State Policy Action Team Meeting
Moving an Infant-Toddler Policy Agenda
Stowe, Vermont
May 21 – 23, 2013

In May 2013, five state teams came together in Stowe, Vermont, with representatives from ZERO TO THREE, the Ounce of Prevention, and the BUILD Initiative to discuss strategies for developing and moving an infant-toddler policy agenda. State teams represented Illinois, Massachusetts, Minnesota, New Jersey, and Pennsylvania.

The goals of the meeting were to:

- Highlight innovative state models and strategies for developing and operationalizing an infant-toddler policy agenda;
- Assist participating states in moving forward a policy agenda for infant, toddlers, and their families; and
- Promote relationships and continued collaborative work among participants.

The sessions at the meeting were planned around these goals. In addition to state team members and national organization staff, there were several invited presenters to round out the expertise, including:

- Lori McClung, Advocacy & Communication Solutions, LLC
- Mary Orr, Minnesota Department of Human Services
- Abby Thorman, Thorman Strategy Group
- Gail Piggott, Alabama Partnership for Children
- Ron Benham, Massachusetts Department of Public Health
- Dan Haggard, New Mexico Children, Youth and Families Department

ZERO TO THREE will work with the five participating states over the next year to help them move forward with goals identified as a result of the meeting. The meeting and technical assistance are generously supported by the Alliance for Early Success.

Review the meeting agenda here.

Large Group Session
Developing an Infant-Toddler Policy Agenda

Presenters:

- Barbara Gebhard, ZERO TO THREE
- Carey McCann, Ounce of Prevention
- Lori McClung, Advocacy & Communication Solutions, LLC

Key Points:

- Developing and implementing an infant-toddler agenda is not a sprint but a marathon – it takes careful and organized planning.
- Engage diverse stakeholders and clarify roles from the beginning.
- Limit the number of infant-toddler agenda items and pick items that are measurable so you can demonstrate impact.

Full Session Notes:

Barbara opened the session with a discussion about the considerations that need to be taken into account when developing a policy agenda.

- Begin with rationale and context. It is important to talk about how an agenda plays out in the birth to 3 years and how it is different from 3-5 years.
- Stress bonding and attachment. The Still Face Video can show the importance of relationships.
- An infant toddler agenda must support families. 85% of children ages 0-2 are not in formal care, and therefore an infant-toddler agenda must look beyond formal care.
- Make it more contextual for 0-3. Emphasize the differences in children that occur in children's development by the age of 3.
- Paint picture of your own state – where infants are – different strategies used to reach infants, toddlers, and their families.
- ZERO TO THREE recommends that a policy agenda should include health, family strengthening, and early learning that leads to good health, strong families, and positive early learning experiences. Services plus the infrastructure equals the system.
- Characteristics of a policy agenda:
    - *Shared*: resonates with constituency groups
    - *Bold:* makes a significant difference to children, families, and communities – dynamic enough to excite passionate support
    - *Strategic*: takes advantage of opportunities – think about opposition
- Not a sprint, but a marathon – consider how many years your plan will cover.

Lori then provided some lessons learned from her work conducting a statewide advocacy campaign in Ohio.

- You are never going to make everyone happy – where is the balance?
- A laundry list is bad – where is the cut-off?
- Pick things that are measurable so you can determine effectiveness.
- Build in evaluation.
- Use common sense – agenda should be relevant to political climate – balance
- Bold agenda gets people excited but realistic one means you may see some small successes early.
- Bonding and attachment is critical – serve and return.

Barbara then discussed some of the processes and tools for developing an agenda.

- Diverse group and commitment of group
- Must have vision – a dream with urgency
- Base priorities on data
- Good facilitation – decision making processes

ZERO TO THREE's tool *Infants and Toddlers in the Policy Picture: A Self-Assessment Checklist for States* is based on research about effective policies and best practices in states.

- The checklist can be used to spark discussion, identify gaps in services, test assumptions, gather input from diverse stakeholders, set priorities, build commitment, and track progress.
- ZERO TO THREE has served as facilitator to help states work through the tool. States have used it in a variety of ways – over the course of several months with multiple meetings, during a one-day conference, through online surveys, etc.
- It is essential that you use the results! Develop action plans with assigned responsibilities, timelines, and measurable outcomes. Priority actions can be incorporated into other state plans.
- ZERO TO THREE has the tool in an Excel spreadsheet if states would like it. It can also be imported into survey monkey.
- ZERO TO THREE has a list of suggested stakeholders to include in the process.

Lori then shared some lessons learned from her work in Ohio around developing a policy agenda.

- Have a diverse group – which can come in many different forms. Who will do the work, and who are the stakeholders? Need specific skills such as communications and facilitation skills.
- Acknowledge underlying tensions and competition for funding. Conflict of interest – maybe those representing groups that get money do not vote on particular things. Bring it up in the beginning.
- Establish ground rules.
- May be a different group that prioritizes than the one that develops the big picture.
- Challenge to work on outcomes – in Kansas, this helped to unify groups.
- In Alabama, people are asked to acknowledge in writing whether there are any conflicts of interest.
- Who is the leader? For how long? Who can speak on your behalf? Think about this in the beginning.
- Today's enemy may be tomorrow's ally.

Carey then discussed examples that highlighted how states moved an infant-toddler policy agenda based on their particular context.

- The Illinois State Board of Education's Early Childhood Block Grant funds a variety of services for very young children (birth to 5 years) and their families. Through statute, a percentage of the total Early Childhood Block Grant funds is set aside to support programs for at-risk infants and toddlers and their families. Currently 14% of all available funds must go to support infants and toddlers.
- In Kansas, there is a set-aside for infants and toddlers in the Children's Initiative Fund, which supports the Early Childhood Block Grant. At least 30% has to be designated for infants and toddlers, but in actuality 50% has supported infant-toddler programs and services.
- Nebraska's Early Childhood Education Endowment ("Sixpence") provides a stable, protected revenue source for quality early childhood programs serving at-risk children ages birth to 3 years. Sixpence is a public-private partnership, including $40 million in state funding and an additional $20 million in private sector dollars. Sixpence generates earnings each year and is not subject to annual appropriations or state fiscal fluctuations. In November 2006, voters approved a constitutional amendment to permanently establish public funding for the endowment through the use of Educational Land Trust Funds.
- In Colorado, advocates were asked by a Senator at the end of the 2013 legislative session to give recommendations regarding the use of additional funds to support infants and toddlers. The advocates were able to seize this opportunity and create The Colorado Infant and Toddler Quality and Availability Grant Program within the Colorado Department of Human Services through legislation. It is a $3 million grant program, which encourages local early childhood councils and county departments of human services to partner to increase the quality and availability of care for programs serving infants and toddlers through the Colorado Child Care Assistance Program.

Lori shared some lessons learned related to moving an agenda.

