

THE ROLE *of* STATE HEALTH POLICY IN  
MULTI-SECTOR SYSTEM *and* SERVICE  
LINKAGES *for* YOUNG CHILDREN

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SEPTEMBER 2008

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## THE ROLE OF STATE HEALTH POLICY IN MULTI-SECTOR SYSTEM AND SERVICE LINKAGES FOR YOUNG CHILDREN

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Additionally, we thank the many state officials and topic experts, too numerous to list, who participated in interviews or shared their expertise by commenting on an earlier draft of this document. The authors also wish to acknowledge Amy Fine and Molly Hicks for sharing their invaluable expertise and perspectives.

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## EXECUTIVE SUMMARY

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**C**hildren must be healthy in order to learn. Their motor skills, coordination, and overall physical health affect social-emotional and cognitive development and academic achievement. The domains of child development are interrelated, demanding a multi-sector approach to foster healthy development. Yet, cross-sector service coordination remains a challenge.

Increasingly, states are recognizing that healthy development requires attention to interrelated developmental needs of children and families, leading them to plan more integrated services. State health policy makers and program administrators, using their authority as health care purchasers, regulators, data warehouses, conveners, and educators, can help bridge the gap between the health sector and other early childhood resources by developing policies that promote coordination at both the state and local levels.

With funding from the W.K. Kellogg Foundation, the National Academy for State Health Policy (NASHP) conducted an exploratory study of the role of state health policy in linking the health sector with other services that support young children's health and development. The purpose of the project was to promote the role of state health policy in efforts to assure cross-sector service linkages for young children and their families, with the ultimate goal of better addressing the comprehensive needs of young children as they grow and develop.

NASHP identified and examined policies in 12 leading states. These states identified a number of success factors, barriers, and opportunities gleaned from their experiences implementing policies to promote the health sector as a key component of multi-sector service linkages for children.

### CRITICAL SUCCESS FACTORS

- A public health approach to childhood health and development promotes the health sector as critical to broader early childhood initiatives. Such a framework recognizes the important role of social, economic, and political determinants of health, and it responds to the changing needs of children for their continued health and development.
- Using early child development as a broad umbrella under which fall health, early learning, family support, and early intervention services provides an inclusive framework for state planning and policy development.
- It is possible to promote multi-sector service linkages that include a health component while simultaneously addressing the need to better coordinate health-sector services.
- State-supported community-based initiatives can balance state requirements with local flexibility.
- Executive agency and legislative champions at the state level are critical.
- Working relationships among state agencies and private partners (including private medical providers, the business sector, and foundations) at the state and local levels are critical regardless of formal structure or authority to require multi-sector linkages.
- Federal health programs and policies can provide opportunities for multi-sector linkages (e.g., Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, Medicaid/Title V agreements, Early Childhood Comprehensive Systems (ECCS) program, and Healthy ChildCare America).

### BARRIERS

- States encounter limited capacity to meet all children's needs.
- Primary care providers and public health agencies have primary concerns that are different from school systems and early learning programs and thus do not always perceive themselves as part of one system that fosters early child health and development.
- Although federal health programs and policies can promote linkages, they also can create barriers (for example, proposed Medicaid rule changes).
- Technological and policy-related barriers limit integration of data sources.

**OPPORTUNITIES**

- In order to move forward, states can adopt or adapt the examples from the 12 states included in this project. These states have implemented state policies and financing mechanisms that foster coordination and linkages, including the health sector. For example, they:
- Coordinate eligibility policies or processes across multiple sectors so that families can more easily identify and access appropriate services;
- Coordinate cross-sector needs identification and assessment by promoting cross-sector screening;
- Establish cross-sector communication or referral processes through centralized referral centers and networks, case management services, and home visiting programs;
- Promote or provide cross-sector consultation or training to connect professionals and enhance skills;
- Support cross-agency and public/private planning, policy development, and governance by establishing or revamping state interagency structures or using less formal mechanisms;
- Share data to coordinate services; and
- Promote community-based cross-sector initiatives that balance state guidance and accountability with flexibility for local needs.

Identifying policies that support the coordination of services for young children across multiple sectors, including health, can set the stage for broader linkages that better address the health and developmental needs of young children. The demand for a multi-sector approach requires programs in each sector to contribute their unique strengths while being flexible and willing to work toward integration so that children and families receive needed services.

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## INTRODUCTION

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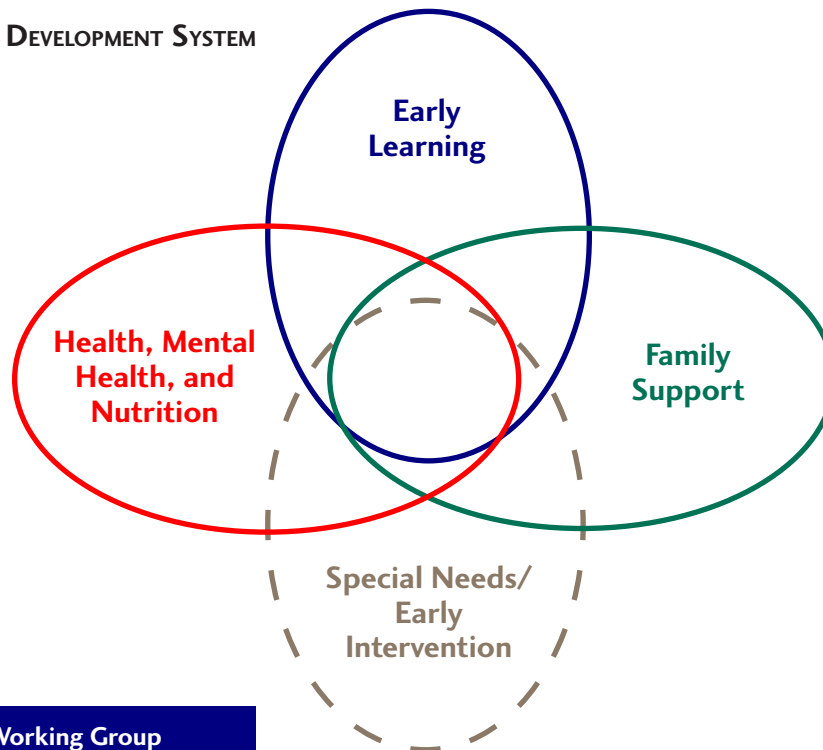
### EARLY CHILDHOOD IS A CRITICAL PERIOD FOR FUTURE HEALTH AND WELL-BEING

There is overwhelming evidence that early brain development is critical to school readiness and success, as well as long-term health and well-being. Research indicates that from birth to age 5, children develop skills on which subsequent development builds, including physical, linguistic, cognitive, emotional, social, regulatory, and moral capacities, all of which are intertwined.<sup>1</sup> This interrelated nature of child development demands a multi-sector approach to support healthy development.

