

New York State Early Childhood Comprehensive Systems

#### NYS Early Childhood Advisory Council

#### September 28, 2017

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### TODAY'S AGENDA

- ECCS background
- 5 year AIM
- Building our CollN
- Primary drivers
- Translating the aims
- Community Updates
- State Alignment
- How You Can Help
- Challenges
- Plans for Year 2





### ECCS BACKGROUND

The NYS Council on Children and Families and grantees in 11 other states have been awarded the Early Childhood Comprehensive Systems (ECCS) Impact grant. This 5 year grant from the Health Resources and Services Administration, Maternal and Child Health Bureau seeks to enhance early childhood systems building and demonstrate improved outcomes in population-based children's developmental health and family well-being using a Collaborative Innovation and Improvement Network (CollN) approach.



Increase awareness, coaching and training about child development and the importance of and utilization of developmental screening **and follow-up** among early childhood professionals

Ε

Use a CollN approach to improve outcomes in population-based children's developmental health and family wellbeing indicators by working across systems and across sectors with a common goal Recognize **social determinants of health** as barriers to healthy early development and school readiness especially for low income children and work to reduce health inequities in screening, service referral and access

Strengthen leadership in continuous quality improvement, develop two-generational approaches and test innovative systems change ideas

Promoting family and community approaches to support early developmental and school success for young children





But, what is our goal?



### NYS ECCS 5 YEAR AIM



Achieve a 25% increase in age-appropriate developmental skills of 3 year old children by 2021



Collaborative Improvement and Innovation Network (CollN)

Use a CollN approach to improve outcomes in population-based children's developmental health and family well-being indicators by working across systems and across sectors with a common goal



### **BUILDING THE ECCS COIIN**

(FEDERAL LEVEL)





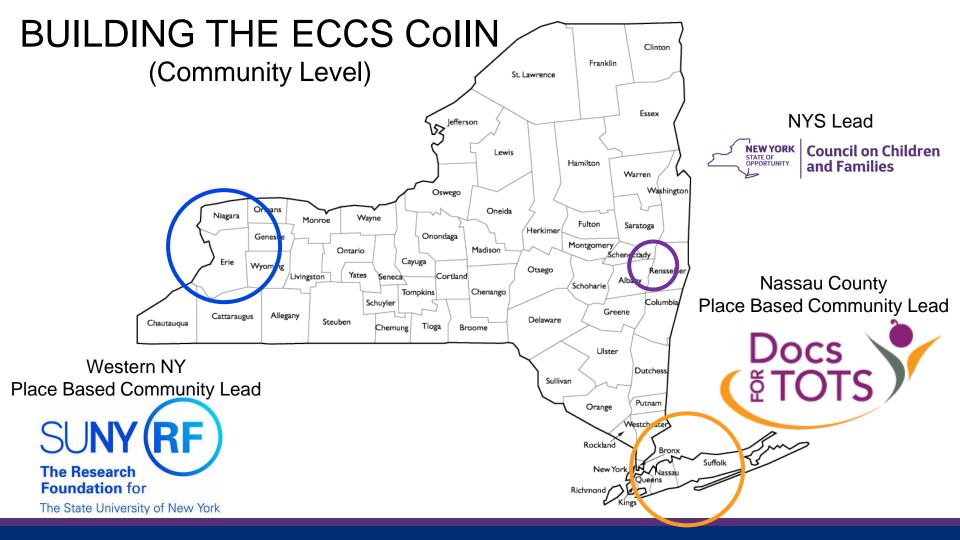
Applied Engineering Management Corporation

# NICHQ

National Institute for Children's Health Quality







### Nassau County ECCS CollN Place-Based Community

- Docs for Tots
  - Liz Isakson, MD, FAAP, Executive Director
  - Melissa Passarelli, MS, Director of Programs



Docs for Tots is a non-profit, nonpartisan organization led by pediatricians to promote practices, policies, and investments that will enable young children to thrive.

