of Niagara
Help Me Grow Western NY
Main Pediatrics
Niagara County Department of Social Services
Niagara University
Parent Partners
The Research Foundation at University of Buffalo
United Way of Buffalo & Erie County

Other State ECCS CoIIN Teams
Alaska Delaware Florida Hawaii Indiana Kansas Louisiana Massachusetts New Jersey Oklahoma Utah

Go to our website www.ccf.ny.gov for a copy of our ECCS CoIIN Overview

Questions?

Please raise your hand to speak so we can unmute you or type in the chat box to share!



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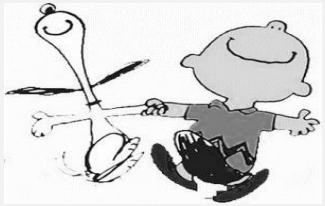

NEW AIMS RELEASED BY NICHQ

July 31, 2021 ECCS Impact Grantees and Place-Based Communities will promote healthy development of children birth through age 3 to achieve:

- 25% relative increase in children birth through age 3 that are achieving age appropriate developmental health in all 5 developmental domains
- 5% relative decrease in disparity among children birth through age 3 that are achieving age appropriate developmental health in all 5 developmental domains
- 15% relative increase in the proportion of family members of children birth through age 3 that report reading, telling stories, and/or singing songs with their child daily
- 15% relative increase in the proportion of primary caregivers reporting improved social support
- 10% relative increase in the proportion of families successfully connected to one or more services that address the social determinants of health (SDOH)

Annual Indicators

1. **Early Identification of Developmental Needs (Driver 1 and Overall Aim):**
The proportion of children birth through age 3 who are achieving 5-domain developmental health as demonstrated by standardized parent-completed developmental-behavioral screening results
1a. Age;
1b. Race/Ethnicity;
1c. Poverty Status; and
1d. Sex/Gender
2. **Linked and Coordinated Systems (Driver 5):**
The proportion of ECCS CoIIN partners reporting improvement in data processes
2a. The proportion of ECCS CoIIN partners with an executed data sharing agreement
2b: The proportion of ECCS CoIIN partners with the ability to use data for ECCS CoIIN reporting
2c: The proportion of ECCS CoIIN partners with the ability to use data for ECCS CoIIN coordinating activities
3. **Family Engagement (Driver 2):**
The proportion of family members reporting that during a typical week s/he read, told stories, and/or sang songs with their child daily

Bi-annual Indicators

1. **Family Engagement (Driver 2)**: Proportion of parents or other primary caregivers reporting improved social support
2. **Social Determinants of Health (Driver 3):**
Proportion of families successfully connected to one or more services that address the social determinants of health (SDOH)
3. **Advocacy and Policy Change (Driver 6):**
The number of new or updated policies that support developmental and relational health promotion as part of ECCS CoIIN work or activities
4. **System Building/Community Awareness: (Driver 4): TBD**

Monthly Driver Measures

1.1: Proportion of children who receive a "routine" developmental-behavioral screen using a parent-completed, valid and reliable screening tool

1.2: Proportion of children that did not meet expectations in one or more domains and were scheduled for follow-up

2.1: Proportion of families leaving provider interaction satisfied with communication with their child's provider

2.2: Proportion of new families that receive information and resources about opportunities to enrich/promote child developmental health

2.3: Proportion of parents or other primary caregivers asked if they have any concerns regarding their child's development, behavior, or learning

2.4: Proportion of ECCS CoIIN activities that include family participation

3.1: Proportion of families assessed for social determinants of health (SDOH) needs

3.2: Proportion of families successfully connected to one or more services that address the social determinants of health (SDOH)

3.3: Proportion of families reporting reduced stress

3.4: Proportion of parents or primary caregivers referred to services because of a positive screen for depression who receive one or more services

4.1: Proportion of providers/programs reporting an awareness of early childhood system developmental health promoting initiatives and supports for families

4.2: Proportion of providers/programs reporting initiatives and supports for families are useful

4.3: Proportion of providers/programs reporting initiatives and supports for families are accessible

4.4: Proportion of community care coordination activities between early childhood providers and services

5.1: The proportion of children referred to any community service, where the referral source knows the status or outcome of the referral