Nationally, about 16 percent of young children have some form of disability, including speech and language delays, cognitive delays, learning disabilities, and emotional or behavioral problems.<sup>2</sup> Early intervention and services that support healthy development in the years prior to starting school can reduce the incidence of disorders that have high costs and long-term consequences for the health, education, child welfare, and juvenile justice systems.<sup>3</sup> However, fewer than half of children with problems are identified before starting school.<sup>4</sup>

According to national and state leaders, an early childhood system must include interconnected health, mental health, and nutrition services along with early learning (such as child care, Head Start), family support (such as Women, Infants and Children [WIC], parenting education), and early intervention, as illustrated in Figure 1.<sup>5</sup> While conceptually it is sometimes useful to view these components as separate but interrelated, at the functional level, where families interface with the service system, each must be integrated with the others. Family support, for example, is integral to physical and mental health, and early learning activities are key for families with special-needs children. Family support may need to be constructed differently in each domain, but ultimately it must be connected seamlessly to strengthen each family in support of its child's health and development.

**FIGURE 1. STATE EARLY CHILDHOOD DEVELOPMENT SYSTEM**



Source: Early Childhood Systems Working Group; [http://www.zerotothree.org/site/DocServer/ECD\\_System\\_and\\_Core\\_Elements\\_Slides\\_Final.pdf?docID=3781](http://www.zerotothree.org/site/DocServer/ECD_System_and_Core_Elements_Slides_Final.pdf?docID=3781)

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## PROJECT OVERVIEW

With funding from the W.K. Kellogg Foundation, NASHP conducted an exploratory study of the role state policy plays in supporting linkages between the health sector and other sectors that support young children's health and development.<sup>6</sup> NASHP examined state agency coordination, system development, and support for local cross-sector initiatives in which the health sector plays an integral role. The purpose of the project was to promote the role of state health policy in efforts to assure cross-sector service linkages for young children and their families, with the ultimate goal of better addressing the comprehensive needs of young children as they grow and develop. The specific objectives of NASHP's project were to:

- Examine the various models states use to create or support multi-sector service linkages and the roles state health agencies play in supporting these linkages;
- Identify issues and ideas for promoting state health policy support of multi-sector service linkages; and
- Expose opportunities to link the health sector with broader early childhood initiatives that promote school readiness in order to achieve positive health outcomes.

NASHP convened an advisory group of state officials to guide this project (see Appendix A). We conducted interviews with experts in the field and performed an environmental scan to identify state early childhood initiatives that include multi-sector service linkages, with a health component, for young children. Our informant interviews and scan resulted in a short list of states for further investigation. NASHP conducted phone interviews with these states to obtain more information about their initiatives, including information about state infrastructure and leadership; financing, including use of Medicaid reimbursement; data and information exchange; accomplishments, barriers, and facilitators to multi-sector service linkages; and translation of policies and initiatives to the local level. Interviewees varied by state, but included representatives of early childhood initiatives, Medicaid, and Maternal and Child Health agencies from 12 states:

- California
- Connecticut
- Illinois
- Iowa
- Kentucky
- Michigan
- North Carolina
- Ohio
- Rhode Island
- Vermont
- Virginia
- Washington

This project did not examine:

- Linkages solely within the health sector. Although these linkages are critical to addressing children's physical, mental, and oral health needs, we examined multi-sector linkages within broader early childhood initiatives.<sup>7</sup> The initial goal was to include only linkages that involve at least three sectors (e.g. health, early learning, and family support), but given a dearth of examples, two-sector linkages were included;
- Early childhood initiatives that do not include a key role for the health sector;
- Initiatives that have not yet resulted in identifiable state health policy; and
- Innovative approaches in states that were not included in this project.

After the interviews, NASHP convened a meeting of state policy experts to discuss models, issues, and challenges from a state perspective and gather recommendations on how to promote state health policy

that supports multi-sector service linkages (see Appendix B for participant list). Throughout this report we refer to “project participants,” which includes all of the people involved: advisory group members, state interviewees, and state policy expert meeting participants.

This report provides:

- Background on the potential role of the health sector in multi-sector initiatives;
- A conceptual framework for incorporating the health sector into multi-sector initiatives; and
- Examples of policies linking the health sector with other early childhood services in the 12 states we examined.

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## SETTING THE CONTEXT

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### **THE HEALTH SECTOR PLAYS A KEY ROLE IN HELPING ACHIEVE OPTIMAL CHILD DEVELOPMENT**

A broad definition of the health sector includes the public and private medical care systems as well as the population-based public health system. Health sector services that are relevant to young children's healthy development include preconception, prenatal, and pediatric primary health care; services that prevent physical health problems and disparities; social-emotional developmental and mental health care; oral health services; and prevention, identification, and follow-up of developmental delays.

High-quality pediatric primary care<sup>8</sup> plays a critical role in promoting healthy development and linking children and their families to needed services. Health care settings are generally seen as the best place to reach the greatest number of children under age 5. Almost 90 percent of young children receive well-child visits at least once a year, while only 30 percent spend time in child care settings or other formal settings where developmental and health needs may be identified.<sup>9</sup> Well-child visits provide opportunities to address key health indicators, monitor development, screen for developmental problems and risk factors, identify family needs, and connect children and their families with other services.