Docs for Tots creates linkages between doctors, policymakers, early childhood practitioners, and other stakeholders to ensure that children grow up healthy. Their focus is on the youngest children and their families, from prenatal to children age five.



### Western NY ECCS CollN Place-Based Community

- The SUNY Research Foundation at the University of Buffalo Jacobs School of Medicine
  - **Dennis Kuo**, **MD**, **MHS**, 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
  - Anna Hays, MD, Clinical Assistant Professor, the University of Buffalo Jacobs School of Medicine



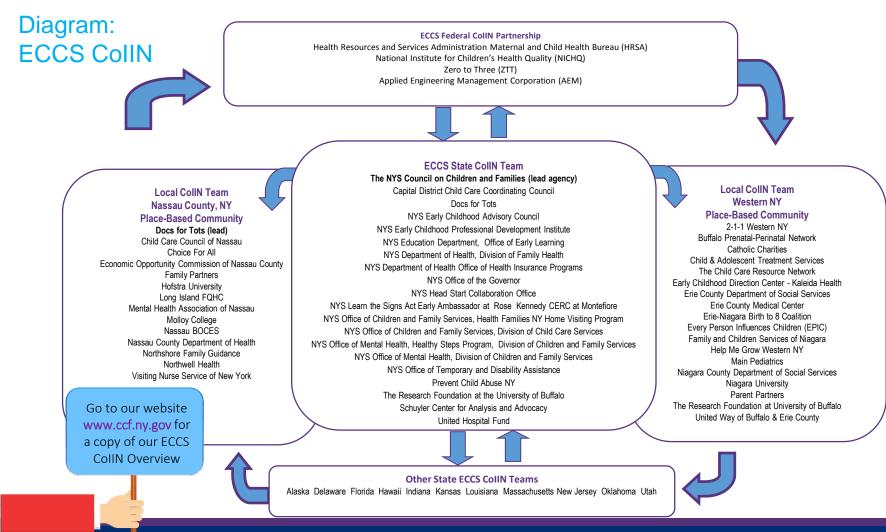
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#### **University at Buffalo**

The State University of New York



#### **BUILDING THE ECCS COIIN** SUNY (RF Docs TOTS The Research (STATE LEVEL) Foundation for The State University of New York EINSTEIN HELP ME **Capital District** New York Early Childhood **Child Care Council** GR **Professional Development Institute** Albert Einstein College of Medicine WESTERN NEW YORK Developing Adults Working with Developing Children HE EARLY YEARS MATTER MOS New York State Early Childhood NYS **NEW YORK** Department New York State STATE OF OPPORTUNITY. EDUCATION DEPARTMENT Advisory Council Head Start of Health Collaboration Knowledge > Skill > Opportunity .aov Building Success for Children Office Ensuring Success for New York NEW YORK **Office of Children NEW YORK Office of Temporary** STATE OF OPPORTUNITY. and Family Services and Disability Assistance STATE **NEW YORK** Office of STATE OF OPPORTUNITY. **Mental Health** United **Hospital Fund** revent Child Abuse Schuvler Center New York for Analysis and Advocacy **NEW YORK Council on Children STATE OF** OPPORTUNITY. and Families



### **ECCS** Primary Drivers

DRIVER 6 Policy and Advocacy

DRIVER 4 Systems Promote Developmental Health

Early Identification of Developmental Needs

**DRIVER 3** 

Social Determinants of Health

**DRIVER 1** 

DRIVER 2 Family Engagement DRIVER 5 Linked and Coordinated Systems

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Improve developmental skills of 3 year old children by 25 %

**5 YEAR AIM** 



KEEP CALM AND SET NEW AIMS

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** 



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** 



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 CollN reporting **ANNUAL INDICATOR DRIVER 5** 

STATE OF

30%

relative increase in the number of new or updated policies that support developmental and relational health promotion **BIANNUAL INDICATOR DRIVER 6** NEW YORK **Council on Children** OPPORTUNITY. and Families

