ECCS State Advisory Team (SAT) Quarterly Meeting
March 9, 2018
10am-11am

If you're having technical difficulties please contact Ciearra Norwood 518-408-4107
Thank you to our State Advisory Team Organizational Members
Our ECCS Network

- State Organizations
- Advocacy Organizations
- Community Based Organizations
- Policy Organizations
- Hospital/Health Related Organizations

56% of our network is connected
Today’s Agenda

• Introductions
• Meeting Schedule
• News
• Community Updates
  • Nassau County
  • Western NY
• Next Steps

Moving Right Along!
SAT Year 2 Meeting Schedule

Always the 2nd Friday of the month
What Have We Been Doing?
1. ECCS brochure complete
2. NYAEYC 2018 Conference
3. Reporting annual and biannual indicator baselines
4. Pyramid Model training
   a) Long Island early care providers and families
   b) WNY providers
   c) NYS Infant Toddler Specialists
5. NYSPEP Community Cafes
6. First 1000 Days on Medicaid Work Groups
7. ECAC Community Initiatives Work-team Statewide Spread
A New Brochure

We think it’s lovely
All children deserve an equal start in life. In New York State, we’re partnering with our communities to make a difference!


HRSA Disclaimer
This project 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 HHS0252970, Early Childhood Comprehensive Systems, 500X-HRSA funded. This information or content and conclusion are those of the author and should not be construed as the official position of the U.S. Department of Health and Human Services or the U.S. Government.

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Our Goals

Children’s opportunities for learning begin even before they are born. In New York State, we’re working to ensure that all children are given an equal start in life. The New York State Council on Children and Families, along with 11 other states, has a 5-year grant from the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, to work together with families, state and community agencies to:

1. Promote child development, by making sure that pediatrics, child care providers, teachers and families are aware of how babies and young children grow and learn.
2. Identify young children who may need additional support and make sure that if they do receive it quickly and easily, because we know that acting early makes a difference.
3. Create partnerships and share resources that support families and children living in our communities.
4. Empower families to support their baby’s learning in ways that are meaningful to them.

In the Communities

We’re focusing our work in two communities: Western New York and Nassau County.

These two communities established teams representing early childhood, that includes family members, pediatrics, county organizations, community-based organizations and their local Help Me Grow initiatives. The partners agree that they have a role to play in supporting the success of families in their communities. Instead of working separately, the teams have come together to focus on the 5-year goal of increasing the developmental skills of 3-year-old children.

Teams meet regularly and are working to create a resource, referral, and follow-up pathway developed with families for their communities to ensure all families have the support they need to thrive. To learn more about the Help Me Grow initiatives in New York State, go to www.helpmegrowny.org.

To find out more about the EDCS work taking place in your community or to support your local EDCS teams, use the contact information for the team leads below.
We’re exhibiting & presenting!

NYAEYC 2018

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Council on Children and Families
Questions?

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

The Starting Line
1. Children birth through age 3 who are achieving 5 domain developmental health

2a. Proportion of ECCS partners with a data sharing agreement

2b. Proportion of partners using data for ECCS reporting

2c. Proportion of partners using ECCS data to coordinate activities

3. Family members reporting that each week they read, told stories, and/or sang songs with their child daily

*2016 National Survey of Children’s Health
Biannual Indicator **Baseline** (measured twice per year)

1. Proportion of parents or other primary caregivers reporting improved social support
   - 0
   - February 2018

2. Proportion of families successfully connected to services that address the SDOH
   - 0
   - February 2018

3. The number of new or updated policies that support developmental health from ECCS work
   - 0
   - February 2018
Once the communities start collecting data over the next 6 months we’ll be able to display run charts of the monthly measures.
Questions?

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ECCS Primary Drivers

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

DRIVER 1
Early Identification of Developmental Needs

DRIVER 2
Family Partnership

DRIVER 3
Social Determinants of Health

DRIVER 4
Systems Promote Developmental Health

DRIVER 5
Linked and Coordinated Systems

DRIVER 6
Policy and Advocacy
Pyramid Model Training
(driver 2 and 4)
Funding Chart
*All In-Kind Funds/** Partial In-Kind Funds

- Project LAUNCH: 7%
- Office of Children and Family Services/Professional Development Program (OCFS/PDP): 0%
- NYS Head Start Collaboration: 1%
- Annie E. Casey Foundation: 6%
- Early Childhood Comprehensive Systems (ECCS): 6%
- New York State United Teachers (NYSUT): 1%
- Office of Mental Health (OMH): 2%
- Agencies that employ Master Cadre Trainers*: 35%
- State Leadership Team Support*: 47%
- State Education Department: 0%
- New York State PBIS Technical Assistance Center (NYSED funds this contract): 0%
Pyramid Modules Presented to date