The public health system focuses primarily on health promotion and disease prevention, and it includes community services in addition to traditional medical encounters. In this context, the public health system refers to the framework and programs operated by state, regional, and local health departments that focus on disease prevention and control, environmental health, injury prevention, preparedness, access to health care, and other health-related population-management programs (e.g. infant mortality and lead poisoning prevention, hearing and vision screening and referral, family planning and reproductive health, and adolescent health).

As a part of the public health system, Title V of the Social Security Act (the Maternal and Child Health Services Block Grant) provides a focal point for addressing a broad range of health needs, and it can play a role in facilitating cross-sector linkages. Home visiting programs, for example, which often fall within Maternal and Child Health agencies, deliver medical, public health, and social services to women and children, including assessment of health and social needs, parenting support and education, and referral to community services. Maternal and Child Health agencies also are charged with facilitating the development of comprehensive, family-centered, community-based, culturally competent coordinated systems of care for children with special health care needs.

Within the health sector, services (primary care, preventive services, mental health, oral health, specialty care, etc.) and funding sources often lack coordination. In addition, most primary care medical services are delivered through the private sector, while public health services often are delivered via the public sector. The variety of funding streams, and the differences between public and private funding policies and practices, can create tension and additional difficulty in integrating programs. Project participants observed that improving coordination of services within the health sector itself would assist in coordinating services across sectors.

### **COORDINATION AND INTEGRATION OF SERVICES REMAINS A CHALLENGE**

Interest in school readiness initiatives is increasing across the country. There is growing recognition that children must be healthy in order to learn and that motor skills, coordination, and overall physical health affect social-emotional and cognitive development and academic achievement.<sup>10</sup> The National Academy of Sciences urges early childhood programs to develop strong relationships with welfare, protective services, early intervention, and health and mental health policies and programs.<sup>11</sup>

Despite recognition of the need, service coordination remains a challenge. There are dozens of programs administered by seven federal departments that deliver services to children.<sup>12</sup> Medicaid, child welfare, mental health, public health, education, and other state agencies have overlapping missions and serve overlapping populations. These complex systems and agencies were created separately at the federal level and typically operate independently of each other unless explicit policies and projects call for integration.

There also are differences in culture, organization, and operation of agencies and programs within the early learning, family support, early intervention, and health sectors. For example, while public education is guaranteed regardless of family resources, many health care services are available only after payment arrangements have been secured. Because health services tend to be delivered through the private sector, government health programs do not have the same relationship with providers that education programs do with schools. It has been suggested that early childhood initiatives could benefit from a commercial and social marketing approach in order to involve physicians, given that this method of information sharing is regularly used and endorsed in the medical community.

The separate federal laws, organizations, financing, eligibility requirements, and cultures through which children's services are delivered lead to lack of coordination and pose barriers to integration. Strong policies in one area (health care, for example) can be undermined by weak policies in another (child care, for example).<sup>13</sup> The fragmentation is problematic particularly for underserved populations and those with special needs.<sup>14</sup> Programs that influence school readiness tend to remain disconnected and often are housed in the education and social service sectors. Although medical screenings are required for school entry, health services are often an afterthought in early care and education initiatives, and, as a result, they are not well integrated into these initiatives.<sup>15</sup>

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## A CONCEPTUAL FRAMEWORK FOR INCORPORATING HEALTH INTO MULTI-SECTOR SERVICE LINKAGES FOR YOUNG CHILDREN

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### **A PUBLIC HEALTH APPROACH TO HEALTHY DEVELOPMENT**

Project participants agreed that a public health approach to child health and development promotes multi-sector coordination more effectively than a traditional medical approach that focuses exclusively on the clinical needs of each child. A public health approach is population-based, equity oriented, and developmentally focused.<sup>16</sup> Within this framework, health is broadly defined to acknowledge that multiple factors and programs, some outside the traditional health sector, contribute to health and healthy development. Such an approach incorporates the socio-ecological model of health, in which individual health status is influenced by personal relationships as well as community and societal factors. As a result, efforts to promote children's health and development address various levels, including the individual (such as medical care), relationships (especially with family), community (such as schools and neighborhoods), and societal factors (including policies and cultural beliefs that influence behavior).

Ideally, a public health approach to early childhood health and development spans multiple sectors – a necessity given that many determinants of health are social, economic, and political rather than medical.<sup>17</sup> Many risk factors affecting early brain development are associated with poverty, malnutrition, illiteracy, violence, toxic exposures, substance abuse, and other risk-taking behaviors, which require a public health approach.<sup>18</sup> As such, within a public health approach, interventions can be implemented by agencies other than public health and primary care providers. Interventions can come from early learning programs such as Head Start and child care centers, early intervention agencies that implement Part C services, and family support programs that serve as delivery sites for preventive and rehabilitative health services.<sup>19, 20</sup> The Special Supplemental Nutrition Program for WIC, Head Start, Reach Out and Read, and other programs that reach the most vulnerable populations often are co-located with health services.<sup>21</sup> These services help ensure adequate prenatal and early childhood nutrition, healthy environments, and timely diagnosis and treatment of developmental delays, all of which are critical for healthy brain development.

The transition from a medical model that emphasizes curbing disease to a public health model that focuses on promoting health is also useful in shifting attention to health disparities and promoting health regardless of gender, race, socioeconomic status, and geography. Racial inequities can lead to differences in health status and school readiness. Disparities in health conditions and access to health services co-occur with disparities in educational achievement, and with child welfare and justice system involvement.<sup>22</sup> Thus, addressing disparities in health can reduce disparities in education and other sectors. For example, more than 90 percent of all New York City lead poisoning cases involve children of color living in 10 neighborhoods.<sup>23</sup> In preschoolers, high rates of lead in the blood can cause brain damage and affect organ functioning, which may reduce intelligence and attention span, cause learning disabilities, and lead to behavioral problems.<sup>24</sup> A public health approach that addresses this environmental risk would help families find safe housing.