- Emphasize outcomes – what you need for quality infant-toddler programs.
- Mental health offers an opportunity with recent shootings.
- Tie to other services such as child welfare or economic development.

Carey closed the session with a discussion of how we evaluate progress.

- Evaluate stages – policy development, placed on future policy agenda, policy adopted or blocked, policy implementation – monitor and evaluate, and policy maintenance.
- Choose which measures pertain to the polices you develop – child and family outcomes, improved services, or system changes.

- Measure progress toward policy goals, advocacy tactics, or interim outcomes.

Lori made a few concluding comments regarding evaluation.

- Did you change the lexicon?
- Are media or policymakers calling you (instead of you calling them)?
- Do polling and surveys.

Resources:

- PowerPoint Presentation *Developing an Infant-Toddler Policy Agenda*
- *Infants and Toddlers in the Policy Picture: A Self-Assessment Checklist for States*

Concurrent Session
Engaging "Hard to Reach" Families

Presenters:

- Maria Mayoral, ZERO TO THREE (facilitator)
- Mary Orr, Minnesota Department of Human Services
- Abby Thorman, Thorman Strategy Group

Session Key Points:

- We need to engage families we consider "hard to reach" in planning and implementing services to ensure they are tailored to their needs. Many existing services and systems were built without these families' needs in mind.
- Aggregate data can mask large differences in outcomes for different populations. When evaluating policy or program effectiveness, it is essential that you look at child outcome data that is disaggregated by race, income, and other characteristics that are relevant for your state.
- We have more power than we think to make change. In both Minnesota and Miami/Dade, early childhood professionals were able to make changes that benefited "hard to reach" families (by targeting existing funding to teen parents in Minnesota and revising QRIS standards and incentives to promote participation by African American and Hispanic providers in Miami/Dade).

Full Session Notes:

Maria Mayoral opened the session with a broad discussion of who "hard to reach" families are and how we can better reach them.

- Session attendees described "hard to reach families" as: families who are invisible to the service delivery system; families who are not connected to the system or don't know where to go; families who are isolated geographically, linguistically, or because they experience poverty; families who haven't had good experiences in the past with the formal service system; and immigrants.
- The language we use to describe these families – "hard to reach"—implies that families are at fault in some way. It is not that families are "hard to reach," but that systems have not been built with their needs in mind.
- Maria shared the poem *My Universal Bone Deep Longing* to illustrate the fact that everyone wants to make a contribution in the world.
- Maria also shared the *Bennett Model of Cultural Competency*, which identifies a continuum of cultural competency that moves through six stages: denial, defense, minimization, acceptance, adaptation, and integration. She stressed the importance of building systems and practices that are culturally responsive.

Representatives from Minnesota and Miami/Dade County, Florida shared two examples of initiatives to better serve "hard to reach" families.

Minnesota

Mary Orr shared information about Minnesota's initiative to connect teen parents on TANF with home visiting services.

- The initiative is a collaboration between the Department of Human Services and the Department of Health.
- A portion of TANF block grant funds is transferred to the Department of Health and then distributed to local jurisdictions to fund home visiting services for teen parents.
- Minnesota is a state-supervised, county-administered state, so while they are trying to collaborate at the state level, the real job is to facilitate collaboration between county health and human service departments.
- 2,000 teen parents received TANF assistance in the state in December 2011. More than 1,600 of them were 18-19 years old. These families are at risk for multi-generational poverty and for greater involvement in the child welfare system due to parenting challenges. Minnesota identified several factors that have contributed to make teen parents hard to reach and serve:
    - They have trouble establishing trusting relationships with adults.
    - They may have difficulty navigating complex service delivery systems.
    - They lack confidence to advocate for themselves and their children.
    - They often have unmet needs of their own.
- The state initiative is based on the successful program in Ramsey County that has been in place since 2003.
    - The Ramsey County initiative required that teen parents on TANF participate in a home visiting program. Public health nurses were used.
    - An evaluation conducted by the University of Minnesota found that participants had higher graduation rates, stable or improved school attendance rates, a decrease in subsequent births, and healthier subsequent births when they occurred.
    - Interactions with home visitors provided an avenue for teens to explore issues that they wouldn't otherwise explore with their TANF caseworkers (the TANF relationship is very compliance-based while the home visiting relationship is more supportive).
- The state would like to expand home visiting services to TANF teen parents to additional parts of the state. A key difference is that teen parents will not be *required* to enroll in home visiting. Participation will be voluntary. The state will evaluate whether this change makes a difference.
- The Governor's budget included $500,000 to serve as seed money to support local collaborations that will connect teen parents on TANF to home visiting. Existing funding will be used to pay for the home visiting services (TANF and MIECHV).

Miami-Dade

Abby Thorman discussed Miami-Dade County's efforts to eliminate racial disparities by changing systems and structures, specifically the county's Quality Rating and Improvement System (QRIS).

- Miami-Dade is larger than 15 states with 2.4 million people and is very diverse. There is a large population of new immigrants; 57% of children are Hispanic, 16% Black non-Hispanic, 18% White non-Hispanic, 6% Haitian. 70% of elementary-age children qualify for free/reduced price lunch; 65% of children speak a language other than English at home.
- Partners in Miami-Dade County received funding from the Kellogg Foundation through the Learning Labs project. Focusing on racial equity was a priority of this systems development work for children 0-8. A broad coalition of community leaders came together around shared goals, evaluating data to identify disparities and plan organizational and collective steps to work to close the gaps.

- Goal: ensure all children have opportunity to develop to their fullest potential – used 4th grade reading scores as the indicator because 4th grade is when children shift from learning to read to reading to learn.
    - Data showed that 4th grade reading scores are trending upward for the full population, including racial- and income-based subgroups, but there are significant gaps between races that have persisted over time.
    - Data showed that race was the biggest predictor of 4th grade reading scores (a larger effect than income).
    - There was broad consensus that this meant that there were structural and institutional issues that were causing these racialized outcomes, which could be changed by the leaders working together.
- The National Equity Project conducted a three-day racial equity retreat for community members, including heads of school systems, all the leading large children's organizations in the community, and county and foundation leaders, to kick off the work.
    - At the meeting, the attendees realized that together they control billions of dollars and that they have the power and responsibility to change the system so that racial gaps do not persist.

Miami-Dade engaged in a process of remaking the QRIS through an equity lens.