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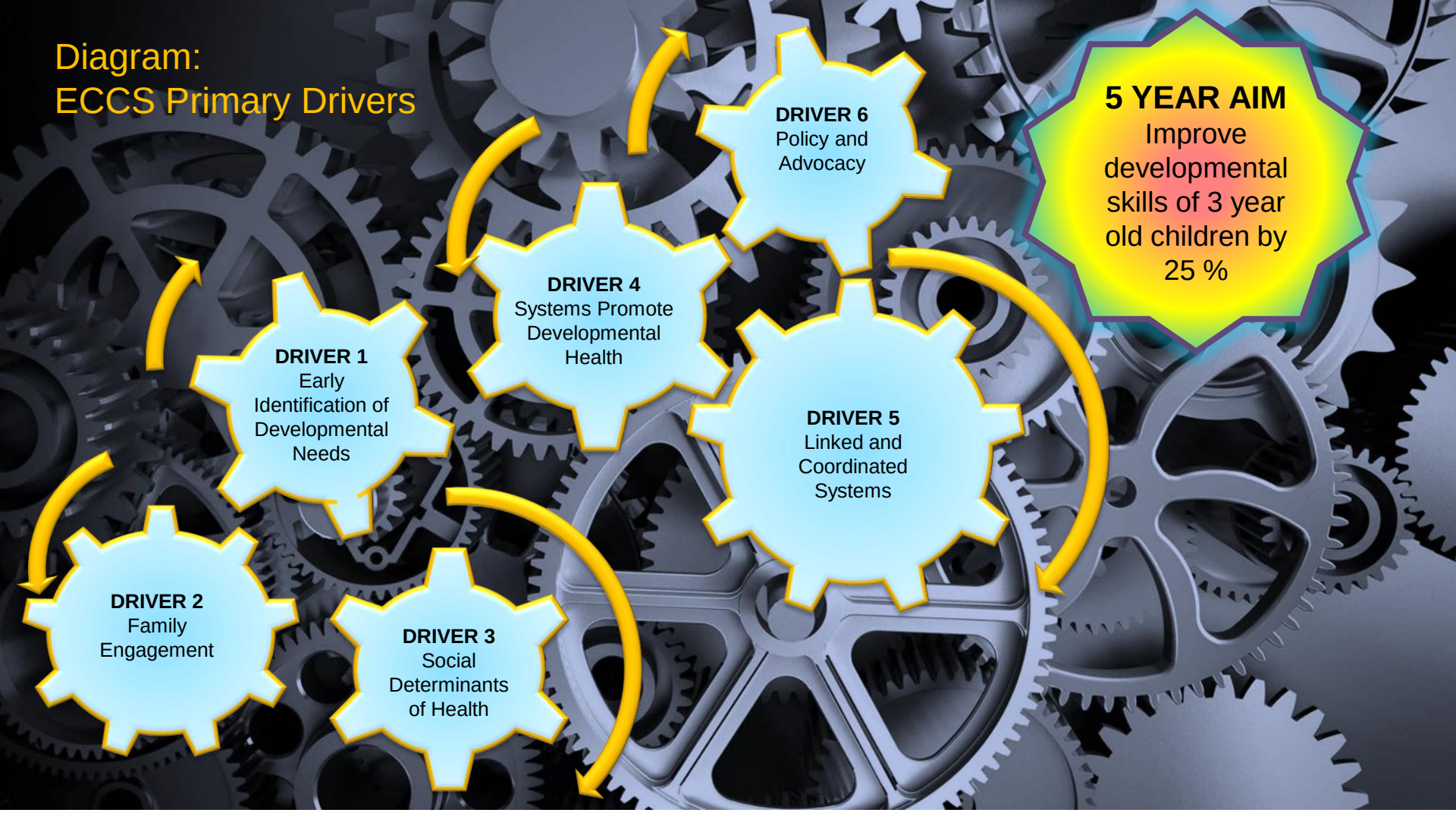
Diagram:
ECCS Primary Drivers



25%

relative increase in children birth through age 3 that are achieving age appropriate developmental health in all 5 developmental domains

ANNUAL INDICATOR

DRIVER 1

15%

relative increase in the proportion of family members of children birth through age 3 that report reading, telling stories, and/or singing songs with their child daily

ANNUAL INDICATOR

DRIVER 2

15%

relative increase in the proportion of primary caregivers reporting improved social support

BIANNUAL INDICATOR

DRIVER 2

15%

relative decrease in disparity among children birth through age 3 that are achieving age appropriate developmental health in all 5 developmental domains (Select one: age, gender, poverty, or race)

ANNUAL INDICATOR

10%

relative increase in the proportion of families successfully connected to one or more services that address social determinants of health

BIANNUAL INDICATOR

DRIVER 3

20%

relative increase in the proportion of identified partners that report improved data processes for CoIIN reporting

ANNUAL INDICATOR

DRIVER 5

30%

relative increase in the number of new or updated policies that support developmental and relational health promotion

BIANNUAL INDICATOR

DRIVER 6

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Measures, Indicators & Driver Alignment

25%

relative increase in children birth through age 3 that are achieving age appropriate developmental health in all 5 developmental domains

AIM

Monthly Measure

- Proportion of children who receive a "routine" developmental-behavioral screen using a parent-completed, valid and reliable screening tool
- Proportion of children that did not meet expectations in one or more domains and were scheduled for follow-up

Annual Indicator

- The proportion of children birth through age 3 who are achieving 5-domain developmental health as demonstrated by standardized parent-completed developmental-behavioral screening results (choose one)
  - Age;
  - Race/Ethnicity;
  - Poverty Status; and
  - Sex/Gender

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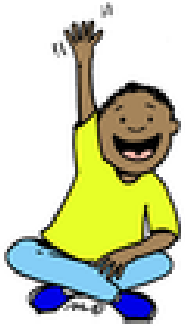
Questions?

Please raise your hand to speak so we can unmute you or type in the chat box to share!



