ECCS State Advisory Team (SAT) Quarterly Meeting
Friday September 21, 2018
10am-11am

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

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Thank you to our State Advisory Team Organizational Members

Albert Einstein College of Medicine
านรบกศรี จัดการเด็กและครอบครัว
capital District Child Care Council
New York State Department of Health
New York State Head Start Collaboration Office
New York State Early Childhood Advisory Council
New York State Office of Children and Family Services
New York State Office of Mental Health
New York State Office of Temporary and Disability Assistance
Prevent Child Abuse New York
Schuyler Center for Analysis and Advocacy
United Hospital Fund
Today’s Agenda

• Introductions
• Meeting Schedule
• Webinars
• LS Highlights
• New developments
• Place-based community team report out
• PARTNER Tool
• On Track for Year 3
SAT Year 3 Meeting Schedule

Typically the 2nd Friday of the month

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NICHQ webinars

• 9/24 Family Partnership Community of Practice
• 9/25 Policy Community of Practice
• 9/26 Action Period Call – Spread Strategy
• 10/10 October Data Office Hours
Year 2 Learning Session - July 2018
Arlington, VA

Highlights!
Janice Gruendel, Ph.D, M.Ed
Center for Study in Social Policy · Senior Fellow, Institute for Child Success · Fellow, Yale University Edward Zigler Center · Harvard Center on the Developing Child Frontier for Innovation

The Arc of Science – being mindful of the impact of early trauma, impacts of poverty, societal injustice but the importance of resilience, joy, hope, health, happiness

Bridgeport Baby Bundle

This graphic, adapted from Anderson et al, 2003; Marmoetal, 1999; and Wilkinson et al, 2003, illustrates the impact of community assets on a flourishing community.
Roderick Bremby
DSS Commissioner, Connecticut

Who asks: Who is our system built for?
Re-boot of the human services system to make the system work for the “user”

Frank Oberklaid, OAM, MD, FRACP, DCH
Center for Community Child Health ∙ the Royal Children’s Hospital Melbourne
Professor ∙ the University of Melbourne Department of Paediatrics ∙ Research Leader the Murdoch Children’s Research Institute

Implemented the Australian EDI nationally – 3 waves of data about the health and well being of 96% of Australian 5 year old children.

Home Visiting is part of the mainstream health system in Australia. Every birth family receives home visits, if determined “at risk” the family receives 12 additional home visits

https://www.rch.org.au/uploadedFiles/Main/Content/ccch/Platforms%20Framework%20Roadmap%202012.pdf

1.5 million children aged 0-4 in Australia \(^1\)

1.2 million 0-4 in NYS \(^2\)

300,00 less

Amanda Perez, MSW
Senior Advocacy Specialist, Zero to Three
I/T Policy in States – State Assessment Toolkit

Dina Lieser, MD
Senior Advisor, HRSA Maternal and Child Health Bureau Division of Home Visiting and Early Childhood Systems
New Federal Opportunities: A Webinar - Ascend - The Aspen Institute

Shannon Rudisill
Executive Director, The Early Childhood Funders Collaborative
Can state leadership work to align funders in the state who support early childhood initiatives, how can the funders work together to become catalytic?
State Team Takeaway

We need family voices and story telling

It may be useful to convene a statewide “Data Day” to understand what early childhood data is collected in our communities and how it can be useful on a larger scale.
Please raise your hand to speak so we can unmute you or type in the chat box to share!
Diagram: ECCS Primary Drivers