- Aggregate data on the QRIS showed that participating providers were increasing quality, but when data was disaggregated, it showed that outcomes were flat in areas with the highest concentrations of new immigrants, languages other than English spoken, and poverty.
- Revised QRIS standards:
    - Eliminated much of the environment rating scales – the full tool is only used in a select number of programs now for infant-toddler classrooms/family child care homes and to maintain observer reliability in preschool classrooms; the provisions for learning subscale is used in all programs along with the CLASS.
    - Cultural competence is built into QRIS standards – using portions of the NAEYC tool (tool is not yet validated).
    - Changed the way supports are offered – the previous system provided a lot of funding to programs that were already doing well but offered less funding to programs in need of help. Most of the programs already doing well were not serving the neediest children.
    - New system targets supports to those programs serving neediest kids – look at highest poverty zip codes and programs that serve children receiving subsidies (at least 30% of children served) or are located in a high-poverty zip code.
    - Programs now have more flexibility in how they can use supports.
    - Changed subcontractor policies so that programs have more decision-making power to choose a TA provider or consultant that can meet their needs.
- Offer ongoing professional development:
    - Community of practice for racial equity.
    - Curriculum learning communities – traditional curriculum training takes place over a three-week period, but Miami-Dade broke it up so teachers can attend shorter trainings over the course of a year with others from their neighborhood. They have homework each month that they are supposed to put into practice at their site with their coworkers and then report on when they come back together.
        - These have been put in place for High/Scope and Creative Curriculum for both Infant/Toddler and Preschool cohorts. Materials are available in English and Spanish.
        - Since this model was implemented, curriculum fidelity has gone up and staff turnover has decreased. Teachers feel empowered and engaged.

Miami-Dade made some additional reforms that have supported the QRIS work:

- New Early Childhood Education Bachelor's degree that is designed around practice.
- Changed the support offered to potential students of the job-embedded Master's program offered by the University of Florida to ensure representative participation in the program (e.g., GRE prep).
- Successfully changed a Miami-Dade College policy requiring that classes be taught in English to be credit-bearing. They now offer a certificate program in Spanish (English prep courses still widely available, but are no longer prerequisites).

Abby closed by describing some of the challenges and lessons learned:

- Many curriculum materials are only available in English. Once materials were translated into Spanish, there was difficulty finding qualified trainers and TA providers who are fluent in Spanish.
- There is a lack of validated tools for cultural competence.
- It was important to create shared values/norms about the purpose of the QRIS with community members. The most important thing Miami-Dade did was really engage community leaders in problem solving.
- Giving people on the ground more autonomy led to positive changes.

Resources:

- *My Universal Bone Deep Longing*
- *Bennett Model of Cultural Competency*
- *Tips for Reaching "Hard to Reach" Families*
- Mary Orr's PowerPoint: *Minnesota TANF: Teen Parents and Family Home Visiting Services*
- Minnesota TANF initiative one-pager
- Abby Thorman's PowerPoint: *Remaking QRIS to Serve Hard to Reach, Hard to Serve Programs and Children*

Concurrent Session
Developing an Integrated Professional Development System

Presenters:

- Gail Nourse, Ounce of Prevention Fund
- Beverly Lynn, Programs for Parents, Inc., New Jersey
- Maureen Murphy, Pennsylvania Key

Session Key Points:

- A coordinated, cross-sector professional development system is vital to building a strong infant-toddler workforce.
- There are key components to an integrated early childhood professional development system.
- State professional development systems can successfully include a specific focus on infants and toddlers.

Full Session Notes:

Gail started the presentation by defining professional development as "facilitated teaching and learning experiences that are transactional, collaborative, and designed to support the acquisition of professional knowledge, skills, ethics/values, and dispositions as well as the application of this knowledge in practice

to benefit all children and families." The key take-away is that by definition professional development is transactional between instructors and early childhood professionals.

Gail also reviewed the components of a professional development system:

1. Core Body of Knowledge
    - What a practitioner should know and do
    - Early Learning Standards can inform
    - Revised over time as state system is developed
2. Professional Development Record
    - A strategy to track an individual's growth and development
3. Core Competencies
    - Competencies for the specific positions/roles that support continuous quality improvement, such as instructors/trainers, relationship-based technical assistance providers, and case managers that support the QRIS
4. Specialized Credentials
    - State determined credentials and placed on the Career Lattice
5. Registries
    - Registry is a database of training and educational opportunities
    - Over time, registries can become more specific, cross-sector, organized by topics and age groups, and clearer on the qualifications of presenters to be eligible to teach
6. Career Lattice
    - Lattice provides a picture of the multiple pathways for professional growth and development of all early childhood practitioners (Head Start, public schools, private schools, technical assistance consultants and instructors/trainers, and higher education faculty)
    - It identifies qualifications, education, and certification at each level of the lattice
7. Career Advising
    - Tools and supports to individual practitioners to support their success in continuous professional growth and accessing educational opportunities, experiences, and resources
8. State-Developed or Approved Professional Development
    - The state ensures that there are high-quality professional development opportunities on key topics or processes.
9. Higher Education/Pathways to Qualifications, Certifications, and Degrees

Gail concluded her part of the presentation by noting that the professional development system can also sponsor specific initiatives that focus on the needs of infants and toddlers, such as providing supports like infant-toddler specialists or mental health consultants, or making sure the professional development system offers opportunities and incentives to the section of the workforce that primarily interacts with infants and toddlers, such as home visitors, early intervention (Part C) specialists, etc.

The conversation from the audience raised key issues that need further exploration, such as:

- In serving infants and toddlers, how does the professional development system capture the experience and expertise of those who are working with this age group, but may not be as highly credentialed?
- The important role of coaching to be responsive to practitioners' environments and expertise, and the most advantageous way to impact teacher-child interactions.
- How can leaders of the professional development system challenge themselves to think out of the box and have creative ideas on how to engage the workforce versus only have a traditional academic/higher education top-down approach to the development of the system? If practitioners

are not participating in the system, investigating why and having them inform how the system is designed and offers professional development opportunities.
- There was a distinction made between less preferred professional development experiences that are a form of "information dump" versus professional development experiences that "build skills" and may include strategies like coaching, interactions with the community, and partnerships.

New Jersey

Professional Impact New Jersey is the organization that promotes and coordinates "systems for the educational development of early childhood and primary education, family child care, and afterschool professionals." New Jersey updates:

- Core knowledge and competencies being updated to align with recent revisions and additions to the registry
- Updated and new career lattice will have five levels
- Early Learning Guidelines that include infants and toddlers are in the process of being disseminated
- Infant-toddler specialists are available to child care programs
- Child Care and Head Start using PITC (Program for Infant and Toddler Carey from WestEd)
- Developed an Infant-Toddler Credential
- Home visiting is not part of the discussion yet about how to include in the professional development system.

Pennsylvania

Maureen Murphy presented on Pennsylvania's Professional Development system, including:

- Early Learning has been consolidated in state government, with PreK, Head Start, Early Head Start, home visiting, child care subsidy and certification, Early Intervention and Keystone Stars (QRIS) in the same department
- An updated version of their Core Body of Knowledge is planned for release on October 1, 2013 – in the development process, they really debated about what level of language this tool should be written at because of the range of practitioners who will be using the tool.
- In Pennsylvania, all programs are required to use the Early Learning Guidelines. In this state, child care, Head Start, and PreK are more on the same page while home visiting and Early Intervention are still separate.
- Career lattice has 8 levels for child care, EHS/HS, Early Intervention, school districts, private academic schools, TA/Consultants/Mentors/Instructors, and higher ed faculty
- Career advising toolkit has web-based resources, reviews career lattice, and provides links to other resources
- Specialized infant-toddler Initiatives:
    - PITC training
    - ECMH consultation
    - Keystone Babies (ARRA funded)

Discussion

- No state seems to have "one door" to the professional development system, but there was consensus in the conversation that states would like to eventually achieve a "no wrong door" professional development system.
- A participant shared the metaphor of a tree to demonstrate how a career lattice works and that everyone needs to have similar child development knowledge which would be the trunk of the tree and then they branch out into their specialty branches both in age group and the delivery of their service.