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Measures, Indicators & Driver Alignment

15%

relative increase in the proportion of family members of children birth through age 3 that report reading, telling stories, and/or singing songs with their child daily

AIM

15%

relative increase in the proportion of primary caregivers reporting improved social support

AIM

Monthly Measure

- Proportion of families leaving provider interaction satisfied with communication with their child's provider
- Proportion of new families that receive information and resources about opportunities to enrich/promote child developmental health
- Proportion of parents or other primary caregivers asked if they have any concerns regarding their child's development, behavior, or learning
- Proportion of ECCS CoIIN activities that include family participation

Bi-annual Indicator

- Proportion of parents or other primary caregivers reporting improved social support

Annual Indicator

- The proportion of family members reporting that during a typical week s/he read, told stories, and/or sang songs with their child daily

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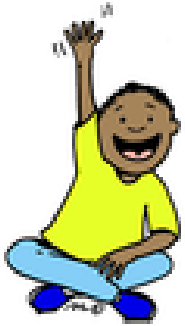

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Measures, Indicators & Driver Alignment

10%

relative increase in the proportion of families successfully connected to one or more services that address social determinants of health

AIM

Monthly Measures

- Proportion of families assessed for social determinants of health (SDOH) needs
- Proportion of families successfully connected to one or more services that address the social determinants of health (SDOH)
- Proportion of families reporting reduced stress
- Proportion of parents or primary caregivers referred to services because of a positive screen for depression who receive one or more services

Bi-annual Indicator

- Proportion of families successfully connected to one or more services that address the social determinants of health (SDOH)

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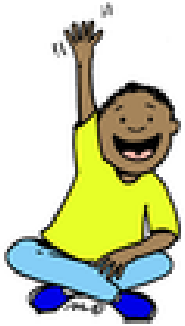

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Measures, Indicators & Driver Alignment

Monthly Measures

- Proportion of providers/programs reporting an awareness of early childhood system developmental health promoting initiatives and supports for families
- Proportion of providers/programs reporting initiatives and supports for families are useful
- Proportion of providers/programs reporting initiatives and supports for families are accessible
- Proportion of community care coordination activities between early childhood providers and services

Biannual Indicator (TBD)

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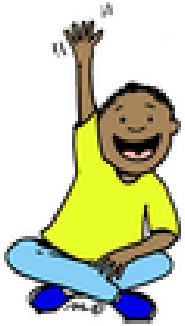

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Measures, Indicators & Driver Alignment

20%

relative increase in the proportion of identified partners that report improved data processes for CoIIN reporting

AIM

Monthly Measures

- The proportion of children referred to any community service, where the referral source knows the status or outcome of the referral
- The proportion of community partners/providers reporting engagement in coordinating activities

Annual Indicator*

- The proportion of ECCS CoIIN partners reporting improvement in data processes
- The proportion of ECCS CoIIN partners with an executed data sharing agreement
- The proportion of ECCS CoIIN partners with the ability to use data for ECCS CoIIN reporting
- The proportion of ECCS CoIIN partners with the ability to use data for ECCS CoIIN coordinating activities

*tied to PARTNER Tool

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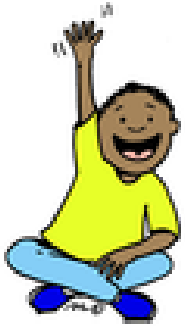

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Measures, Indicators & Driver Alignment

30%

relative increase in the number of new or updated policies that support developmental and relational health promotion

AIM

Monthly Measures

- The number of outreach actions taken to increase understanding of developmental health promotion

Bi-annual Indicator*

- The number of new or updated policies that support developmental and relational health promotion as part of ECCS CoIIN work or activities

*tied to survey monkey

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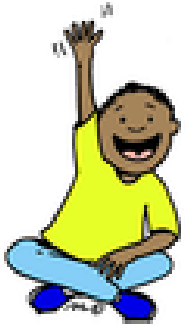

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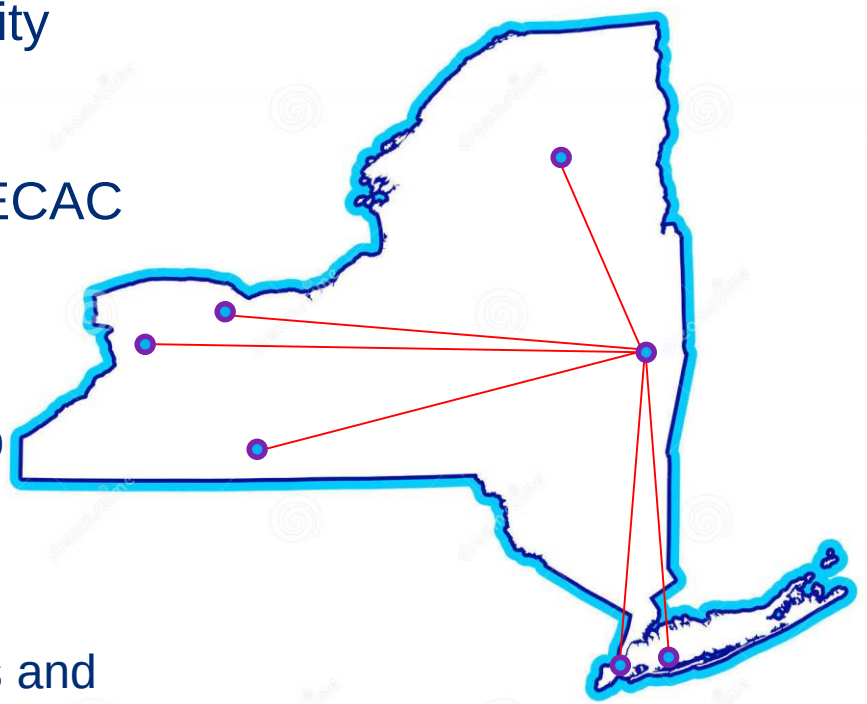
Statewide Update