DRIVER 1
Early Identification of Developmental Needs

DRIVER 2
Family Engagement

DRIVER 3
Social Determinants of Health

DRIVER 4
Systems Promote Developmental Health

DRIVER 5
Linked and Coordinated Systems

DRIVER 6
Policy and Advocacy

5 YEAR AIM
Improve developmental skills of 3 year old children by 25%
ECCS Primary Drivers

5 YEAR AIM
Improve developmental skills of 3 year old children by 25%

DRIVER 1
Family Partnership

DRIVER 2
Universal Developmental Promotion

DRIVER 3
Social Determinants of Health

DRIVER 4
Coordinated Systems

DRIVER 5
Policy
<table>
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<tr>
<th>Screening</th>
<th>Number of children 0-47 months who received a developmental screening in the previous month</th>
<th>Measures efforts to screen more children and meet aims</th>
<th>25% increase from first measure</th>
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<tr>
<td>Age appropriate development</td>
<td>Percentage of children screened in the previous month who achieve 5 domain developmental health</td>
<td>Measure progress toward the project aim of increasing the children achieving developmental health</td>
<td>25% or higher increase from first measure</td>
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<td>Referral for Assessment or Monitoring</td>
<td>Percentage of children in the previous month who did not achieve age appropriate developmental health in one or more of the five domains who were referred for assessment or developmental monitoring.</td>
<td>Measure how often children who are not achieving age appropriate developmental health are referred for assessment or monitoring</td>
<td>25% increase from first measurement</td>
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<td>Referral for Services</td>
<td>Percentage of children who were referred for assessment or monitoring and subsequently referred for services</td>
<td>Measure how often children are referred for services following assessment and developmental monitoring</td>
<td>25% increase from first measurement</td>
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<tr>
<td>INNOVATION MEASURES</td>
<td><strong>Receipt of Services Following a Referral</strong></td>
<td>Percentage of children referred for services who are receiving services related to the referral</td>
<td>Identify gaps in services for children who are not achieving age appropriate developmental health in all 5 domains to inform process or program improvements and coordination of services</td>
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<tr>
<td>INNOVATION MEASURES</td>
<td><strong>Time Between Referral and Receipt of Services</strong></td>
<td>The number of days between referral and receipt of services</td>
<td>Identify timeliness of services for children who are not achieving age appropriate developmental health in all five domains to inform process or program improvements and coordination of services</td>
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Measurement Strategy Complete

October 2018
- Improvement Measures replace existing measures
- Innovation Measures for consideration

Nov 2018
- Communities consider relevant measures for their communities

February 2019
- Communities co-create with the coordinating center relevant measures for their communities
- Innovation Measures for consideration

January 2019
- Improvement Measures for social determinants, anticipatory guidance, family satisfaction and coordinated systems

New York State of Opportunity | Council on Children and Families
Please raise your hand to speak so we can unmute you or type in the chat box to share!
Place-Based Community Update: Nassau County

Liz Isakson, MD, FAAP
- Executive Director
- ECCS Place Based Community Lead
- contact: liz@docsfortots.org

Melissa Passarelli, MS
- Director of Programs
- ECCS Place Based Community Lead
- contact: melissa@docsfortots.org
Help Me Grow – Long Island Numbers to Know (1/16/18- 9/12/18)

- **Total call volume:** 225  
  - Steadily increased the number of intakes (full care coordination)
- **Intensive care coordination:** 7.6 hours average/case (most frequent activity = follow-up with caregiver)
- **Entry points:**
  - 38% of referrals came from health care providers
  - 2-1-1 callers = 15%
  - Other callers = 31%
  - HMG online screen = 9%
  - Other: community partner, WIC outreach, Nassau County birth mailings
Help Me Grow – Long Island Numbers to Know
(1/16/18 - 9/12/18)

• **Top concerns:**
  – Communication (28%)
  – Basic Need (24%)
  – Child Care (13%)

• **Connection rate:**
  – Connected: 47%
  – Not connected: 23%
  – Pending: 12%
  – Unknown: 18%
Developmental Screening via HMG-UI
(1/16/18 - 9/12/18)

- 2 sites currently screening
- 4 sites trained and set to screen
- 2 sites scheduled for training
- In-person screening event
- Working on obtaining data from sites currently screening
Outreach  
(1/16/18 - 9/12/18)

- Participated in 71 different outreach events (resource fairs, baby showers, collaborative meetings, presentations, trainings, visits)
- Audience breakdown:
  - Caregivers/parents: 25.5%
  - Child Care Providers: 4.8%
  - Child Health Providers: 16.6%
  - Community partners: 53.2%
- Examples:
  - Physician Outreach: In-services, pediatric resident experiences
  - Community connections: focus on immigrant organizations
  - Community Presentations: County Legislature, EI Providers
  - Direct Family Outreach: Screen for Success
Quality Improvement

- **Internal**
  - Changed definition of “closed”
  - Changed when a “closing the loop” letter would be sent
  - Changed process for triaging cases
  - Changed how non-CAP time was scheduled/handled (i.e. meetings, outreach, vacation, sick time, mailing documents)
  - Changed expectations for callers
  - Hired a second full-time employee!

