

Council on Children and Families

NYS ECCS IMPACT

New York State Early Childhood Comprehensive Systems

NYS Early Childhood Advisory Council September 28, 2017

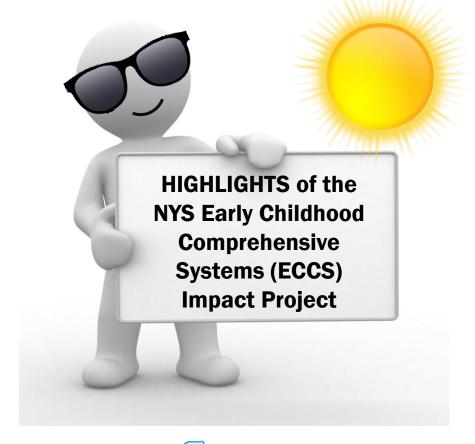
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TODAY'S AGENDA

- 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

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

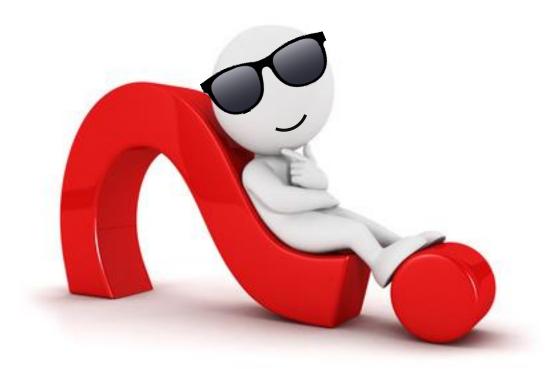
Strengthen leadership in continuous quality improvement, develop two-generational approaches and test innovative systems change ideas

S

E

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 CollN

(FEDERAL LEVEL)

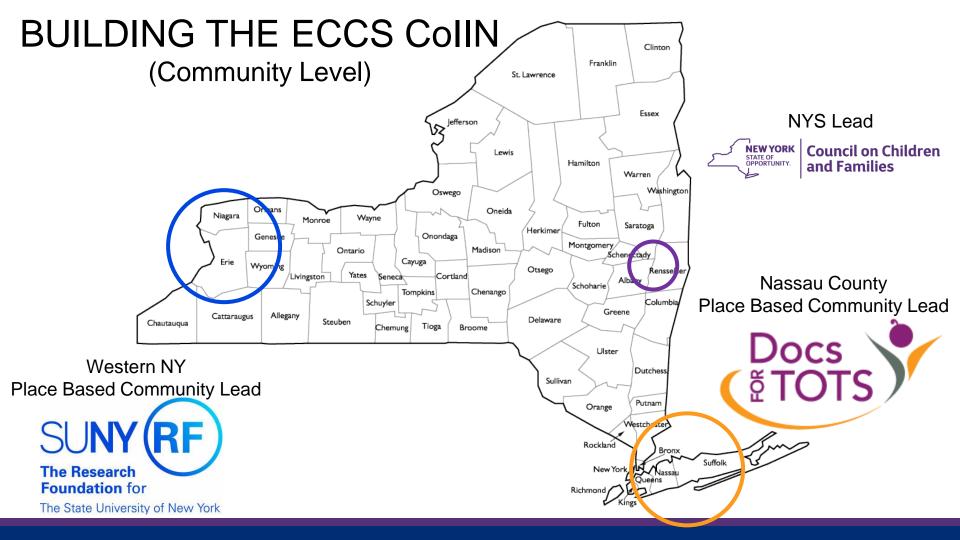












Nassau County ECCS CollN Place-Based Community

- 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



The State University of New York





BUILDING THE ECCS CollN

(STATE LEVEL)





The State University of New York











Early Childhood **Advisory Council**



New York State EDUCATION DEPARTMENT Knowledge > Skill > Opportunity







Building Success for Children

Ensuring Success for New York



Office of Temporary and Disability Assistance



















Diagram: **ECCS CollN**

ECCS Federal CollN 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)