A public health approach to child health and development recognizes the developmental trajectories of cognitive, social, physical, and other skills, and the complexity of the developmental continuum. Accordingly, children move among programs as their health needs change. Addressing current developmental concerns and issues will foster healthy development later in life.

The socio-ecological health model described above requires the involvement of families, communities, and public policy. An approach that recognizes the critical influence of parents on childhood development can help children's primary care providers and policy makers identify opportunities to link programs that address active parental engagement, adequate family resources, perinatal depression, substance abuse, violence, and cultural differences in parenting roles. An approach that recognizes the influence of community can help state policy makers find ways

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to support community-based approaches to linking programs that support parents, schools, health care settings, and local programs so that they are accessible, available, and responsive to community needs. Legislators, advocates, and private funders also play a critical role in supporting, monitoring, and sustaining efforts that might not otherwise survive changes in state government leadership.

Project participants emphasized that state Medicaid agencies can use a public health approach and attend to the quality of care being purchased. Medicaid reimbursement policies that promote screening and surveillance, coordination and care management, shared data requirements, and reimbursement eligibility for a broader array of providers – not just health care providers – can promote service linkages. Medicaid agencies can conduct outreach and education on the need for preventive care; implement pay-for-performance programs; and create contract requirements within Medicaid managed care plans that reward quality and care coordination and ensure that beneficiaries move among programs as their health needs warrant.

### **STATES CAN FACILITATE THE ROLE OF THE HEALTH SECTOR IN MULTI-SECTOR SERVICE LINKAGES FOR YOUNG CHILDREN**

Many states recognize the inefficiencies inherent in fragmented, duplicated, and uncoordinated services; they believe that healthy development requires attention to the interrelated developmental needs of children and families. Increasingly, states are developing mechanisms to create more coordinated and integrated services for early childhood services. These state efforts are supported by a number of national initiatives that foster more comprehensive approaches to early childhood health and development. Two initiatives that approach integration from a health sector perspective are described below.

The federal Maternal and Child Health Bureau's state Early Childhood Comprehensive Systems (ECCS) program provides state Title V Maternal and Child Health programs with funding to plan, develop, and implement collaborations for integrated, comprehensive, community-based systems of care for young children. All plans are required to focus on state system planning for health care and medical homes, early care and education, social-emotional development and mental health, parenting education, and family support. This work is often described as a "system of systems." Central to this initiative is the belief that efforts to address one component of early childhood development affect the other components as well, promoting the notion that health must be a critical component of early childhood initiatives. Among other things, states must describe state action to offer young children access to a medical home that provides comprehensive developmental services. As of FY07, all but three states were funded, and 30 of them had developed mechanisms for system integration.<sup>25</sup> In the future, integration will be even more critical, as ECCS program renewal guidelines emphasize deepening the multi-agency nature of state systems building activities.<sup>26</sup> Because the ECCS program is so central to states' integrated comprehensive systems for children, examples derived from the ECCS program are included throughout this report.

The Assuring Better Child Health and Development (ABCD) program, sponsored by the Commonwealth Fund and administered by NASHP, is designed to strengthen primary health care services and systems that support the healthy development of young children. The ABCD experience has shown that active partnerships that include state health and early education agencies, children's primary care providers, community agency representatives, and advocates are critical to promoting Medicaid and other state health policies that encourage healthy development.<sup>27</sup>

States, using their authority as health care purchasers, regulators, data warehouses, conveners, and educators, can help bridge the gap between the health sector and other early childhood services by developing policies that promote coordination at both the state and local levels.<sup>28</sup> Policies that can facilitate coordination across sectors include:

- Eligibility policies and processes;
- Needs identification and assessment;
- Communication and referral processes; and
- Professional consultation and training.

State policies also can support the infrastructure needed for multi-sector coordination. These policies can:

- Encourage or require integration and/or coordination among state agencies and programs through cross-agency planning, policy development, and governance structures;
- Share or link data; and
- Set the framework for community-level service integration.

The following sections explore ways to use policy to promote health as a key component of multi-sector service linkages for young children and describe examples of state policies in the 12 featured states. More information on each state appears in Appendix C.

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## STATE HEALTH POLICIES THAT COORDINATE OR LINK SERVICES FOR YOUNG CHILDREN ACROSS SECTORS

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State policies can promote coordination among the public agencies involved in identification, referral, and provision of effective early childhood services and help link these services with private sector primary health care providers. A common feature of successful programs is a single access point for coordinated information, assistance, and services, including uniform child screening, assessment, and appropriate referrals for Head Start, food stamps, and health insurance programs, for example.<sup>29</sup>

### California

The California Department of Health Care Services' One-e-App Web tool ([www.oneeapp.org](http://www.oneeapp.org)) streamlines enrollment and retention in a range of health and social service programs, including health care coverage programs, WIC, Earned Income Tax Credit, food stamps, and Temporary Assistance for Needy Families. One-e-App provides access to a multitude of health and social services programs based on county preferences. Currently, 10 counties use One-e-App. One-e-App Express Lane Eligibility, used by school districts in two counties, is an effort to enroll children in Medicaid by linking enrollment to other programs with similar eligibility rules, such as food stamps and the school lunch program.

### ELIGIBILITY POLICIES OR PROCESSES

Integration and consistency of service eligibility criteria and processes can ensure families are aware of – and can access – appropriate services, including health, early care and education, and family supports.

Some states coordinate outreach for public health insurance programs with various early childhood programs. Health insurance can provide a means to access comprehensive and developmental health care and related early childhood services, all of which help children grow up healthy and ready to learn. In a previous survey, 16 states said their online Medicaid and State Children's Health Insurance Program (SCHIP) applications are linked to other programs, including food stamps,

WIC, early intervention, and Head Start programs. Utah Clicks ([www.utahclicks.org](http://www.utahclicks.org)) is one example of an online resource that provides an integrated front-end interface for various programs that often remain disconnected.<sup>30</sup>

Enrollment in and use of government programs, including health insurance, is often higher among whites than people of color as the result of obstacles such as language and cultural differences, lack of knowledge of programs, and mistrust of government providers.<sup>31</sup> Efforts to coordinate enrollment of eligible children in Medicaid and SCHIP programs can help make sure children have access to medical care that serves as a gateway to other services and can also address disparities in uptake rates and use of government programs.