- **External (systems)**
  - Met with patient navigators to improve referral pathways from health centers
  - Noticed trends in barriers and worked with partners to address them. Examples include:
    - CPSE cases -> ECDC
    - Diapers -> Allied Foundation
Lessons Learned

• It takes a LOT of time/attempts to connect the highest need families
• QI at a systems-level (i.e. with partner organizations) poses unique challenges
• Advocacy at the systems level is not enough to help individual families in the short term
Please raise your hand to speak so we can unmute you or type in the chat box to share!
Place-Based Community Update: Western New York

Dennis Kuo, MD, MHS
-Associate Professor and Division Chief, General Pediatrics, University at Buffalo
-Medical Director of Primary Care Services at Women & Children’s Hospital of Buffalo
-ECCS Place-Based Community Lead
WNY ECCS CollIN Update

• Learning Collaborative:
  • To raise awareness about developmental monitoring, screening and follow-up among pediatric clinicians, early child care providers and families.
  • To test, implement, disseminate and plan to sustain strategies identified to improve and promote monitoring, screening and follow-up for developmental concerns.
  • To show a 25% increase in age-appropriate developmental skills among their communities’ 3-year-old children by the year 2021.

• Participating Practice Sites:
  1. Tonawanda Pediatrics
  2. Main Pediatrics
  3. Neighborhood Health Center
  4. Towne Garden
  5. Niagara St.
WNY ECCS CoIIIN Update cont.

• CoIIIN Update:
  • Formalizing work group meetings and leaders
  • Obtaining data sharing agreements
  • Streamlining data collection mechanisms with each practice
    • Continuous PDSA cycle discussions
Learning Collaborative Data
Learning Collaborative Data cont.

**Discussed with Family**

**All Practices**

Data Set: Combined 9, 18, 24 & 30-mo Visits

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<tr>
<th>Month</th>
<th>Data Count</th>
<th>Percent Discussed</th>
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<td>100</td>
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<td>Feb</td>
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<td>Mar</td>
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<td>Apr</td>
<td>154</td>
<td>90</td>
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<tr>
<td>May</td>
<td>163</td>
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Total Number by Month:
- Jan: 8
- Feb: 98
- Mar: 126
- Apr: 154
- May: 163
Learning Collaborative Data cont.
# ECCS CoLLIN Logic Model

## Situation

- Increase awareness
- Increase standardized child development and maternal depression screenings
- Expand screening settings
- Reduce health inequities
- Expand Help Me Grow Infrastructure

## Priorities
- Increase the developmental skills among three-year-old children

## Inputs

- UBMD Pediatrics
- Help Me Grow
- NYS Council on Children and Families
- Tonawanda Pediatrics
- Main Pediatrics
- Neighborhood Health Center
- Towne Garden
- Niagara St Pediatrics
- Parent Advocates

## Outputs

### WHO?
- Workgroups:
  1. Practice Engagement: Improve use of screening systems through primary care practice engagement
  2. Ghostbusters: Identify, develop, and test clear referral pathways and protocols that can be used across sectors
- Data: Ensure timely accurate screening, referral, and feedback data is captured, displayed, shared, and reported across sectors

### WHAT?
- CoLLIN groups
- Leadership Team meetings
- Learning Collaborative Work group monthly meetings
- State partnership and reporting
- Data collection and sharing protocols Webinars

## Activities

- Pilot data sharing agreements with 6 pediatric outpatient clinics
- Increase developmental screening to 80% for all recommended ages in practices
- Collect benchmark data from practices and across sectors