Connecting to statewide and community initiatives

Ensuring initiatives are connected to ECAC

- First 1000 Days Initiative
- ECAC workgroups
- Schenectady 0-5 Early Literacy Group
- Rochester Grow
- Early Childhood Alliance
- NYS EHDI Program
- New York State Infant Toddler Policies and Practices Group
- Help Me Grow WNY & Help Me Grow LI



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Place-Based Community Update: Nassau County

Nassau ECCS

Building an early childhood comprehensive system on Long Island

Melissa Passarelli, MA
Director of Programs, Docs for Tots
Nassau ECCS/HMG-LI Coordinator

Docs FOR TOTS

HELP ME GROW LONG ISLAND

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Nassau ECCS & Help Me Grow - LI

ECCS 2016 5-Year Goal:

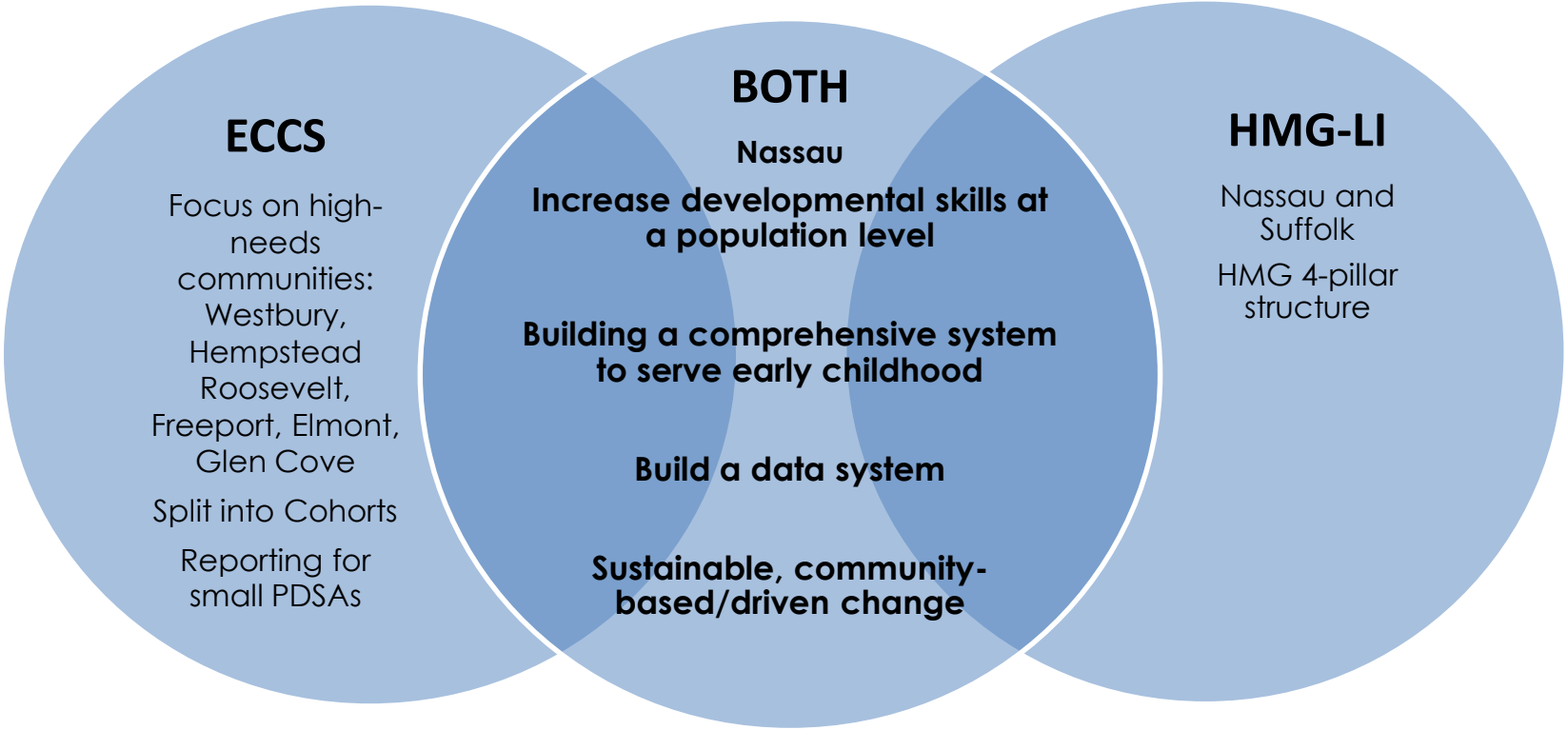
Improve developmental skills of 3YOs by 25% over 5 years

Help Me Grow – Long Island Goal:

Improve developmental outcomes of children 0-5 on Long Island

Short-Term Goal for both:

Launch Help Me Grow - Long Island in January 2018


ECCS
Focus on high-needs communities: Westbury, Hempstead Roosevelt, Freeport, Elmont, Glen Cove
Split into Cohorts
Reporting for small PDSAs
BOTH
Nassau
Increase developmental skills at a population level
Building a comprehensive system to serve early childhood
Build a data system
Sustainable, community-based/driven change
HMG-LI
Nassau and Suffolk
HMG 4-pillar structure