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

Mollov College Nassau BOCES

Nassau County Department of Health Northshore Family Guidance Northwell Health

Visiting Nurse Service of New York

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



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 CollN 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

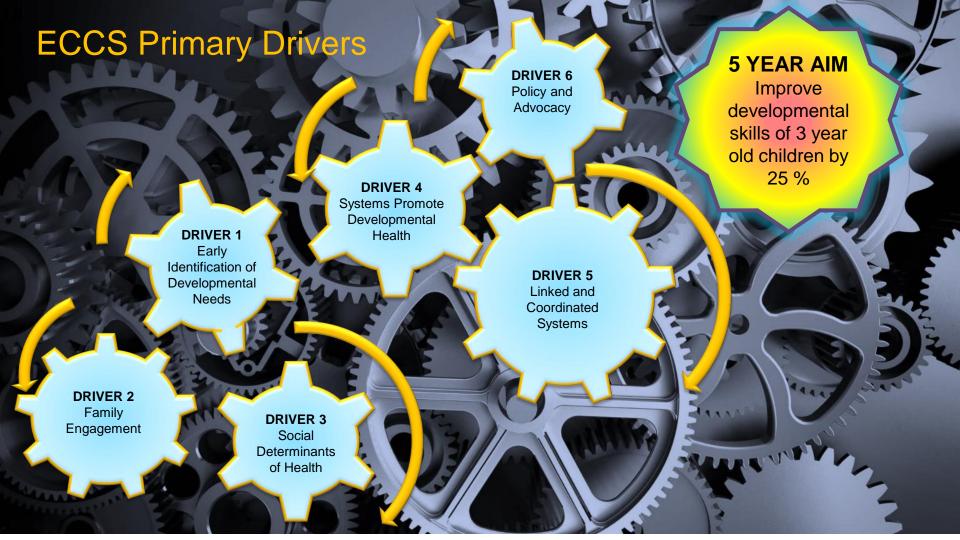
The Research Foundation at University of Buffalo United Way of Buffalo & Erie County





Alaska Delaware Florida Hawaii Indiana Kansas Louisiana Massachusetts New Jersey Oklahoma Utah







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 CollN reporting ANNUAL INDICATOR DRIVER 5

NEW YORK STATE OF OPPORTUNITY. 30%

relative increase in the number of new or updated policies that support developmental and relational health promotion BIANNUAL INDICATOR DRIVER 6