### NEEDS IDENTIFICATION AND ASSESSMENT

Early identification of risks to healthy development – such as developmental delays, perinatal depression, lack of family resources, and violence – is critical to ensuring that needs are addressed before they negatively influence physical health, developmental trajectories, and school readiness. Early identification of risk factors also can reduce health disparities that affect early learning. Asthma, for example, is the leading cause of school absences and is more prevalent in African-American children than in white children.<sup>32</sup> There are a number of ways to identify children and families who are eligible for cross-sector support services. Some strategies focus on enhancement of developmental services within the primary care sector, such as clarifying coverage of screening and follow-up services. Other strategies focus on training early childhood professionals outside the health sector in conducting developmental screenings and ensuring that these practitioners are reimbursed for this service.

## Illinois

Illinois has used a variety of strategies to expand and improve services that promote healthy child development. It is the first state to provide affordable, comprehensive health insurance for every child, as well as preschool for all. The Illinois Medicaid program's public health approach emphasizes the interrelated nature of child and family health and well-being. It accomplishes this by enhancing maternal health through perinatal care and broadening well-child care to include social-emotional health. The Medicaid program reimburses primary care providers who use a validated screening tool to screen mothers of all infants covered by Medicaid for perinatal depression. The screening occurs as a part of the risk assessment that takes place during the infant's well-child or episodic visit. If the mother is not covered by Medicaid, the provider may bill for the service under the infant's Medicaid ID number. In an effort to connect services across sectors, infants whose mothers are diagnosed with postpartum depression are eligible for Part C Early Intervention services. Legislation in 2008, intended to increase awareness and promote early detection and treatment of perinatal depression, requires health care professionals who provide prenatal, postnatal, labor and

delivery, and infant care services to provide education to women and their families about perinatal mental health disorders. Medicaid also requires providers participating in its new Primary Care Case Management program to include an objective developmental screening as part of an Early and Periodic Screening, Diagnosis, and Treatment visit; providers are monitored and receive individual feedback on performance in this area. Family Case Management agencies that are enrolled as medical providers are required to conduct objective developmental screenings for all infants and pregnant women who are beneficiaries of the department's medical programs. Children in state foster care custody are assessed on social-emotional development. Child care providers are trained on developmental screening including social-emotional health and related changes to Medicaid policies. Developmental screenings are conducted by all Preschool for All programs funded with education dollars, and referrals are made to health and other needed services. These efforts to increase screening are the first steps in connecting women and children to resources that can assist in promoting healthy child development.

### CROSS-SECTOR COMMUNICATION AND REFERRAL PROCESSES

State policies can help ensure that children and families with identified needs receive appropriate health and developmental services. Policies such as income support, skill-building programs, and access to high-quality child care focus more broadly on eliminating barriers that families encounter as they work toward children's early learning and development.

Some states are developing centralized referral centers or networks to promote service linkages or are providing coordinated case management services to help children, families, and providers navigate services. Home visiting programs are a good way to reach across sectors because they provide health and parent support as well as information on a variety of community resources.

Meeting participants noted that children and families who are referred for services do not always receive those services. Factors such as available resources to provide services, follow-up on the part of providers and families, and cultural issues affect service delivery. For instance, white families are twice as likely as other referred families to obtain home support services for parenting skills.<sup>33</sup> Although this issue remains a barrier to multi-sector linkages, policies that strengthen referral networks provide an opportunity to improve service delivery and address service disparities.

In order to ensure that the health sector is included in care coordination, states may need to pay special attention to integrating public sector health programs with private sector medical services. Many communities have networks or partnerships that assist children and families with multiple needs, but they often do not know how to effectively engage and communicate with primary care providers.<sup>34</sup> Because they tend to focus on core health outcomes, primary health care providers often do not perceive themselves as part of a continuum of services that children and

## Connecticut

Help Me Grow is a program of the Connecticut Children's Trust fund working in collaboration with the United Way of Connecticut/Infoline, the Connecticut Birth to Three System (through the Department of Developmental Services), and the State Department of Education Preschool Special Education Program. Help Me Grow has developed a statewide network to help families and providers access appropriate services for young children (birth to 8) who are at risk for developmental, health, or behavioral problems. Program components include the Child Development Infoline, a statewide toll-free telephone number that provides centralized care coordination for developmental services; partnerships with community-based agencies as referral resources; and child development community liaisons that serve as conduits between the community-based services and the telephone access point. Infoline care coordinators conduct assessments and connect children with appropriate programs and services. Families are connected with community-based services and supports; follow-up is provided to ensure successful linkages. In addition to information on healthy development and care coordination, Help Me Grow provides referral feedback to providers. The Infoline is funded as a collaboration of four state agencies and serves as a single point of access for services provided by the agencies.

## Kentucky

Kentucky's KIDS Now initiative includes a child care health consultation program called Kentucky Healthy Start in Child Care. The program employs statewide consultants who provide training and consultation to early care and education centers on health (including social-emotional well being), safety, and nutrition. The Healthy Start consultants also serve as liaisons between the early care and education centers and the Early Childhood Mental Health Program. The ECMH program has trained mental health specialists located throughout the state who help early childhood agencies, private practices, and child care centers recognize and effectively manage behavioral health issues and assist families as they navigate the system. In many instances, the Healthy Start in Child Care consultants and ECMH specialists co-train to address universal and targeted interventions for young children with identified social and emotional challenges.

families need for healthy development. As a result, primary care providers often do not know about existing resources or how to access them. They also cite frustration with the lack of information they get back from referral agencies; providers reported that they were least likely to receive the results of referrals to community organizations.<sup>35</sup>

States can help primary health care providers link to early childhood services in other sectors by providing information about existing resources and inviting them to meet with representatives of the local service agencies; designing programs that encourage the identification of an individual who facilitates referrals; and informing resource agencies about what they can do to encourage primary care providers to make referrals to the agency, such as reporting back the results of a referral.