- There is a concern that there may be duplication of professional development in shared topics that are distributed separately in each silo. Massachusetts shared that with Race to the Top they are working on professional development cross-sector.

Resources:

- Gail Nourse's PowerPoint: *Developing an Integrated Professional Development System*
- Beverly Lynn's PowerPoint: *Developing an Integrated Professional Development System – Birth to Three*
- Maureen Murphy's PowerPoint: *Infant-Toddler Professional Development in PA*

Concurrent Session
Establishing a Coordinated Screening and Referral System

Presenters:

- Carey McCann, Ounce of Prevention
- Gail Piggott, Alabama Partnership for Children

Session Key Points:

- Developmental screening can take place in a variety of systems (health, child care, home visiting). Policies need to ensure they complement each other so that all children are being screened, but not over-screened.
- Physicians are willing and able to screen and refer children when they have the support they need – access to, and training on, valid screening tools; assistance implementing referral processes; and the ability to be paid for screening and referring children.
- Help Me Grow is an effective screening and referral model because it builds on services that already exist by better coordinating them to ensure children receive the services they need.

Full Session Notes:

Carey opened the session with a brief discussion of what developmental screening is, why it is important, and what policies states are grappling with.

- Developmental screening is a process to identify children who may have or may be at risk of a developmental delay or disability and need further evaluation.
    - It is a key preventative service. A very effective strategy for ensuring all children receive regular screening is incorporating it into well-child visits.
    - Developmental screening can take place in a variety of settings including pediatrician offices and child care centers. When it is taking place in multiple settings, we need to be sure children aren't being screened multiple times in multiple places (though we are really more concerned that there are children who are not being screened at all).
- There is rapid development during the first five years – children develop at different rates, so one-time screening does not work; it needs to occur on a regular schedule so development can be assessed.
- 12-16% of children have developmental disorders, and half aren't identified by the time they reach kindergarten.
- Delays in one domain can have negative effects on other domains, so we need to catch them early.
- Developmental screening creates teachable moments for parents and providers.
- We want to promote screening with a valid tool. When a tool is not used, only 30% of children with a delay are identified.

- The AAP recommends pediatricians conduct developmental surveillance at every well-child visit, with screenings using a validated tool at specific visits.
- States are grappling with a number of policy questions related to developmental screening:
    - How do we ensure all children receive the screens they need?
    - What schedule should be used?
    - Who should be trained, and what training should be used?
    - Referral practices - where, how, what services are available?
    - Shared data systems?
    - Specific efforts to target low-income children?
- There are existing policies that require developmental screening such as: Head Start Performance Standards, some home visiting program models, some Quality Rating and Improvement Systems.
    - States need to think about how to get these system rules to complement each other – for example, pediatricians might be responsible for screening at 9 months and child care at another time.

<u>Alabama Help Me Grow (HMG)</u>

- HMG helps states identify at-risk children and connect them to community-based programs and services through centralized information and referral centers. HMG core components:
    - Child health care provider outreach to support early detection and intervention
    - Community outreach to promote use of HMG and to provide networking opportunities among families and service providers
    - Centralized telephone access point for connecting children and families to services and care coordination
    - Data collection
- Alabama's Assuring Better Child Health and Development (ABCD) initiative led to interest in HMG. ABCD was launched in 1999 by The Commonwealth Fund with the goal of strengthening the capacity of the health care system to support the early development of children from low-income families.
    - ABCD revealed that physicians in Alabama were eager to screen children, but they didn't know what to do with referrals.
    - ABCD led to a Medicaid change/clarification that opened the floodgates for physicians to use the ASQ for developmental screening.
        - Initially there was some concern by Early Intervention (EI) that physicians doing screening would lead to too many children being referred to EI. EI serves 2% of children; 17% are served by Part B once children are in school – this suggests there are many children who need services that are not currently being identified before school.
- Alabama just finished their second year of planning for HMG. Alabama Partnership for Children is the convener of all the partners involved (United Way, AAP, Dept. of Children's Affairs, Dept. of Mental Health, Dept. of Education, Dept. of Public Health, CCR&R, etc.).
- Planning has focused on capacity building and community outreach
    - Many rural communities do not have pediatricians; families go to community health centers instead. This has required a different type of outreach.
    - Reach Out and Read (pediatricians provide books to parents at well-child visits) is being coupled with HMG.
- State-level group has also worked through barriers to implementation
    - HIPPA regulations
    - Physicians now get paid for screening by Medicaid, CHIP, and private insurance
    - Health care providers had to be educated to understand that child care providers are qualified to conduct screening.

- Alabama purchased and integrated the ASQ tools into systems – county health clinics, home visiting, child care consultants, EI, Head Start, and preschool.
    - All systems are using the same tool and have unified data collection so the state will have aggregate data for the first time for very young children.
    - Purchase of tools and training was funded through the ECCS grant.
- HMG is being implemented fully in Jefferson County (Birmingham)
    - Jefferson County has a well-developed 211 system (online and phone).
    - Practice managers for physicians' offices have been very effective at implementing referral processes and engaging others.
    - HMG staff are developing ongoing relationships with programs in the community and supporting the maintenance of an updated resource inventory of services.
- Alabama is building HMG through existing Early Education Committees.

Discussion of Alabama's experience

- The concern by EI that screening might lead to over-referral to Part C is one many states share. In Pennsylvania, when Head Start started screening they over-referred, but EI worked with HS grantees to help them better understand what screening results mean and where children should be referred. This led to a decrease in referrals of children who are not eligible for Part C.
- Screeners need feedback – what happened after the screen; if referred to EI and not eligible were they referred somewhere else? Processes need to be put in place to ensure a feedback loop.
- Alabama is adapting Kentucky Partnership for Children's screening and referral flow-chart. It is useful for identifying deficits so they can be addressed.