Help Me Grow – Long Island and ECCS connections

Corresponding Primary Drivers

Centralized Access Point P1, P2, P3, P5	Data Collection and Analysis P5,P6	Physician outreach P1, P5	Community Outreach P2, P3, P5
- Parent-driven access to support on developmental issues – parent voice is directly heard from - Cross systems of health, child care, WIC, etc. - Care coordination to address existing disparities in access to EI and other developmental services - Care coordination to address barriers for families – meet the families needs - Care coordinators have specialized training that builds community-wide early childhood linkages – they get to know the system to help parents navigate - Can specifically target communities so that they know about HMG and use the service.	- Gives us screening data by domain which we have not been able to figure out how to do in the health setting - Can build it so collecting normal as well as abnormal screening into the system - Gives us demographic information in a database that can be analyzed to show baseline disparity and assess change - Can build in parent satisfaction into the data collections with calls/email contacts - Identifies areas of greatest parental concern and need - Identifies gaps in services – where linkages can be made.	- Builds on existing strength - DFT's TA model is fine for larger practices, but HMG allows for outreach to physicians in smaller practices to be brought into the screening system -Allows for physician leadership, which is important to the ECCS impact funders.	- Builds on Nassau's existing PRN – they are happy about that – pleases private funders and local stakeholders to keep them engaged and part of the process - Allows for data base of existing resources to be built out – what is out there for families with young children - Can do social network analysis to see how the community partners are improving connections between one another and moving toward coordinated system.

ECCS/HMG 5 Year Plan

2017	2018	2019	2020	2021
Drive parent and provider knowledge of developmental milestones, screening • Improve coordinated efforts around community outreach • Improve coordinated efforts around provider outreach Build CAP (call center, web development) Statewide involvement and planning for wider implementation PARTNER tool "pre-test"	HMG-LI Launches Data collection-> reporting for ECCS Ongoing quality improvement of the 4 pillars Physicians outside of FQHC involvement in DS Community screening efforts considered/expanded – ECE? WIC/EI? Selected community outreach for HMG system use Start Cohort B/C? Statewide involvement and planning for wider implementation	HMG-LI continues Data collection-> reporting for ECCS Ongoing quality improvement of the 4 pillars. e.g. • QA of care coordination • Work with partners to meet unmet needs for referral More screens recorded – grow "n" to closer to the 7000 target population Statewide involvement and planning for wider implementation PARTNER tool "mid-test"	HMG-LI Launches Data collection-> reporting for ECCS Ongoing quality improvement of the 4 pillars using data from the system Statewide involvement and planning for wider implementation	Repeat Westbury EDI to see if there has been improvement since 2012 in outcomes Compare screens in 2021 to 2018 data year Look for improvements in linkages/referrals Continue QA/QI process PARTNER tool "post test"

What We've Accomplished So Far

- Built a local cross sector team, including a "Family Partner Advisory Team"
- Broken the Help Me Grow – Long Island Leadership Team into four work groups to plan for the structure of HMG-LI
  - Set to make final recommendations to the Leadership Team on September 14th
  - Once these recommendations are agreed to, the rest of the year will be spent putting them into motion for a January 2018 launch date
- Began partnering with local sites to improve developmental health promotion and screening in our focus communities
  - WIC Baby Showers (Westbury and Roosevelt)
  - Roosevelt Community Block Party
  - Health Fairs (Westbury and Roosevelt)

Submitted PDSAs

- **Developmental Screening Data:** Worked with Long Island Federally Qualified Health Centers to determine whether a billing code report would be an accurate reflection of developmental screening rates
  - Update: Testing showed that billing codes did not accurately capture screening rates

- **EI Data**: NYC EI Data is broken down by borough, race, and ethnicity. Plan to reach out to state partners to see if this data can be retrieved for Nassau.
  - Update: Awaiting reports from NYS DOH

- **CAP Development:** Completing the necessary tasks to develop a Centralized access point for HMG LI.
  - Update: Have come up with a final recommendation for CAP structure to report to the Leadership team

- **Help Me Grow Workgroup Development:** Completing the necessary tasks to develop all four HMG workgroups.
  - **Physician Outreach Work Group:** A pediatric survey about developmental/maternal screening practices was sent out through the local AAP chapter and the pediatric societies of Nassau and Suffolk. 65 responses have thus far been received
  - **Community Outreach Work Group:** An outreach list of organizations to engage in this work has been generated, and work group members were tasked with reaching out about partnering to improve developmental health among families
  - **Data Work Group:** A plan has been developed for benchmarking progress with Help Me Grow

What's Next

- Finalize and move forward with HMG-LI structure for January 2018 launch *(Driver 5: Linked and Coordinated Systems)*
- Work with Nassau Infant Toddler Specialist to identify and train select child care sites in Westbury to perform developmental screening *(Driver 1: Early detection)*
- Have Family Partners do peer-to-peer outreach about developmental health promotion and screening *(Driver 2: Family engagement)*

Questions?

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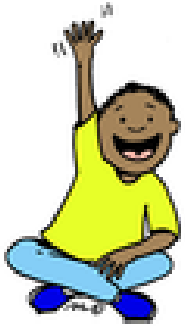

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Place- Based Community Update: Western NY

Questions?

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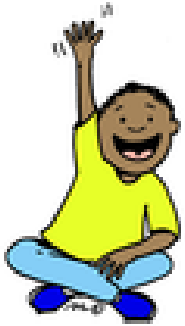

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We need your help!