5,125 people trained
321 training events
ECCS Supported Pyramid Model Training

Positive Solutions for Families with parents of young children and early care providers
Roosevelt and Westbury

Parents Interacting with Infants with Early Care providers and family support providers
Western NY

Parents Interacting with Infants with NYS Infant Toddler Specialists
Rochester

Council on Children and Families
Community Cafes
(driver 2 & 6)
ECCS Supporting NYSPEP

ECCS is supporting NYSPEP’s efforts to provide Community Café orientation training to selected communities.

The Community Cafes engage community and family voice so we can work together to impact discussions around policy change for families and children.
Questions?

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First 1000 Days on Medicaid
(driver 6)
ECCS Supporting the work of The First 1000 Days on Medicaid

ECCS has been invited to participate in the First 1000 Days on Medicaid work groups

We will be working closely with workgroups focusing on:

- Statewide Home Visiting
- Data System Development for Cross Sector Referrals
- Pilot and Evaluate Peer Family Navigators in Multiple Settings
- Kindergarten Developmental Inventory
The ECCS Team had the opportunity to attend the NYS Department of Health Office of Health Insurance Programs VBP University and the VBP Bootcamp in February!

VBP University

Awarded to
Ciearra Norwood
Kristin Weller
February 2, 2018
Statewide Community of Practice (driver 5 & 6)

ECAC Collaboration (driver 5 & 6)
Statewide Spread and Sustainability

Jennifer Powell, Principal
Powell and Associates, L.L.C.
Health Care Design & Quality Improvement

Dana Friedman, Ed.D
NYS Early Childhood Advisory Council
Community Initiatives Work Team
Statewide Spread and Sustainability

**Why:** We need a plan/platform for spreading the findings from the CoIIIN throughout the project period to other place-based communities throughout NYS

**How:** Bi-weekly calls with Jen Powell and Dana Friedman (ECAC Community Initiatives Work team) to develop strategy

**Plan:** Develop (or modify an existing) community maturity scale to provide a quantitative analysis of community readiness to begin collective action work. Share the results with our SAT and the ECAC. Provide a mechanism to communicate community issues at the state level. Once we know where communities have landed, the Community Initiatives Work team can support them moving forward.
Questions?

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ECCS Primary Drivers

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

Anna F. Hays, MD
-Clinical Assistant Professor, University at Buffalo
-ECCS Place-Based Community Lead
Western New York ECCS

Dennis Kuo, MD, MHS
Updates

• CollIN – Design Meeting
• Learning Collaborative
Design Meeting Objectives - January 11, 2018

1. Generate understanding of the human perspective and generate empathy for families to inform the design of key features of a community system

2. Ensure a level understanding of the current environment and emerging innovations/trends

3. Identify problems, gaps and challenges to inform how we might build a better system of care

4. Identify, refine and prioritize key features of a human centered ECCS system
Prework and Meeting

- Prework – key informant interviews
- Meeting
  - 24 family/provider members
  - Reviewed journey – family and physician
  - Design exercises and next steps
Strawman Key Features

1. Family pathways for every child at potential risk
2. Family pathways for child in EI services
3. Feedback loop to referral providers, to service providers and families
4. Easily accessible repository of education materials for families
5. Family support systems in key age transitions
6. Family education on research-based best practices
7. Clinician/staff training on top five key diagnoses
Key Features: Weighted Voting
Key features

• Referral feedback loop / data repository
• Community norms and values
• Pathways for every child 0-3 years
• Family during key transitions
Learning collaborative

• Six practices
• Two webinars
  – Introduction
  – PDSA cycles
• Data collection starting now – just baseline data
Instructions: Each place-based community team that is testing improvement changes completes a worksheet for all PDSA cycles completed. Upload to Cotoab on the 7th of each month for tests performed the previous month. (Note: use this worksheet concurrently as you plan, implement, and evaluate the test – don’t wait until the end of the month – it can be a good planning and documentation tool throughout the test)

Objective for this PDSA Cycle:
Is this cycle used to develop, test, implement, or spread a change?
What question(s) do we want to answer on this PDSA cycle?

Plan:
Answer questions: Who, What, When, Where will the test of change occur?

Plan for collection of data: Who, What, When, Where?

Predictions (for questions above based on plan):

Do:
Report the competed change or test, data collected and begin analysis.