<u>Illinois' ABCD II Project</u>

- Illinois' project analyzed Medicaid policy to identify changes that could be made to promote developmental screening.
- Pilot projects in three health environments – a pediatric practice in Chicago, a family physician in a suburb, a public health department in a rural area.
    - People came together to discuss what to do about referrals. Discussions revealed the communities had more resources than they thought to refer to – they were just unconnected.
- Illinois had universal health care insurance for all kids at the time (Kids IL).
- Illinois directly administers Medicaid and managed care organizations – thought about policy changes in both
- At the same time as the ABCD project, EI started using the ASQ-SE as part of intake; social-emotional consultants were working with screeners (this is no longer mandatory).
- Illinois advocacy organizations made the decision to push for developmental screening even though they knew the state did not have all the resources necessary for referrals. Thought was that screening would create demand for services and put pressure on the state.
    - New York took the opposite approach and focused on expanding services before ramping up the screening system.
- The ABCD II Project led to several Medicaid policy changes – all were made administratively, no state plan amendment or legislative changes were necessary.
    - Physicians can delineate all of their services as available for reimbursement within a well-child visit – no longer one bundled payment.
    - Physicians can bill for perinatal depression screening on the child's number – screening child by screening mother.
    - Local health departments can use the ASQ and ASQ-SE – both are on Medicaid's list of valid and reliable tools, and state offers training on both.

        - Private foundation provided state dollars to draw down federal match to provide training on ASQ instruments.
    - Clarified EI eligibility criteria for physicians – a child is eligible for EI if the mother has been diagnosed with a severe mental disorder (including perinatal depression).
    - Required managed care organizations to engage in continuous quality improvement around developmental screening and maternal depression screening.
    - Primary care case management medical home model includes a periodicity schedule.
- The state also worked with practice managers to think through workflow processes and referral practices.
- Illinois' MIECHV program is currently collaborating with pediatricians around screenings – home visitors are screening children at 6 months and physicians are doing it at 9 months.

Resources:

- Ounce of Prevention Fund's *Snapshots: Incorporating Comprehensive Developmental Screening into Programs and Services for Young Children*
- Gail Piggott's PowerPoint
- *Illinois ABCD II Project: Medicaid Policy Accomplishments*
- *Illinois ABCD II Project: Lessons Learned – System Transformation*

Concurrent Session
Effectively Communicating Your Infant-Toddler Policy Agenda

Presenter:

- Lori McClung, Advocacy & Communication Solutions, LLC

Session Key Points:

- Infant-toddler messages should be refreshed every few years as the climate changes.
- It is important to know your audience and where they are coming from to develop messages that are most impactful.
- The best messengers are those who have relationships with children, such as parents, educators, and pediatricians.

Full Session Notes:

Lori shared tips around three important concepts (methods, messages, and messengers) for communicating around infants and toddlers:

Methods

- Communication needs to be integral to everything an organization does and part of its everyday work.
- Communication should be integral to *all* staff members within an organization, so make sure there's staff training.
    - Call to action is to get everyone in an organization saying the same message and passing out materials.
- Be willing to refresh communication messaging every few years as the climate changes. Examples:
    - Messaging about the return on investment (ROI) for investments in infants and toddlers is not working well in some places, because the messaging is too technical.
    - Saying "scientists say"/"researchers say"/"data shows" is no longer testing well (people are cynical and believe that anyone can be paid to give data that supports a claim).

Messages

- Know your audience and where they are coming from.
  Examples:
  - Saying "investing in infants and toddlers helps disadvantaged students" is not as effective because not everyone can see themselves in that message. A better message is that "everyone in class benefits if everyone comes to class ready to learn."
  - People can't grasp how investments in infants and toddlers cause benefits in high school because high school is too far away. A better message is to say that "investing in infants and toddlers prepares children for kindergarten."
  - A way to get past "babies on the couch" when talking about infant-toddler mental health (IMH) is to give people specific examples regarding IMH vs. a long laundry list of data points.
- Be more positive about messages – positive messages are more impactful, while negative messages turn people off.
  - Example: Instead of talking about how investments in infants and toddlers keep kids out of jail, say investments send more kids to college.
  - If you use a negative message, pivot quickly to a positive message.
- Have a tagline with big picture details. However, your mission is NOT your message!
- If the facts don't fit the frame, they are disregarded.
- Lori identified five elements of an effective message:
  1. Easy to grasp
  2. Jargon free
     - Example: Use "families" instead of "caregivers" (caregivers is interpreted as too clinical).
     - Get away from using exclusively academic messaging.
  3. Presents a solution
  4. Injects new elements into the debate
  5. Invites the audience to fill in the blanks
- She then provided a template for the five levels of framing infant-toddler messaging (you fill in the blanks depending on your issue/initiative):
  Level 1: Infants and toddlers are important, so we need to pay attention to their interests.
  Level 2: This is important to children because of _____ and to the community because of _____.
  Level 3: _____ is an issue in the community.
  Level 4: Helping infants and toddlers can solve this problem in the community because of _____.
  Level 5: My organization is the entity to help resolve this problem.
- Lori provided a few additional messaging tips:
  - Start with the first level and only go deeper as necessary.
  - If you have data that lays the groundwork, put it out there.
  - If the facts don't fit the frame, they will be disregarded.

Messengers

- The best messengers are those who have relationships with children.
- According to message testing, the top messengers are:
  - Educators (preschool and child care providers)
  - Pediatricians and medical care providers
  - Parents
  - Business leaders as messengers tested well among Republicans
- How do you get baby champions? Find people who have personal experiences to share.

- You don't need 50 people giving the message, just 2-3 very strong messengers.

Lori ended the session by encouraging the early childhood community to use a unified voice. A rising tide helps lift all boats, so everyone in the field should get on that boat—meaning if there is a hot infant-toddler topic during a certain period, everyone in the field should be in support of it (rather than diminishing it or diverting attention to the topic they are most invested in). Eventually the field will be in a position to promote *their* topic. She concluded by stating that a year one goal for the infant-toddler field should be getting the field aligned with the best messengers.

Large Group Session
Leveraging Funding Sources to Support Infant-Toddler Services

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Presenters:

- Charlie Bruner, Child and Family Policy Center/BUILD Initiative
- Ron Benham, Massachusetts Department of Public Health

Session Key Points:

- States should be looking to Medicaid as a key funder for 0-3 services.
- Massachusetts is a proven example of what is possible when a state works in partnership with state Medicaid staff to utilize Medicaid funds strategically for early intervention services - or even other services on behalf of the 0-3 population.
- The Affordable Care Act can be an opportunity for states to garner greater support on behalf of children 0-5. Think strategically and structure programs and the language around programs in a way that will allow these funds to be used for "development" of young children.

Full Session Notes:

Charlie opened the session with an analysis of federal and state budgets and the proportion that is used for programs serving very young children. He then discussed EPSDT and opportunities for Medicaid to support birth to three services.

Budget:

- Of the $3.685 trillion in the 2011 federal budget
    - children aged 3-18 received 8.5%
    - infants and toddlers received 1.8%
    - Of the infant/toddler funding, Medicaid/EPSDT serves 56% of infants and toddlers, WIC serves 28.5%, CCDF/TANF Child Care serves 4%, and Early Head Start serves 1%. MIECHV serves less than 1%.
- For every dollar invested in the education and development of school-aged children (6-18), 6.7 cents is invested in an infant or toddler (0-2). 24.9 cents is invested in a preschooler (3-5).These figures reflect both federal and state funds. These are per child numbers.
- If you look at President Obama's early childhood initiative, that amounts to $10 billion/year. That is 3/10 of 1% of the overall federal budget.