Driver Diagram

AIM STATEMENT PRIMARY DRIVER SECONDARY DRIVER PRIMARY DRIVER SECONDARY DRIVER SD1: Services are appropriate, available, accessible, evidence-based, family-SD1: Screening is conducted in a variety of settings so all children are assessed (e.g. centered, equitable, and incorporate family education and celebration of well-child visits, childcare settings, WIC & SNAP appointments, home visits, etc. Cohort A Aim: P4: Systems Promote By January 2018, ECCS Impact P1: Early Identification of SD2: All components of the community-wide system are aware of healthy Developmental Health and Grantees and Placed-based SD2: Screening services use evidence-based tools and methods and seek a full developmental promotion services and help link families to them. Developmental Needs Meet Needs of Children & picture of developmental health including SDOH and vulnerabilities. Communities will promote Aligned and coordinated Families healthy development of SD3: Development enhancing activities are provided to families and other community-wide systems Services throughout the ECCS caregiving entities (child care, etc.). children birth to age 5 to SD3: Hard to reach families are engaged using a variety of methods. that promote developmental promote developmental health health are available, accessible, and provide early identification SD4: Feedback from parents/caregivers on the quality of services is sought and of high quality, and are used by of developmental needs for all SD4: Services that provide screening do so in a manner that is timely, efficient, 25% relative increase in utilized for improvement. families. children & families, especially effective family-centered, and equitable. the proportion of children those that are vulnerable. birth through age 5 who SD5: Effective care coordination and cross sector communication enhances family receive a "routine" access and utilization of services. SD5: Developmental monitoring, screening, and follow-up plans are in place and developmental-behavioral incorporate work flow and data use. screening using a valid & SD1: Data systems support collaboration coordination and continuous improvement reliable screening tool P5: Linked and Coordinated P2: Family Engagement SD1: Family motivations, strengths, talents and skills are recognized and capitalized SD2: Interagency data sharing agreements delineate agency and provider 10% relative increase in Systems promote and maintain upon for families to be key promoters of healthy child development. responsibilities including sharing and privacy protocols. the proportion of children Linked and coordinated systems family dignity and integrity by birth through age 5, who promote continuity. supporting active involvement in SD3: Reliable and effective systems exist to track screening, referral, evaluation, achieve 5 domain SD2: Families have support necessary to access, navigate and promote the collaboration, and cross-sector identifying, promoting, receipt of services, outcome monitoring sharing in all aspects of developmental health of their children. developmental health (in improving, and managing child monitoring, screening, followeach domain) as developmental health in ways up, and service delivery while SD4: Cross-sector infrastructure supports on-going training, technical assistance and demonstrated by that are meaningful to them. SD3: Build trusting relationships between families and professionals. ensuring privacy and legal rights support for developmental monitoring, screening, and follow-up activities. standardized of families. development-behavioral SD5: Seamless response to identified needs. screening results P3: Address Social SD1: Benefits, stressors, and risks associated with SDOH are incorporated into 10% relative reduction in SD1: Community-based systems collaborate to plan and engage in advocacy developmental health delivery, monitoring, screening, and follow-up. Determinants of Health disparity for referral to creating local programs to enhance child development. Systems address social community services for determinants of health. P6: Advocacy & Policy developmental health SD2: Family coping capacity is addressed and supports confidence in caregiving SD2: Policies & reimbursement/payment models provide requirements and/or including related needs and Change financial incentives and disincentives, to conduct developmental monitoring, promotion between the traccore and support families Systems promote child screening, and follow-up in child care, healthcare and other settings. groups wit • development and support k and maximize SD3: Families are aware of, and have access to services that mitigate stressors and lowe families through advocacy and associated with SDOH Go to our website SD3: State monitoring, screening, referral, and follow-up guidelines, practice policy change at the local, state, standards, protocols and regulations are in place and enforced. and federal level. www.ccf.ny.gov for SD4: Families have the social and economic support to promote developmental a copy of ECCS **Driver Diagram!**



Secondary Drivers	Change Ideas		
S1. Data systems support collaboration,	1a. Use swim-lane diagrams and system mapping to identify gaps in linkages between ECCS		
coordination, and continuous improvement	entities and programs		
	1b. Develop a data system for tracking developmental screenings completed across various settings		
	Develop a data system for tracking referrals, acceptance of referrals, and receipt of services. Id. Standardize data documentation and reporting across ECCS 1e. Utilize uniform statewide referral form		
	1f. Develop a central intake system to link families to multiple types of services and reduce duplication		
	1g. Your team's ideas:		
S2. Interagency data sharing agreements	2a. Create cross-system agreements to share Quality Improvement data while using protections		
delineate agency and provider responsibilities	available (i.e. protection of QI data under HIPAA and Federal regulations)		
including sharing and privacy protocols	2b. Ensure data sharing agreements are in place and include necessary elements		
	2c. Consider minimum data sets to define and capture data elements including outcomes 2c. Your team's ideas:		
C2 Daliable and effective systems spirit to treat	2- Create and harmonics data coveres to allow sharing of information		
S3. Reliable and effective systems exist to track	3a. Create and harmonize data sources to allow sharing of information		
referral, evaluation, receipt of services, and	3b. Develop uniform release of information forms for families to agree to exchange of information		
outcome monitoring	between service providers 3c. Your team's ideas:		
	oc. rour team s ideas:		
S4. Cross-sector infrastructure supports on-	4a. Create processes, systems, and resources to support data capture, use, and analysis across		
going training, technical assistance, and support	service providers		