State medical home initiatives provide an opportunity to promote the health sector as a critical component of service linkages. The medical home, an approach in which patients receive continuous and comprehensive care, was intended to respond to the duplication and service gaps that occurred as a result of lack of communication among multiple providers. Among the key principles of a patient-centered medical home are a personal physician (or other health care provider, depending on the definition of medical home); whole-person orientation, delivery within the context of family and community; and coordinated care across providers, conditions, and settings.<sup>36</sup> Referral forms and policies that require information to be shared with primary care providers and community resources can help close the loop between referral and treatment.

### PROFESSIONAL CONSULTATION OR TRAINING

States also can help coordinate services across multiple sectors by offering cross-sector consultation or training. By linking health professionals, child care providers, and families

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in this way, states can maximize resources and develop comprehensive, coordinated services to nurture child health and development. Many states provide health and mental health consultations to preschools and child care centers to meet children's needs and enhance the skills of child care providers. States also can provide cross-sector training on early childhood for various types of practitioners. The Healthy Child Care America program, which operated from 1995 to 2005, was a collaborative effort of health professionals, child care providers, and families. Supported by the Maternal and Child Health Bureau, it funded 50 state grantees to maximize child health, safety, well-being, and developmental potential through quality child care and medical homes.<sup>37</sup> Although the national program has ended, many states continue to support consultation and training across multiple sectors. Project participants noted that child care providers need both health and mental health consultations, which should be part of a continuum of available services.

### **FINANCING THAT SUPPORTS SERVICE LINKAGES**

Financing policies can support service coordination and integration in many ways, from increasing efficiency of existing resources to maximizing public revenue. Policies also can create increased flexibility of categorical funding and build public-private partnerships to increase financial support and maximize non-monetary resources.<sup>38</sup> States can explore options to link services through federal program funding and reimbursement for services, state legislative appropriations, and private dollars.

Multiple funding streams with different requirements often lead to a lack of program coordination. Coordinated funding, or strategic pooling of flexible funding resources, and increased flexibility of funding streams can help reduce duplication and maximize existing funds.

In addition to the dilemma of categorical funding, the funding itself is often inadequate. Primary care providers encounter a number of barriers to linking with services in other sectors. These challenges include limited reimbursement for developmental services, for creating linkages through referral and follow-up, and for certain types of service providers who are not eligible for Medicaid billing. When providers who are paid for visits rather than outcomes find billing codes and procedures difficult to navigate, they may stop providing certain services.

The EPSDT program provides a unique opportunity to coordinate and link services for young children. EPSDT provides comprehensive and preventive health services for infants, children, and adolescents enrolled in Medicaid and represents a significant funding source for health promotion, maintenance, and developmental services. EPSDT requires states to cover a broad array of services and ensure that children receive the intended care, which includes informing eligible families and caregivers about EPSDT, providing or arranging for screening services, and arranging corrective treatment, either directly or through referral. Covered services include transportation to services, whether they occur at clinics, schools, or in other community settings. Furthermore, Medicaid agencies are required to use state health and Title V agencies to link and arrange care and follow-up and must pay these agencies for both administration and medical assistance activities. The rules also specify that Medicaid agencies should help families access other public health, mental health, and educational programs.<sup>39</sup>

The opportunities provided through the Medicaid ESPDT program to coordinate and integrate services may be jeopardized by guidelines proposed by the Centers for Medicare and Medicaid Services. Health care and rehabilitation services for children with special health care needs and public health nursing in home, school, and community settings have been a Medicaid priority for decades, but the continuation of these services is threatened by the proposed regulations. A moratorium expiring on April 1, 2009, has put the regulations on hold.<sup>40</sup> The regulations would prohibit the use of schools to administer Medicaid, as well as billing for case management services that are "integral to the administration of a non-medical program such as ... child welfare or ... special education."<sup>41</sup>

## Iowa

Title V agencies operate within a public health approach and foster multi-sector collaboration by, for example, working with schools to connect health and education. The Iowa Medicaid agency contracts with the Title V agency to provide consultation, technical assistance, and training pertaining to the Early and Periodic Screening, Diagnosis, and Treatment program, including outreach, informing services, care coordination services, and/or screening for Medicaid-eligible infants, children, and youth. The Medicaid agency provides the Title V agency with a daily list of names, addresses, and phone numbers of Medicaid clients who are eligible for EPSDT informing and care coordination services. The local contract agencies are then able to explain the benefits of preventive health care and other services available to Medicaid families. Expenditures for the services described in this agreement are eligible for federal match through the Medicaid program. Iowa's agreement between Medicaid and Title V makes Title V providers eligible for wraparound services such as transportation. Title V providers notify newly eligible Medicaid recipients of covered services, ask if they need help accessing services (such as dental, immunization, screening), and help connect them to services.

See Table 1 for additional examples of state policies discussed in the preceding sections (from the 12 states included in this report) and which help to coordinate services for young children across multiple sectors, including the health sector. The table is organized according to the areas described above:

- 1) eligibility policies or processes;
- 2) needs identification and assessment;
- 3) communication and referral processes; and
- 4) professional consultation or training.