He then moved into a discussion of insurance, EPSDT, and opportunities for Medicaid funding to support birth to three services.

- Average # of visits annually under EPSDT for 0-2 year olds - 2.2 visits each year. Infants/toddlers are being seen by health care providers. This is the most likely place to reach these children - go where they are served. This makes Medicaid an opportunity to reach infants and toddlers.

- Primary/preventive health services for children (ages 0-5): Data from the National Survey of Children's Health 2011-2012 - These statistics are available by state and can also be broken down by poverty level and race/ethnicity.
    - 89.7% children reported as having well child visit in the past 12 months
    - 58.2% children reported as having ongoing comprehensive care within a medical home.
    - 30.8% children reported as having been screened for being at risk of delays using a parent-reported screening tool during a health care visit.

Medicaid/EPSDT opportunities for supporting children birth to three:

- These opportunities come through the health system. This also allows you to provide services to both the child and to families in terms of support services. These opportunities would best come through the child health practitioner, the care coordinator/community service networker and community services.
- Child health practitioner:
    - Developmental surveillance and screening
    - Anticipatory guidance
    - Referral for medically necessary services
    - Referral to care coordination
- Care coordinator (fully fundable under Medicaid)
    - Motivational interviewing and whole child approach to identify further needs
    - Identification of available services and supports which can meet those needs
    - Connection (referral/scheduling/follow-up) to services
- Community services (fundable under Medicaid)
    - Medically necessary services
    - Other community services
- The federal Medicaid office wants to support states in finding creative ways to support these services under Medicaid.
- States worry more about liability and containment of costs and therefore have traditionally been less interested in finding ways to cover these costs.

Referral programs:

- The strength of programs like Help Me Grow is that they allow you to do outreach to communities and particularly emphasize those families that are more isolated and not in other programs.
- Referrals to community centers, parenting programs, faith-based institutions, etc. are of great help and support to families in supporting their children. While these programs aren't funded under Medicaid, they link families to services that ARE funded under Medicaid.

<u>Massachusetts</u>

Ron presented a historical perspective on Early Intervention (EI) in Massachusetts. He opened by saying that the lack of people with an understanding of fiscal issues makes this work a challenge. Our understanding of this must grow if we are to find ways to take advantage of funding opportunities to support young children.

- If we are not about comprehensive services for young children, then we are doing a disservice to children and families.
- MA current EI eligibility for children under three years of age:
    - Children with a diagnosis known to result in developmental delay
    - Children evaluated and found to have a developmental delay of 30% in one domain
    - Children at risk of developmental delay - Very few children that present at risk of a delay are later to found to have a delay

- Current system: All EI services are purchased through community agencies. They bill private insurers and Medicaid directly. The Department of Public Health is the payer of last resort. It is projected that $150 million+ will be spent in direct services in FY 2014, serving 33,000+ children.
- You should be best friends with your Medicaid people and those in the state who know how to do what you want to do.
- Importance of emphasizing DEVELOPMENT not EDUCATION for insurance purposes. Staff people are Developmental Specialists, not Education Specialists, for that reason.
- Who pays in MA?
    - State appropriation - $29 million (used to be $40 million a few years back, but they have cost shifted to get others to pay)
    - Third party - $50 million
    - Medicaid - $67.5 million
    - Total: $149.5 million
- Make the business case - "better outcomes saves money".
- Early Intervention officials work closely in partnership with state Medicaid officials. Make them your friend and not your enemy to get things done.
- 7 reimbursable services
    - Home Visits (includes travel) - $77.12/hour
    - Center Individual - $64.68/hour
    - Community-Based Group - $29.60/hour
    - EI Only Group - $22.52/hour
    - Parent Group (pay for one parent/family - facilitator is paid through funding for each parent) - $28.92/parent
    - Assessment - $103.44/hour
    - Intensive Service/Autism - $61.52/hour - Any child enrolled in Medicaid under age three with a diagnosis in the spectrum can get appropriate services. They spent 5-6 years working on making this happen in MA. This was a huge shift of costs away from the Dept of Public Health to Medicaid and private insurance.
- We must be more politically active and intentional in our advocacy or funding for Early Intervention will go down. States are cutting eligibility now.
- Relationships are critical in getting funding/making changes to the system to move funding forward.
- Future opportunities for comprehensive infant and toddler services:
    - RTT-ELC
    - MIECHV
    - Title V
    - Other federal initiatives
    - Science
    - These federal opportunities are the first in our lifetime to talk about a comprehensive system of early childhood services. What is sustainable after these federal funds end? We must think about this relative to comprehensive systems. We have to talk about what is coming next NOW to have any chance of future success.
- If we don't up the knowledge specific to financing Early Intervention services, then all the other efforts relative to quality are at risk. We will serve fewer children, and the relevance of this program will be undermined.
- New proposal from the Infant Toddlers Coordinators Association to have state EI coordinators attend fiscal boot camp. Take them through a process of TA and webinars to provide better understanding of financing tools that can be used for future investment. As turnover occurs, this will help replenish our supply of people who have fiscal knowledge and can keep moving this

agenda forward. Part C people generally come from clinical backgrounds and are not fiscal people. We must train them to understand the fiscal side.

- Challenges to getting there:
    - Sequestration
    - Individual state's recovery from recession
    - Commitment to infants and toddlers as a class
    - Collective vision and effort
- If we are not active and don't raise our voices for infants and toddlers, we are not going to get there. What is our vision and effort that will drive us to success?

A few key points were made during the discussion.

- Children are not the focus of attention of the Affordable Care Act.
- How can we develop health reform through accountable care organizations, medical homes, and other payment structures that will improve health quality and population-based outcomes and reduce health care costs? Children are not the problem in terms of health care costs today, but they are the solution in terms of health care costs tomorrow.

Resources:

- *Charlie Bruner's PowerPoint: Federal Financing and Very Young Children*
- *Ron Benham's PowerPoint: Early Intervention in Massachusetts – A Historical Fiscal Perspective*

Concurrent Session
Including Data on Infants and Toddlers in the Development of Data Systems

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Presenters:

- Jamie Colvard, ZERO TO THREE (facilitator)
- Tracey Campanini, Pennsylvania Office of Child Development and Early Learning
- Theresa Hawley, Illinois Office of Early Childhood Development

Session Key Points:

- Effective use of data systems will help policymakers improve program quality, workforce quality, access to high-quality programs, and child outcomes.
- To avoid "reinventing the wheel," it is important to draw from the experiences and expertise that has resulted from developing health care data systems and apply knowledge to data collection in other early childhood fields (e.g. using unique identifiers to connect data and information across systems and longitudinally).
- Given the high costs of developing and maintaining comprehensive, integrated data systems, it is important to obtain and secure dedicated sources of funding as well as leverage existing resources that will help launch and sustain these efforts (e.g. RTT ELC states have included funding).