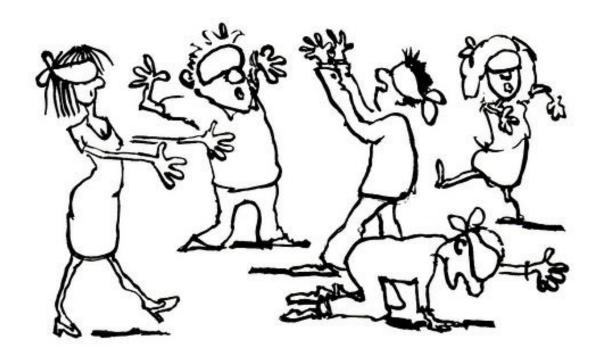
Questions?

Have I lost anyone?











Action Process

AIM **Improve** the developmental skills of 3 vear old children by 25% over 5 vears

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?

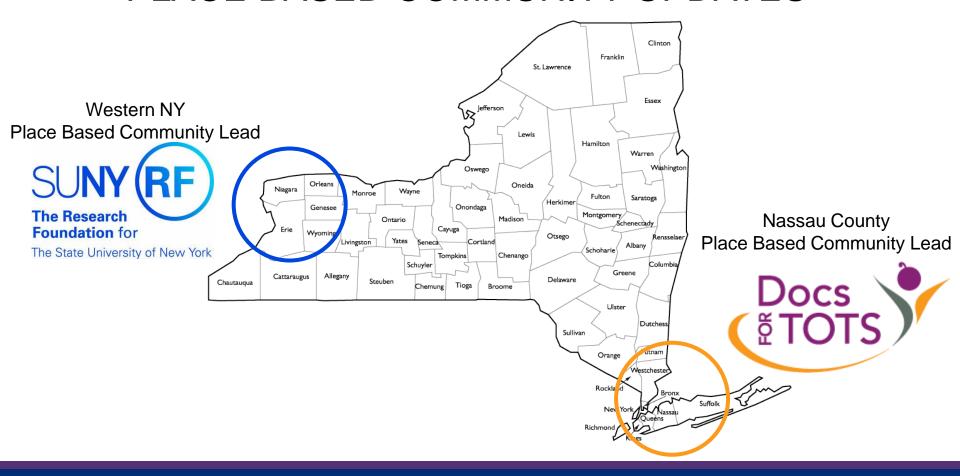
ANNUAL INDICATOR

Survey CollN/HMG Partners:

The proportion of ECCS partners reporting improvements in data processes (data agreements and coordinating activities)

ln

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)

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)

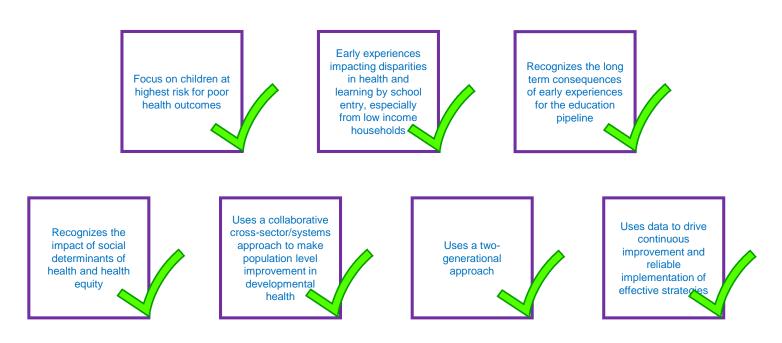
Alignment with New York State Initiatives





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	Early Learning: -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	Early Learning: -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		Coordinated and Responsive Systems: -Maximize early childhood program funding to increase access for early childhood services
NYS ECCS	Alignment w	vith the ECAC	Coordinated and Responsive Systems: -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		Coordinated and Responsive Systems: -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

- 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

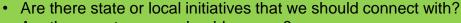
EARLY INTERVENTION SOCIAL **SERVICES**

- Ensure families are receiving evaluation and services when needed (work with pediatricians to ensure awareness of their local El)
- 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

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 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

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



NEW YORK STATE OF OPPORTUNITY. and Families

Contact Us

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