**TABLE 1: STATE HEALTH POLICIES THAT ENCOURAGE SERVICE COORDINATION AND LINKAGES FOR YOUNG CHILDREN ACROSS HEALTH AND EARLY LEARNING, FAMILY SUPPORT, AND/OR EARLY INTERVENTION SECTORS**

<p>COORDINATING ELIGIBILITY POLICIES OR PROCESSES ACROSS MULTIPLE SECTORS</p>	<ul style="list-style-type: none"> <li>• The <b>California</b> Department of Health Care Service's One-e-App Web tool (<a href="http://www.oneeapp.org">www.oneeapp.org</a>) streamlines enrollment and retention in a range of health and social service programs and can provide program access based on county preferences.</li> <li>• <b>First 5 California</b>, a multi-sector initiative whose largest statewide program focuses on school readiness, partners with state and county agencies (including local First 5 county commissions) to expand access to health care. It provides support for the local Children's Health Initiatives, which operate in about half of the counties. First 5 pools funding to fill service gaps and coordinate categorical programs, including health services.</li> <li>• <b>Iowa's</b> insurance code requires insurers to provide access to preventive health services consistent with Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program, providing the opportunity to coordinate health care and related community services for enrollees.</li> <li>• <b>North Carolina's</b> multi-sector early childhood initiative, Smart Start, funds 10 Health Check (Medicaid) coordinators – in addition to 90 funded by Medicaid – to identify income-eligible children for enrollment and increase use of Medicaid services, particularly preventive health services.</li> <li>• <b>Washington</b> has a Web-based parent line (ParentHelp123) sponsored by WithinReach that includes child care, health, and food-security programs. Parents enter basic information, and staff determines eligibility.</li> </ul>
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TABLE 1: CONTINUED

<p>COORDINATING CROSS-SECTOR NEEDS IDENTIFICATION AND ASSESSMENT</p>	<ul style="list-style-type: none"> <li>• <b>Connecticut's</b> Medicaid program plans to use a pay-for-performance mechanism to encourage child health providers to perform standardized developmental screenings. Providers will be able to connect children identified during screening with multi-sector evaluation and intervention services through Child Development Infoline. In addition, several early childhood providers in Connecticut, including physician practices, home visiting programs, and school readiness sites, are using the Ages and Stages monitoring system. Child Development Infoline scores Ages and Stages results and sends reports to the child's medical home for follow-up.</li> <li>• <b>Illinois</b> links the health and early intervention sectors through several policies. The state enacted legislation that requires screening for perinatal depression. Illinois' Early Intervention system has clarified that it considers major depression within the first year postpartum to be a "severe mental disorder" as defined in Early Intervention eligibility criteria, thus qualifying a child whose mother has been diagnosed with post-partum depression for Early Intervention services.</li> <li>• Policies in <b>Illinois</b> related to developmental screening connect the health and early learning sectors. Child care providers are trained in developmental screening, including social and emotional health and related Medicaid policies. Developmental screenings are conducted by Preschool for All programs funded with education dollars, and referrals are made to health and other needed services. Children in state foster care custody also are assessed on social-emotional development.</li> <li>• <b>Illinois</b> provides ongoing training for Medicaid Managed Care Organizations' network providers, pediatric/family physician sites, and child care providers on social-emotional development, perinatal depression, and developmental screening. Private foundation dollars secure a federal match under an administrative claim in order to offer provider training on EPSDT requirements. Medicaid now reimburses services provided by licensed social workers.</li> <li>• The Medicaid agency in <b>Iowa</b> contracts with the Title V agency to provide consultation, technical assistance, and training pertaining to the EPSDT program including Medicaid outreach, informing services, care coordination services within health and other sectors, and/or screening services for Medicaid-eligible infants, children, and youth.</li> <li>• Policies in <b>Rhode Island</b> related to developmental screening link the health, early learning, and early intervention sectors. Rhode Island integrates developmental screening into universal newborn risk assessment, with follow-up through a home visiting program linked to Early Intervention. Watch Me Grow is piloting developmental screening for all young children in child care and medical home settings to recognize and address later-onset problems, such as Autism Spectrum Disorders.</li> <li>• <b>Vermont's</b> Children's Integrated Services' (CIS) activities include outreach, early identification and referral, multidisciplinary assessment and evaluation, individualized child and family outcomes planning, service delivery, and transition. In state FY 2010, a new performance-based financing structure will further support the CIS Team by blending funding from Medicaid, general funds, and Part C. This funding will enable CIS systems to provide more efficient cross-sector screening, referral, and assessment for individuals with a suspected developmental delay, condition, or risk.</li> <li>• <b>Virginia's</b> state Medicaid agency and Early Intervention program (Part C) have developed a plan for moving Part C services from Outpatient Rehabilitation into EPSDT in order to support comprehensive multi-sector assessment and services for all children.</li> <li>• <b>Virginia's</b> state health department incorporated developmental screening into the comprehensive physical examination form used for entry into preschool and school.</li> </ul>
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TABLE 1: CONTINUED

<p>POLICIES THAT ESTABLISH CROSS-SECTOR COMMUNICATION OR REFERRAL PROCESSES</p>	<ul style="list-style-type: none"> <li>• <b>Connecticut's</b> Help Me Grow program provides centralized multi-sector care coordination through the state's 211 Infoline. Care coordinators conduct assessments and connect children and families to appropriate community-based services and supports. Follow-up is provided to ensure successful linkages. The Infoline provides information on healthy development and care coordination as well as referral feedback to providers. It is funded as a collaboration of four state agencies and serves as a single point of access for services provided by those agencies.</li> <li>• <b>Illinois</b> uses a primary care case management program to support a medical home model. Within this reimbursement system, primary care providers take responsibility for care coordination across multiple sectors. Providers can call a provider helpline to access a referral resource directory of medical professionals and community-based agencies that can help address patients' needs (e.g. WIC, transportation).</li> <li>• <b>Iowa</b> uses EPSDT local care coordinators to support families and providers and help link them to various multi-sector community resources.</li> <li>• <b>North Carolina's</b> community care networks promote medical homes and care coordination. Network members are paid to link patients to a medical home and are required to coordinate referrals to specialists and social service agencies. The networks receive an additional payment to hire case managers.</li> <li>• <b>Vermont's</b> Children's Integrated Services Teams function as a referral hub at the regional level for access to a continuum of multi-sector prevention, early intervention, and therapeutic services. Referrals flow to CIS from a variety of providers, including health, mental health, Child Abuse Prevention and Treatment Act, schools, WIC, parent child centers, and other community support agencies.</li> <li>• Through collaborative efforts, <b>Virginia's</b> Part C Early Intervention program developed a provider referral form with feedback to referring providers, which meets multi-sector privacy and confidentiality guidelines. The Home Visiting Consortium is adapting this form for child care and health care providers to make referrals to home visiting services.</li> <li>• <b>Virginia's</b> state-funded early childhood home visiting programs (housed in five different state agencies and two private agencies) formed the Virginia Home Visiting Consortium. Charged by the Governor's Working Group on Early Childhood Initiatives with improving efficiency and effectiveness, the consortium is moving forward on recommendations related to data collection, resource sharing, core training, referral forms, and a guidance document for local communities on how to create a continuum of home visits from pregnancy to age 5.</li> <li>• <b>Washington</b> issued a request for proposals for communities to integrate the state's home visiting programs, which provide health and family support services.</li> </ul>
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TABLE 1: CONTINUED