Full Session Notes:

Jamie opened the session by noting that effective use of data systems will help policymakers improve program quality, workforce quality, access to high-quality programs, and child outcomes.

- It is important to disaggregate data to get a true picture of outcomes for different groups (Miami's QRIS is a good example).
- It is important to collect data that reflects the ingredients for quality and impact on children – make sure everyone is defining the outcomes and what you are collecting the same way.
- Start by thinking about what questions you are trying to answer (example: Are children ready for school?), and then decide what data you need to answer them

- Providers need to be able to use and understand the value of data for their own work and quality improvement – this will lead to better data entry.
- Some things are hard or impossible to measure – we need to be mindful of that and look at the story the data is telling us.
- Trust is key to getting people to collect and share data.

She then shared the Early Childhood Data Collaborative's list of 10 fundamentals that all early childhood data systems should have.

1. The use of a unique statewide child identifier *and highlighted the need to have this single ID in order to link characteristics to outcomes and track variables longitudinally*
2. Child-level demographic and program participation information
3. Child-level data on development *in order to measure true impact and outcomes*
4. Ability to link child-level data with other systems *to avoid silos and agencies collecting own data which might be on same children yet not connected*
5. Unique program site identifier
6. Program site data
7. Unique workforce identifier
8. Individual workforce demographics
9. State governance body to manage data is important *since there is a need for a neutral party and one that has access to all the information*
10. Transparent privacy protection and security practices *to promote trust and sharing as well as to ensure no privacy laws are broken*

<u>Illinois</u>

There are multiple sectors, programs, and state agencies that serve very young children and their families.

- Health care system (Medicaid/SCHIP and privately-funded programs): These systems collect a lot of data on their patients, including demographics and services received. Data are more widely available for the publicly-funded programs.
- Child care system: There are data on the children and families who receive subsidies and who attend programs funded by the state. But the data picture is not complete (e.g. children receiving more than one service, demographics of providers, etc.). There is little data on children in child care that is paid for privately.
- Home visiting: In Illinois, these services are funded by Department of Human Services ($20M) as well as through State Board of Education. Each program collects its own data, which makes it hard to aggregate statewide numbers or understand collective impact.
- Early Intervention (EI)

Theresa identified several general challenges related to data collection and analysis.

- Every funder has its own data infrastructure. Some programs have multiple funders so need to comply with different requirements.
- Agencies use different definitions.
- Systems have been developed at different times using different technologies, and may not be compatible with each other.
- Many program models have their own data systems that may not be capable of collecting the information needed at the state level.
- No one owns data integration, and no one agency has the resources to accomplish it – you need strong interagency agreements, leadership committed to data integration, and dedicated funding.

Theresa then shared some of Illinois' successes

- Illinois developed policy questions to guide data system development (included in list of resources below).
- Starting about a year ago, all Prevention Initiative funded programs (home visiting and center-based programs) enter participant information into the statewide *Student Information System*, which follows students through grade 12. Data is reported in aggregate form at the state level, and all children receive a unique ID number.
- MIECHV is building a statewide data system.
- Illinois used SACC grant money to put out an RFI to design the "unified data system dream." The goal is to assign a unique identifier to each person in the different systems in order to pull in data and streamline it.
- The medical community knows how to build and use systems more effectively than early childhood – we can learn from them (example: state agency thought an integrated data system would cost $15 million, contractor experienced in medical field estimated it at $4 million because they are familiar with new technology).
- Illinois Early Childhood Asset Map (IECAM) maps the demographics and services throughout the state using GIS technology. Agencies use it to make funding decisions. The level of need analysis is very detailed, but it is still hard to get unduplicated counts of children served.
- The push for a data system is coming from multiple places including advocates, government, families. etc. There is also strong support from State Superintendent and Secretary of Human Services.
- Illinois' Phase 1 Race to the Top Early Learning Challenge application describes the data work.

<u>Pennsylvania</u>

Tracey began by describing Pennsylvania's data system called Pennsylvania Enterprise Linking Information Across Networks, commonly referred to as PELICAN.

- PELICAN includes several subsystems in PA, such as: Early Intervention, Early Learning Services, and Certification/ Licensing
- The driving force behind PELICAN was PA Pre-K Counts, state-funded Head Start, and child care. The database was developed to collect demographics and aggregated assessment information about children's school readiness.
- PELICAN includes program, staff, and child demographic/assessment data. Information is viewable at the individual user level, but aggregated or unidentified at the state level.
- All state-funded QRIS participants at 2 higher tiers and PKC/HS grantees are expected to enter their information into the PELICAN system.
- The state created a Keystone Early Learning Framework and put out an RFP to crosswalk child assessment tools to outcomes to develop a list of approved tools programs can use. These include Teaching Strategies Gold, Brigance (both ECDI and HSDI), and the Ounce Scale.
- PA has been doing work to bridge systems. They have an Excel template for critical elements collected in other data systems that need to be incorporated into PELICAN as well as ways to import this information into other systems such as the SLDS system.
- Although children are assigned unique identifiers that link to the K-12 system when they are entered into PELICAN, this process isn't always as clean as it should be – when a child enters kindergarten, a new identifier might mistakenly be created for them, resulting in two unconnected entries.
- The state is able to download participant enrollment data and aggregate 3rd grade testing as well as 8th and 11th, which provides longitudinal feedback in aggregate form of the children's educational progression. Work is underway to also connect the Kindergarten Entry Inventory results.

- MIECHV is developing a bridge system that has import/export capabilities. It links to PA's evidence-based models' data collection system. Data from the MIECHV system will automatically bridge over to PELICAN every night – new children are assigned a unique ID.
- PELICAN was funded through ARRA and state investments.

Tracey shared some lessons learned/things to consider when working with vendors, noting that it is very difficult and expensive to make changes to database design once you've already started collecting data.

- Involve providers and other stakeholders in discussions from the beginning
- Understand what models are out there already that might have better capability
- Real-time data information is a challenge (currently need overnight to complete request)
- Investigate what other states have done (e.g. GA – has unique ID and have good system)
- Understand how data and coding happens –what is hard coded and what can be flexible for changes

Tracey also shared information about Pennsylvania's workforce registry, TA data system, and Risk and Reach report.