### TRANSLATING THE AIMS

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TIME FO

### **Driver Diagram**

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IM STATEMENT		PRIMARY DRIVER		SECONDARY DRIVER		PRIMARY DRIVER		SECONDARY DRIVER
LAim: ry 2018, ECCS Impact s and Placed-based ities will promote		P1: Early Identification of Developmental Needs Aligned and coordinated community-wide systems promote developmental health and provide early identification of developmental needs for all children & families, especially those that are vulnerable.		SD1: Screening is conducted in a variety of settings so all children are assessed (e.g. well-child visits, childcare settings, WIC & SNAP appointments, home visits, etc.	ſ	P4: Systems Promote Developmental Health and Meet Needs of Children & Families Services throughout the ECCS that promote developmental health are available, accessible, of high quality, and are used by families.	•	SD1: Services are appropriate, available, accessible, evidence-based, family- centered, equitable, and incorporate family education and celebration of milestones.
				SD2: Screening services use evidence-based tools and methods and seek a full picture of developmental health including SDOH and vulnerabilities.				SD2: All components of the community-wide system are aware of healthy developmental promotion services and help link families to them.
y development of n birth to age 5 to				SD3: Hard to reach families are engaged using a variety of methods.				SD3: Development enhancing activities are provided to families and other caregiving entities (child care, etc.).
e: % relative increase in e proportion of children,				SD4: Services that provide screening do so in a manner that is timely, efficient, effective family-centered, and equitable.				SD4: Feedback from parents/caregivers on the quality of services is sought and utilized for improvement.
th through age 5 who eive a "routine" velopmental- behavioral				SDS: Developmental monitoring, screening, and follow-up plans are in place and incorporate work flow and data use.				SDS: Effective care coordination and cross sector communication enhances family access and utilization of services.
eening using a valid &							Ιr	SD1: Data systems support collaboration coordination and continuous improvement
iable screening tool % relative increase in e proportion of children	•	P2: Family Engagement Systems promote and maintain family dignity and integrity by supporting active involvement in identifying, promoting, improving, and managing child developmental health in ways that are meaningful to them. P3: Address Social Determinants of Health Systems address social determinants of health, including related needs and concerner and support families		SD1: Family motivations, strengths, talents and skills are recognized and capitalized upon for families to be key promoters of healthy child development.	•	P5: Linked and Coordinated Systems Linked and coordinated systems promote continuity, collaboration, and cross-sector sharing in all aspects of monitoring, screening, follow- up, and service delivery while ensuring privacy and legal rights of families.	•-	SD2: Interagency data sharing agreements delineate agency and provider responsibilities including sharing and privacy protocols.
h through age 5, who ieve 5 domain relopmental health (in				SD2: Families have support necessary to access, navigate and promote the developmental health of their children.				SD3: Reliable and effective systems exist to track screening, referral, evaluation, receipt of services, outcome monitoring.
ch domain) as monstrated by indardized				SD3: Build trusting relationships between families and professionals.				SD4: Cross-sector infrastructure supports on-going training, technical assistance and support for developmental monitoring, screening, and follow-up activities.
velopment-behavioral reening results								SD5: Seamless response to identified needs.
% relative reduction in parity for referral to				SD1: Benefits, stressors, and risks associated with SDOH are incorporated into developmental health delivery, monitoring, screening, and follow-up.		P6: Advocacy & Policy Change Systems promote child		SD1: Community-based systems collaborate to plan and engage in advocacy creating local programs to enhance child development.
mmunity services for velopmental health omotion between the				SD2: Family coping capacity is addressed and supports confidence in caregiving				SD2: Policies & reimbursement/payment models provide requirements and/or financial incentives and disincentives, to conduct developmental monitoring, screening, and follow-up in child care, healthcare and other settings.
ups wit llowe Go to our website			SD3: Families are aware of, and have access to services that mitigate stressors associated with SDOH		development and support families through advocacy and policy change at the local, state,		SD3: State monitoring, screening, referral, and follow-up guidelines, practice standards, protocols and regulations are in place and enforced.	
www.ccf	- T.					and federal level.		SD4: Families have the social and economic support to promote developmental
а сору								health.
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Secondary Drivers	Change Ideas				
S1. Data systems support collaboration, coordination, and continuous improvement	<ul> <li>1a. Use swim-lane diagrams and system mapping to identify gaps in linkages between ECCS entities and programs</li> <li>1b. Develop a data system for tracking developmental screenings completed across various settings</li> <li>1c. Develop a data system for tracking referrals, acceptance of referrals, and receipt of services.</li> <li>1d. Standardize data documentation and reporting across ECCS</li> <li>1e. Utilize uniform statewide referral form</li> <li>1f. Develop a central intake system to link families to multiple types of services and reduce duplication</li> <li>1g. Your team's ideas:</li> </ul>				
S2. Interagency data sharing agreements delineate agency and provider responsibilities including sharing and privacy protocols	<ul> <li>2a. Create cross-system agreements to share Quality Improvement data while using protections available (i.e. protection of QI data under HIPAA and Federal regulations)</li> <li>2b. Ensure data sharing agreements are in place and include necessary elements</li> <li>2c. Consider minimum data sets to define and capture data elements including outcomes</li> <li>2c. Your team's ideas:</li> </ul>				
S3. Reliable and effective systems exist to track referral, evaluation, receipt of services, and outcome monitoring	<ul> <li>3a. Create and harmonize data sources to allow sharing of information</li> <li>3b. Develop uniform release of information forms for families to agree to exchange of information between service providers</li> <li>3c. Your team's ideas:</li> </ul>				
S4. Cross-sector infrastructure supports on- going training, technical assistance, and support	4a. Create processes, systems, and resources to support data capture, use, and analysis across service providers				