(with two things)

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#1 PARTNER Tool (Program to Analyze, Record, and Track Networks to Enhance Relationships)

What: The PARTNER network analysis tool designed to measure collaboration among people (i.e. how members are connected, how resources are leveraged, exchanged and the levels of trust between them).

Method: The tool includes an online survey and an program that analyzes the data.

Outcome: By using the tool, we will be able to demonstrate how our ECCS CoIIN has changed over time and progress made in how community members and organizations participate. We will report out at the SAT. *The outcome of the tool is tied to the Driver 5 AIM*.

When: Completed once per year by SAT members between September and December

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Who else uses the PARTNER Tool?

kids count

first2000days
Early Childhood Development Network

CDHS CO COLORADO
Office of Early Childhood
Department of Human Services

Robert Wood Johnson Foundation

DEPARTMENT OF HEALTH & HUMAN SERVICES USA
Assistant Secretary for Preparedness and Response

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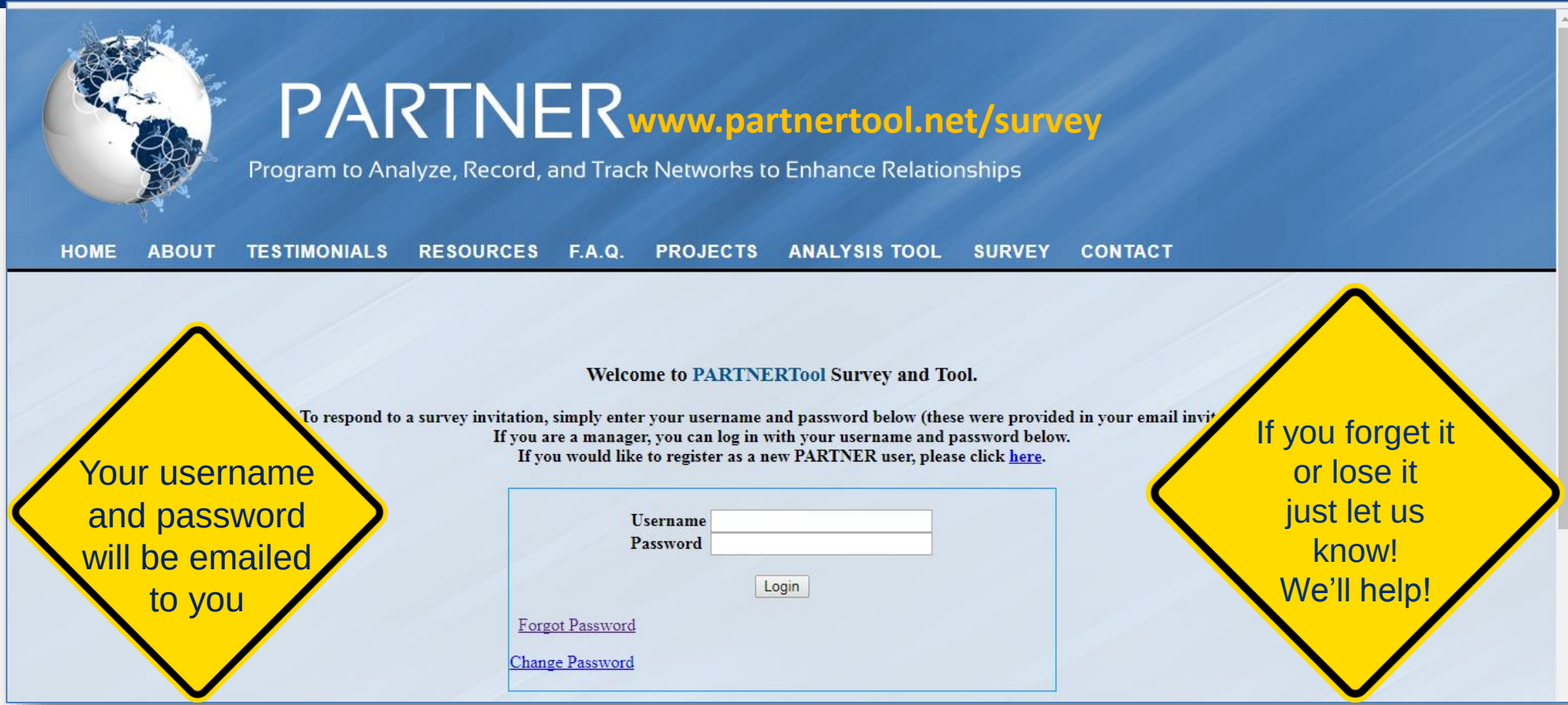