## Participation

- Increase and spread the utilization of standardized child development and maternal depression screenings from 20% to 50%
- Increase cross-systems and cross-governmental integration to ensure data sharing between all systems

## Outcomes - Impact

### Short Term

- Ensure integration of early childhood systems
- Improve age appropriate developmental skills of children ages 9-11 to ensure kindergarten readiness
- Expand the settings in which screenings are conducted and the professionals who conduct them
- Reduce health inequities in screening, service referral, and access

### Medium Term

### Long Term
Work Groups
NICHQ Primary Drive 2: Universal Developmental Promotion

#1: Practice Engagement Work Group
OBJECTIVE: Improve use of developmental screening systems through primary care practice engagement

#2: Ghostbusters Workgroup: Clear Pathways and Family Support Systems
OBJECTIVE: Identify, develop, and test clear referral pathways and protocols that can be used by practices for all families with young children they serve.

#3: Data Workgroup: Data Capture and Reporting
OBJECTIVE: Ensure that timely and accurate developmental screening, referral, feedback, and reporting data is captured, displayed, shared, and reported.

*The Work Groups will be meeting next Thursday, September 27th*
Short Term Objectives

1. “Meet and Greet” with each participating practice site and determine data collection mechanism
   • Lea will be meeting with each of the 5 practice sites separately

2. Establish data sharing agreements
   • Obtaining a data sharing agreement with Albany Promise will help us to determine best practices for referral follow up

3. Set goals for each of the three workgroups

4. Implement new PDSA cycles on a continual basis with each practice site
Family Leader Updates
Emily Mondschein and Ali Perfetti

• Scheduled monthly phone calls with Lea
• Helping to establish family advocates in each of the 5 Practices
Please raise your hand to speak so we can unmute you or type in the chat box to share!
#1 PARTNER Tool  
(Program to Analyze, Record, and Track Networks to Enhance Relationships)

**What:** The PARTNER network analysis tool designed to measure collaboration among organizations (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 a 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. *The outcome of the tool is tied to the Driver 5 AIM.*

**When:** Completed once per year by SAT members between September and December.
Welcome to PARTNER Tool Survey and Tool.

To respond to a survey invitation, simply enter your username and password below (these were provided in your email invitation).

If you are a manager, you can log in with your username and password below.

If you would like to register as a new PARTNER user, please click here.

Username
Password
Login
Forgot Password
Change Password

Your username and password will be emailed to you

If you forget it or lose it just let us know! We’ll help!
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.
Potential Challenges

• May take up to 25 minutes to complete depending on the number of connections you’ve identified as well as the speed of your network connection.

• The strength of our data depends on 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.
Please raise your hand to speak so we can unmute you or type in the chat box to share!
Connections

- NYS Governor’s Early Childhood Advisory Council (ECAC)
- ECAC workgroup on developmental screening and maternal depression
- NYS Department of Health (DOH) Office of Health Insurance Program (OHIP)
  - First 1000 Days on Medicaid initiative workgroup
- NYS Early Intervention Coordinating Council quarterly meetings
- Co-chairing the NYS Parenting Education Partnership
- NYS Home Visiting Coalition
- NYS Association for Infant Mental Health
- NYS Infant Toddler Policy and Practices
- Project TEACH and maternal depression resources
- NYS Infant and Early Childhood Mental Health TA initiative
Last Year at this Time:

✓ • PARTNER Tool
  • Maturity Scale
✓ • Solidified 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
✓ • Implemented Central Access Point for HMG-LI
✓ • Presenting at local and statewide conferences
✓ • Equity and Implicit bias training
Please join us, September 25th and join the effort to advance race and ethnic equity. Our keynote speaker, John A. Powell, is an internationally recognized expert in the areas of civil rights and civil liberties and a wide range of issues including race, structural racism, ethnicity and poverty. He is the Director of the Haas Institute for a Fair and Inclusive Society at U.C. Berkeley, which supports research to generate specific prescriptions for change in policy and practice that address disparities related to race and ethnicity.

See the full agenda here.

http://events.r20.constantcontact.com/register/event?oeidk=a07efjhv4az78c780d1&llr=k8y5z6cab
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