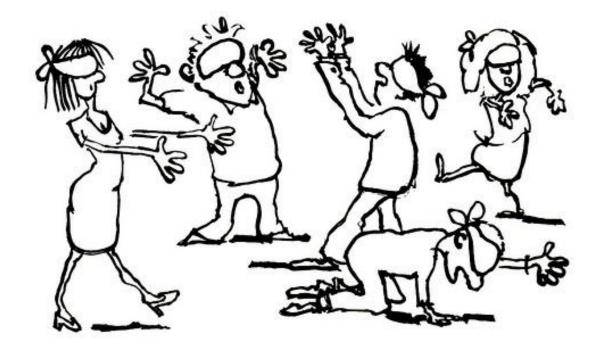
### **Questions?**

#### Have I lost anyone?











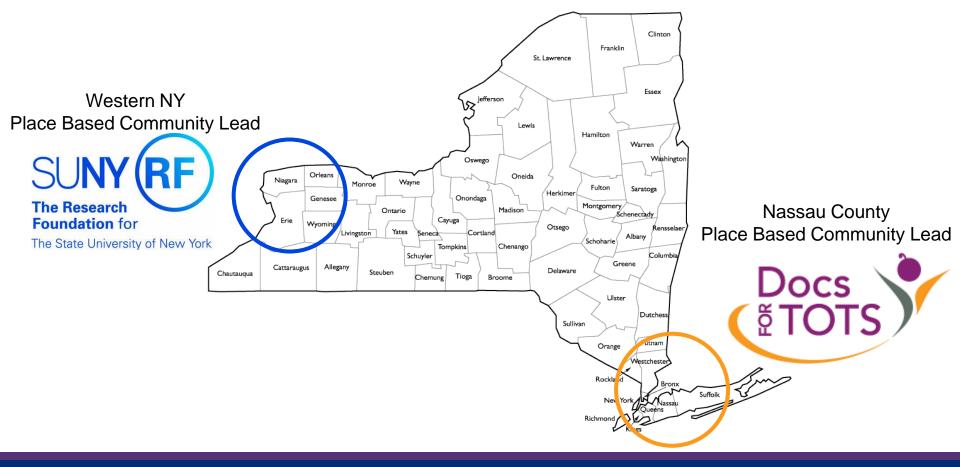
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### **Action Process**