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PARTNER Tool

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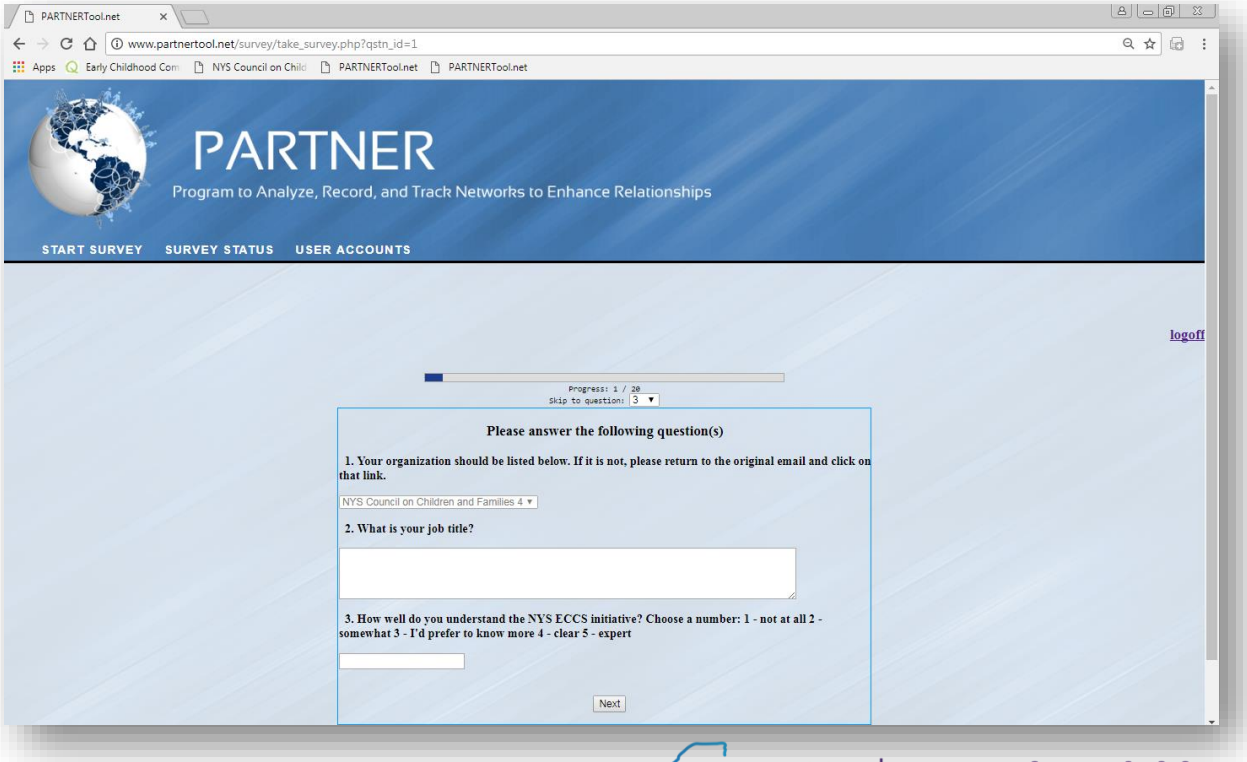
Start Your Survey

Your organization will be pre-filled.

You may log off at anytime and your responses will be saved.

Just log back in to return to where you left off by clicking Next



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Potential Challenges

- May take up to 25 minutes to complete depending upon the number of connections you've identified as well as the speed of your network connection.

- The strength of our data depends upon our response rate. This can be a challenge especially when working with managers and directors with competing priorities (we know you're busy).

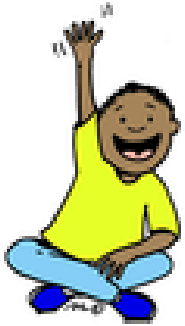
Highlights

- You can log in and log out!
- It need not be completed in one sitting.
- You have a month to complete it.
- You only have to do this one time per year

ldren

Questions?

Please raise your hand to speak so we can unmute you or type in the chat box to share!



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#2 Survey Monkey

What: Survey Monkey

Method: Surveying to ask three questions to assess policy changes as a result of this ECCS collaborative.

1. Do you have any new or updated policies that support **developmental and relational health promotion*** as part of ECCS CoIIN work activities?
2. If yes, how many?
3. If no, why not?

Outcome: Survey questions are connected to our AIM for primary driver 6.

When: Completed two times per year – December and June

*The process of improving developmental health as well as relational health. This is achieved through education, building skills, and advocating for change at individual, family, community and population and system levels

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Potential Challenges

- May take 10 minutes to complete.
- Respondents understanding the definition of developmental and relational health promotion.
- The strength of our data depends upon our response rate. This can be a challenge especially when working with managers and directors with competing priorities (we know you're busy).

Highlights

- It will be delivered to your inbox.
- The definition of developmental and relational health will be included with the survey and respondents only have to include NEW policies directly related to this ECCS project – this number might be ZERO and that's okay!
- It only takes 10 minutes at most.
- You have a month to complete it.

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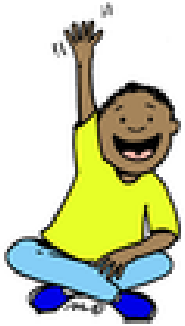
Questions?

Please raise your hand to speak so we can unmute you or type in the chat box to share!



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EARLY CARE	• Screen, support and refer children to services and engage parents • Engage legally exempt providers • Refer families to community support
PHYSICIANS	• Engage prenatal care providers • Continue to collectively problem solve challenges around screening and referral • Increase knowledge of and provide resources for children with delays or may be at risk for delays • Provide families anticipatory guidance and celebration of milestones during well baby visits
HOME VISITING	• Connect home visitors to pediatricians, obstetricians and early care providers • Increase community awareness of home visiting programs
PARENT EDUCATORS	• Continue to discuss ways to engage families and strengthen partnership with families • Understand family identification of community assets • Support families whose children don't qualify for early intervention and children who are at risk for delays

EARLY INTERVENTION

- Ensure families are receiving evaluation and services when needed **(work with pediatricians to ensure awareness of their local EI)**
- Ensure connection with pediatricians **(work closely with local EIOs to ensure referral and services)**
- Act as a resource for families who don't qualify for early intervention

SOCIAL SERVICES

- Integrate developmental monitoring and health promotion into social services
- Modify, support and leverage existing programs that might support resource coordination and sustained support for families

MEDICAID

- First 1000 Days Initiative participation!
- Continue to inform Medicaid of challenges pediatricians are identifying at the community level around billing for developmental screening and ability to access community level data
- Continue discussions around how value based payments are connected to our work

PARTNERS

- Are there state or local initiatives that we should connect with?
- Are there partners we should engage?
- Are there funding opportunities that can further support developmental health promotion?