- The state is currently enhancing its workforce registry. It collects employment history, professional development, and qualifications on all providers and aligns them with the core knowledge and competencies. It can verify provider qualifications and approve credentials and has a portable approval on qualifications that can transfer outside of state (in case provider moves).
- The state has a separate system for tracking TA provided to child care providers (TAAPS) that enables TA providers to see what other services child care providers have received and build on previous TA. It helps show what it takes to move a program from one level to the next in their QRIS system.
- Pennsylvania creates a Reach and Risk report annually that pulls data from PELICAN into an excel spreadsheet that: includes an analysis of economic, maternal, birth outcome, academic, and toxic stress risk factors that can harm a child's chances of doing well in school; compiles information on the number of children served through OCDEL programs; and identifies counties and cities most likely to benefit from early childhood investments, based on these risk factors.

Resources:

- Jamie Colvard's PowerPoint: *Including Data on Infants and Toddlers in the Development of Data Systems*
- Theresa Hawley's PowerPoint: *Birth to Three Data - Strategies and Successes in Illinois*
- Illinois' Early Childhood Asset Map
- Illinois Learning Council Early Childhood Data Work Group's Key Questions
- Pennsylvania's Reach and Risk Report

Concurrent Session
Improving the Quality of Existing Services for Infants, Toddlers, and Their Families

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Presenters:

- Gerry Cobb, Build Initiative (facilitator)
- Dan Haggard, New Mexico Children, Youth and Families Department
- Chris Pond, Massachusetts Department of Early Education and Care

Session Key Points:

- Increasing the quality of services for infants and toddlers requires multiple strategies and partners.
- A cross-sector systems approach is critical to improving quality.
- States should intentionally build on what they have, keeping a broad vision and set of values in mind, and be persistent in taking advantage of opportunities.

Full Session Notes:

Chris and Dan responded to a series of questions posed by Gerry about increasing the quality of existing services for infants, toddlers and their families.

1. What are the strategies your states are using to improve the quality of infant-toddler services?

Massachusetts:

- QRIS
    - Had a mixed delivery system from the beginning.
    - ITERS and infant-toddler standards were embedded, but QRIS is not mandated unless funding is received through the state agency.
    - Hired regional professional development and TA providers to support programs.
    - Offered grants ($2,500 to $5,000) to move up levels.
    - Developed online courses on components, which were available in different languages.
    - Are looking at alignment with accreditation.
- Core knowledge, competencies, and dispositions for infant-toddler consultants
    - Region I states developed with ZERO TO THREE National Infant & Toddler Child Care Initiative.
    - Developed a self-assessment tool for consultants.
- EEC has been supporting training on the Ages and Stages Questionnaire with families served by Coordinated Family and Community Engagement Grantees and through Department of Housing and Community Development contracted homeless shelters and providers.
- The Department of Early Education and Care works closely with Part C and MIECHV, and has developed a document with Part C to clarify the roles and responsibilities between Part C and child care.
- Infant-toddler assessment training was done in 2010.

New Mexico:

- QRIS
    - On their third generation of QRIS; previous generations were in 1995 and 1998.
    - Reimbursement rates tied to QRIS.
    - Are significantly increasing infant-toddler reimbursement rates.
    - Are developing ways to rate home-based services.
    - Focused on the means, not the end.
- System of systems
    - Began work in 1990s with Wheelock's Partners in Change initiative to develop a professional development system.
    - "System of systems" includes home visiting, Part C and section 619, Early Head Start/Head Start, and center-based and home-based child care.
    - You must lay a solid foundation, wherein everyone understands why you are doing something.
- Early childhood mental health
    - Holding day-long lectures on research to practice in early childhood mental health.

- Found that there were few services for clinical treatment of children so developed two service definitions under Medicaid.
- Embedded ECMH competencies into the professional development system.
- Starting infant teams, with level 3 endorsed therapists working with wards of the state and the adults (child welfare, courts, Part C, foster parents) involved with them; funded through state funds and Medicaid.

2. How have you taken a systems-based approach to this work, assuring that the strategies you are using are cross-sector in approach?

Massachusetts:

- Developed agreements with other state agencies, such as The Department of Mental Health to increase infant mental health training and other areas related to mental health issues, The Department of Housing and Community Development to support homeless shelter staff and childcare staff serving young children in homelessness and with the Children's Trust Fund on Strengthening Families.
- Gave grants to private organizations, such as to public television to develop resources for families and to United Way to do public engagement campaigns in communities.

New Mexico:

- Built common vocabulary and understanding across systems.
- Developed a universal course of study across higher education with three pathways: teachers (birth to 4 years, 4 years to 3rd grade), leadership, and home visiting and early intervention.
- Developed early learning guidelines as the foundation of the QRIS. Providers are learning how to observe and plan a curriculum, engage in reflective practice, and implement common values and practices.
- Implementing consultation, training, and TA systems for programs, which are developing a common understanding of TA and coaching.

3. What are the key elements that need to be emphasized in a systems-based approach to this goal of improving quality?

New Mexico:

- Create opportunities to develop relationships by spending time together with a common focus.
- Public policy isn't a linear process! It is not always neat and tidy and in order. You must have a vision and seize the opportunities. Build a stable of people who work well together. Hang in there, and stay true to your convictions (such as a mixed delivery system for pre-K).

Massachusetts:

- Build sustainability by embedding initiatives in programs and the system.
- Be closely involved with programs that are working directly with families in order to make their experiences more seamless.
- Build a strong professional development system, not just the topic of the month.
- Support staff to encourage less turnover.
- Have identified goals and available resources to reach them.
- Build on what you have and improve it, such as validation of the QRIS.

4. How do you educate parents around quality?

Massachusetts:

- EEC created a grant that supports families (Coordinated Family and Community Engagement Grantees).
- Developed brochures for parents based on the early learning guidelines.
- EEC and the United Way have launched a joint initiative to provide more information on the science of brain building (Brain Building in Progress campaign)

New Mexico:

- Low-income families don't generally shop for quality child care based on ratings.
- Initially, the state intentionally started implementing QRIS in programs with 75% of children on subsidy and moved down to programs with lower percentages of subsidized children.
- 18 years later, banks are willing to loan funds to open high quality programs in low-income areas.
- The first two levels of QRIS are included in licensing; programs have one year to move up to level 3 but are paid incentive rates from the beginning of that time.

Discussion:

Q: Is FFN care included in your states' QRIS?
A: It is available to FFN providers in both Massachusetts and New Mexico but most providers don't participate. In New Mexico, child care for infants and toddlers is split about half and half between center-based and home-based care.

Q: Is there a central intake mechanism for all early childhood services, including home visiting?
A: No, not in either Massachusetts or New Mexico.

Q: is home visiting integrated into the QRIS?
A: New Mexico is planning for this. A Home Visiting Accountability Act recently passed, which defined components and standards for home visiting services.

Q: Is the subsidy payment in New Mexico based on enrollment or attendance?
A: It is based on enrollment unless the child misses more than five days per month. Co-payments by parents are based on their income, not the child care setting.

Both Chris and Dan offered some closing thoughts to end the session

Massachusetts:

- Be thoughtful and don't overwhelm programs and parents with lots of new initiatives.

New Mexico:

- It takes time to make change.
- It is not our place to impose; we need to partner.