AIM Improve the develop- mental skills of 3 year old children by 25% over 5 years	PRIMARY DRIVER Driver 5: Linked and coordinated systems promote collaboration and cross-sector sharing in all aspects of monitoring, screening, referral and service delivery	SECONDARY DRIVER Data systems support collaboration, coordination and continuous improvement	CHANGE IDEA Launch Long Island Help Me Grow by January 2018 & Develop Help Me Grow central access point (intake system) to link families to multiple types of services and reduce duplication	MONTHLY MEASURE Survey CollN/HMG Partners: In the past month, did your site engage in any HMG activities? How many families with children birth through age three have you referred to a community resource to support developmental health? Of those children, how many do you know the status of the outcome?	ANNUAL INDICATOR Survey CollN/HMG Partners: The proportion of ECCS partners reporting improvements in data processes (data agreements and coordinating activities)	
					C a	n

### PLACE BASED COMMUNITY UPDATES



## Nassau ECCS

#### ECCS 5 Year Goal:

 Improve developmental skills of 3 year olds by 25% over 5 years

#### Help Me Grow Long Island 5 Year Goal:

 Improve developmental outcomes of children 0-5 on Long Island

#### **Accomplishments:**

- Built a local cross sector team, including a "Family Partner Advisory Team"
- Divided the Help Me Grow Long Island Leadership Team into four work groups to plan for the structure of HMG-LI
  - Prepare for January 2018
     launch
- 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)

#### **Next Steps:**

- 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 peerto-peer outreach about developmental health promotion and screening (Driver 2: Family engagement) Docs

## Western NY ECCS

#### **Driver Focus**

- Driver 1- Early
   Identification
- Driver 2- Family Engagement

#### **Population**

• Testing in 5-6 pediatric practices in Erie and Niagara counties using a human centered design process to address screening, referral and follow-up including family engagement

#### **Next Steps**

- Designate an improvement team that includes families, medical and education
- Select and train practice teams
- Discover and design (mapping the system and testing change ideas)

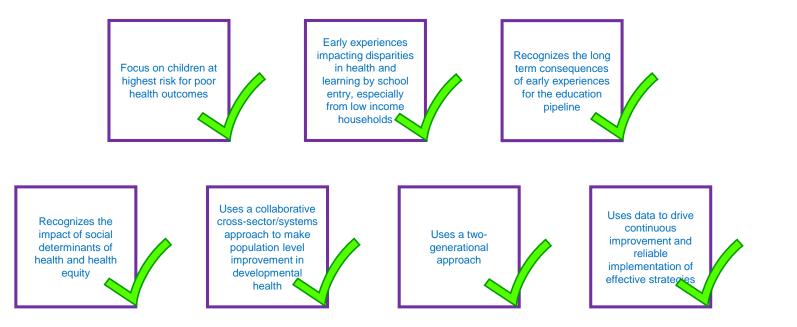
#### Alignment with New York State Initiatives