Challenges

- Developing a statewide ECCS message
- NYS does not have an integrated statewide ECDS
- Operationalizing data collection
- Integrating social determinants of health and health equity into the work
- Engaging families!
- Different billing practices among pediatricians and electronic medical records
- Understanding community assets and service access
- Closing referral gap
- Aligning HMG implementation with ECCS framework

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Improvements

Developing a statewide ECCS message

NYS does not have an integrated statewide ECDS

Operationalizing data collection

Integrating social determinants of health and health equity into the work

Engaging families!

Docs for Tots in Nassau county has connected several active family partners to support their local ECCS initiative

Different billing practices among pediatricians and electronic medical records

1000 Days Initiative

PDSA cycles in development at FQHCs in Nassau County

Understanding community assets and service access

SURVEYS to families and providers

Closing referral gap

SURVEYS to families and providers

Aligning HMG implementation with ECCS framework

Questions?

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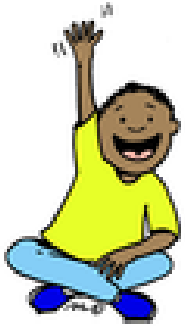

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Plans for Year 2

- PARTNER Tool
- Solidifying statewide messaging
- Surveying families and providers
- Establishing outreach/awareness campaign with families and providers (e.x. using the LTSAE materials or Talking is Teaching)
- Pyramid Model training with Long Island early care providers
- Establishing referral and follow-up processes in medical practices
- Implementing Central Access Point for HMG-LI - continuing to work with HMG WNY and HMG National
- Presenting at local and statewide conferences

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Questions?

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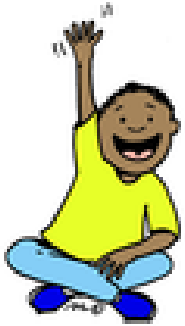

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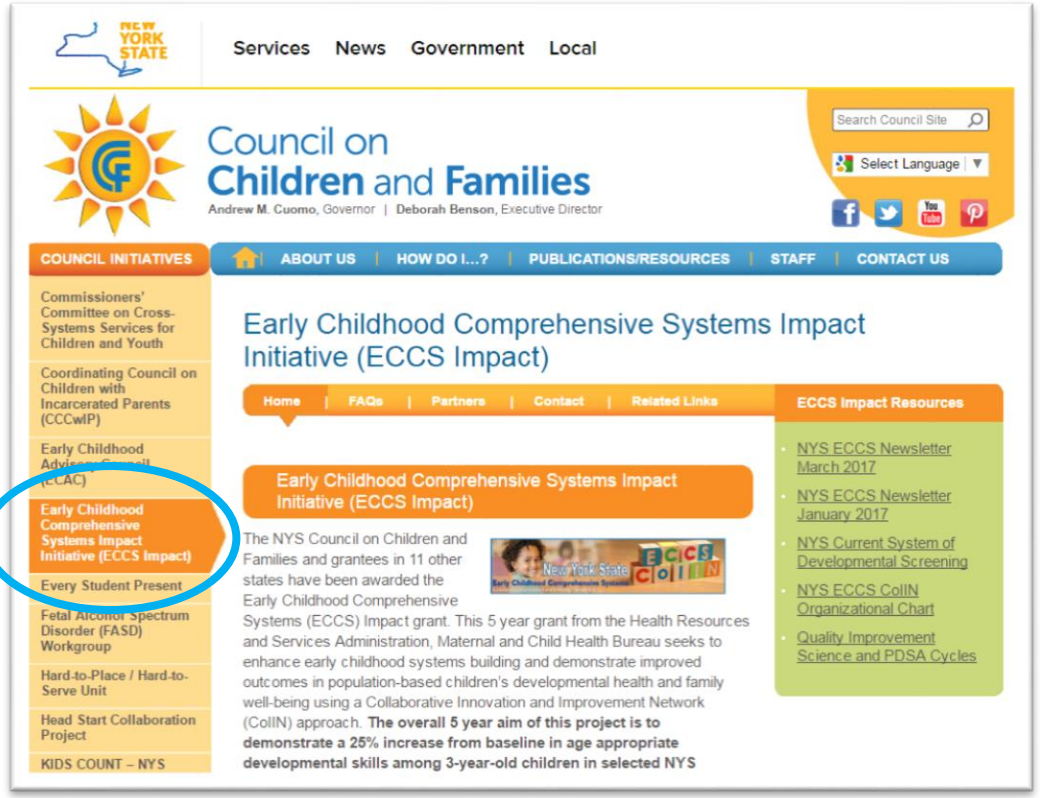

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Thank You for taking the time today to participate and support the work we're doing!!

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