Study:
Complete analysis of data

Compare the data to your predictions and summarize the learning

Act:
Are we ready to make a change? Plan for the next cycle.
Select the appropriate patient visit data set:  □ 9-month  □ 18-month  □ 24-month  □ 30-month

### Developmental Screening

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<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<td>B. Is there documentation that developmental screening results were discussed with the patient's family at the time of the screening?</td>
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<tr>
<td>C. Was a positive developmental screen identified?</td>
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<tr>
<td>D. If a positive developmental screen was identified, is there documentation in the medical record that the patient was referred for follow-up care within 3 calendar days? (Note: Follow-up care examples include Part C Early Intervention Program, developmental-behavioral pediatrician, child psychologist, speech and language evaluation.)</td>
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### Autism Screening

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### Instructions:
- Review 10 records per physician per data cycle. For MOC credit: a minimum of 10 records for 4 consecutive months showing improvement by requesting physician.
- Return this information by the 30th of each month to: ngushue@upa.chob.edu or fax to Nancy Gushue at 716-323-0292.
- No patient identifiers should be recorded or transmitted with this form.
Family Partner [fam-uh-lee pahrt-ner] noun. A person who is part of a social unit consisting of adults or parents and their children, who shares or is associated with another in some action or endeavor; sharer; associate. Increase family engagement. Family partners are individuals who will gain opportunities for networking, building leadership skills, improving your child’s pediatric office, strengthening communication skills, and providing outreach to support other families.

What is the responsibility of our family partner?

Orientation
- Meet & greet with practice to become acquainted with staff and layout of office
- Be aware of patient record-keeping – electronic or paper
- Learn what the PDSA cycle is and how to facilitate it
- Become familiar with developmental screening assessments within the practice

Half-hour monthly meeting with Improvement Team Family Partners
- A safe place to ask questions
- Receive guidance and input
- Network with other parent partners to locate services and resources for families who have need within the practice
- Share ideas on how we can follow up with families who have received a diagnosis based on a particular screening

Half-hour touch-base weekly meeting with Practice Providers
What do we want practices to share with the parents on a weekly basis?
- Parent partner responsibilities
- Various diagnosis within the practice population, so parents are able to locate resources that would benefit the child within the community.
- Create a document of appointment dates/times of appointments for patients with (newly) diagnosed children
- Discuss results of weekly screenings and what the follow through will entail. Refer to parent perspective on how this process will unfold for patient.

Be able to discuss with Practice Providers
- How to use people-first language
- The importance of recognizing the parent as the true expert on their child’s health, while not abandoning their oversight
- Create an atmosphere that allows the family to feel comfortable during their well visit
- Health, nutrition, vaccines, or any other topics that could improve the well-being of a patient that parents may not feel comfortable asking about
- The importance of having resources readily available in the office pertaining to Early Intervention, Preschool Transition (CPSE), and local support groups

What characteristics are we looking for in a family partner?
The family partner should be able to:
* Attend family engagement webinars & meetings
* Participate in creating quality improvement PDSA cycles
* Understand confidentiality through disclosures and patient privacy documents/clearances
* Value the importance of cultural diversity
* Understand the early intervention process, preferably by having experience with their own child
* Have access to the necessary accommodations and support to participate effectively

In 2016, the U.S. Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB) launched an effort to identify ways to improve early childhood systems, resources and coordination across sectors and aims to improve outcomes in population-based children’s developmental health and family well-being.
Some lessons learned so far

• Family engagement and partnership – build from beginning
• Journey and pathways is about families and providers
• Practices understand the broad implications of this project
• Persistence and patience needed through a busy flu season
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
• 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

• 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

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

• 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?
Solving Our Challenges – Communities utilizing Help Me Grow

Developing a statewide message
ECCS brochure is completed both communities incorporating the work of HMG into their approaches.

Operationalizing data collection & aligning HMG
Both communities are able to use their HMG data system to operationalize the ECCS data

Closing referral loop
Both ECCS communities using a HMG approach to begin tracking referrals and closing the referral loop
Engaging families
Nassau has established a Family Advisory Group and will be training with early care providers around screening and communicating with families.

Western NY has family members on their improvement team and will be part of the practice transformation team.

Different practices among healthcare centers and electronic medical records
PDSAs in 6 Western NY practices may uncover additional challenges among healthcare centers.

Understanding community assets and service access
Western NY design meeting
Nassau County surveying families and early care providers.
Challenges Yet to Tackle

NYS does not have an integrated statewide ECDS

Ensuring integration of social determinants of health and health equity into the work

Ensuring an approach that is replicable for communities in NYS
Questions?

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Contact Us

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