DRIVER 1 Early Identification	DRIVER 2 Family Engagement	DRIVER 3 Social Determinants	DRIVER 4 Promotion of Developmental Health	DRIVER 5 Linked and Coordinated Systems	DRIVER 6 Policy and Advocacy
Healthy Children: -Promote universal developmental screening Support strategies to increase developmental screening and referral in primary care settings	Strong Families: -Focus state efforts on effectively engaging and increasing parent voice in state policies and programs	Strong Families: -Develop a system for providing comprehensive home visiting for families	Strong Families: -Increase awareness of parenting education -Increase accessibility -Promote parent understanding and QUALITYstarsNY	<b>Early Learning:</b> -Align the current set of early care and education programs to be come an integrated system for children birth to age 8 -Increase the ability of communities to respond to the needs of children and families -Increase community awareness of early learning opportunities	Healthy Children: -Participate in stakeholder meetings to promote Medicaid and other health policy to support universal developmental and maternal depression screening -Engage in stakeholder meetings to advance policy directives to support developmental screening in early care
	Healthy Children: -Promote celebration of milestones and positive parenting as key areas of parent education	Healthy Children: -Increase partnerships that advance key outcomes for children and address social determinants of health -Support maternal depression screening in primary care settings and co-located behavioral health strategies	Healthy Children: -Advance statewide Pyramid Model training on social emotional development and advance IMH endorsement	Coordinated and Responsive Systems: -Address opportunities across agencies to support a coordinated and responsive system of supports for families	<b>Early Learning:</b> -Explore ways the state can promote and support community efforts to build coalitions, collect data and implement programming.
			Early Learning: -Promote the use of NY Early Learning Framework -Ensure professional and development programs prepare early childhood practitioners -Support developmentally appropriate practice in programs birth to 2		<b>Coordinated and Responsive Systems:</b> -Maximize early childhood program funding to increase access for early childhood services
NYS ECCS	Alignment w	vith the ECAC	<b>Coordinated and Responsive Systems:</b> -Develop and implement a public engagement campaign to inform and obtain the support of leaders for early childhood initiatives -Increase awareness of all child-serving professionals of the resources available for children in the community		<b>Coordinated and Responsive Systems:</b> -Provide support to statewide initiatives designed to support communities in developing and implementing strategies to improve services for children and families

### ECCS Alignment with the First 1000 Days on Medicaid



Big Picture: We're here for the same reasons!

### ECCS Alignment with the First 1000 Days on Medicaid

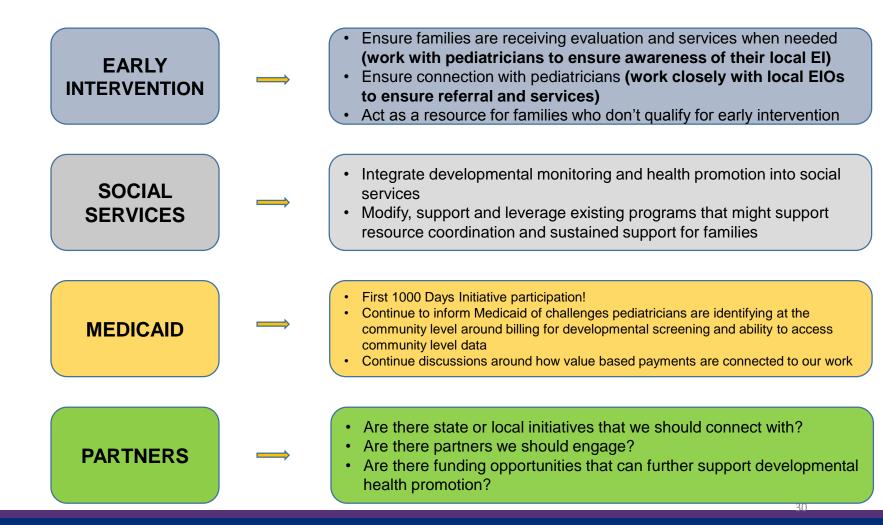
1. Continue our connection with Medicaid to share our successes – outcomes

2. We may be able to test the recommendations set forth by the First 1000 Dayscreated an infrastructure in two communities with the will and capacity to measure them.

3. Data driven process – conducting PDSA cycles in pediatric offices, attending to social determinants of health and measuring the success of our community collaborative – sharing with Medicaid what success looks like for families when there is a coordinated and responsive system.



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



### 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?**

#### Comments? Thoughts?







### 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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OPPORTUNITY

### **Contact Us**

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