<p style="text-align: center;">POLICIES THAT PROMOTE OR PROVIDE CROSS-SECTOR CONSULTATION OR TRAINING</p>	<ul style="list-style-type: none"> <li>• The <b>California</b> EPSDT program links the health and early learning sectors by reimbursing for child observation in the preschool setting. For a child who is a Medicaid beneficiary and mental health client, the observation is billable if related to the psychiatric diagnosis or treatment planning and the observation is performed by a county mental health professional or a contracting agency with an EPSDT contract agreement.</li> <li>• <b>Connecticut's</b> Early Childhood Education Cabinet aims to provide health, mental health, and education consultations to preschool programs. Connecticut already funds an Early Childhood Consultation Program with 20 mental health consultants working in early care settings statewide. It also has regulations requiring health consultations in child care settings. The Department of Public Health, through the Early Childhood Comprehensive Systems grant and private funding, is supporting an integrated approach to training consultants across disciplines.</li> <li>• <b>Kentucky</b> Childcare Health Consultants (Healthy Start in Childcare) work with early care and education centers on early child development, safety, nutrition, and health. As part of the health component, they provide training on social and emotional wellness of young children. The Early Childhood Mental Health Program includes trained mental health specialists located around the state. These ECMH specialists work with early childhood agencies, private practices, and child care centers to help them recognize and manage behavioral health issues and help families navigate the system.</li> <li>• <b>Illinois</b> has incorporated mental health consultation into education, child care, Part C, and Title V programs. Illinois provides more than \$1.5 million for mental health consultations for early childhood providers.</li> <li>• <b>Michigan</b> formed a state-level social and emotional training committee to involve all early childhood partners, including public health, Early Intervention, and Head Start. The committee is promoting common definitions and social-emotional development milestones.</li> <li>• <b>North Carolina</b> Smart Start funds about 70 of 100 child care health consultants. The University of North Carolina at Chapel Hill functions as a training center for a mandatory state training course (as well as the National Training Institute for Child Care Health Consultants). North Carolina is considering Medicaid reimbursement for child care health consultants who participate in this state training. Smart Start also funds 25 to 30 child inclusion and behavior specialists who provide referrals to community resources and services.</li> <li>• <b>Rhode Island's</b> Watch Me Grow program is working to increase the number of children receiving screening, assessment, and services by training child care providers to conduct screenings and share the results with health care providers and parents.</li> <li>• Working through Head Start and child care providers, <b>Virginia</b> health consultants provide education, training, and consultation to improve immunization rates and childhood asthma management.</li> <li>• Since 1995, <b>Washington's</b> Child Care Health Consultation program has used public health nurses specially trained in children's health, child development, social-emotional development, infant/toddler care, and special health care needs to provide consultation services to licensed child care settings in each county. This program is modeled after the federal Healthy Child Care America Initiative. CCHC is funded through the federal child care block grant.</li> <li>• Also in <b>Washington</b>, 2008 legislation created three mental health consultation pilot programs through the Department of Early Learning to provide mental health consultation in child care centers. The pilot programs aim to demonstrate how they will support the five protective factors in the national Strengthening Families Through Early Care and Education Initiative.</li> </ul>
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STATE POLICIES THAT SUPPORT THE INFRASTRUCTURE TO FOSTER  
MULTI-SECTOR COORDINATION

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## Washington

State-level momentum has been building to support coordinated action for early learning in Washington. In 2005, Gov. Chris Gregoire and the Washington State Legislature began an effort to promote quality early learning and parenting and to ensure that all Washington children are ready to succeed in school and thrive in life. In 2006, as momentum was building to create the Department of Early Learning to coordinate state-funded early learning programs, public and private funding partners joined to create Thrive by Five Washington. Thrive by Five is an organization designed to improve parenting education and support, child care, preschool, and other early learning environments in Washington. Thrive by Five combines the assets of the public and private sectors to help achieve sustainable social change. The public sector offers experience, public resources and infrastructure, and political legitimacy. Private organizations, such as foundations and businesses, bring expertise, credibility, nimbleness, rigor, and flexible funding.

By connecting the work of Early Childhood Comprehensive Systems through the Office of Maternal and Child Health and the Build Initiative efforts, Washington also has created a collaborative and comprehensive strategic framework called Kids Matter. (The Build Initiative provides funding and technical assistance to help states create coordinated early learning systems. The Build Initiative currently funds efforts in seven states.) Kids Matter aims to provide a common framework and language and encourage connections among public and private stakeholders at the local and state levels to coordinate efforts aimed at keeping children healthy and ready for school. This framework identifies achievable outcomes within four goal areas: access to health insurance and medical homes; mental health and social-emotional development; early care and education/child care; and parenting information and support.

Sources: [www.thrivebyfivewa.org](http://www.thrivebyfivewa.org) and [www.earlylearning.org/kids-matter](http://www.earlylearning.org/kids-matter). For more information about the Build Initiative, see [www.buildinitiative.org](http://www.buildinitiative.org).

## CROSS-AGENCY PLANNING, POLICY DEVELOPMENT, AND GOVERNANCE

States can support interagency planning that promotes multi-sector coordination of services for young children in various ways. Structures such as newly created cabinet-level state offices and independent nonprofit agencies can integrate or coordinate various state programs (and even private sector involvement). Many states have developed these structures, heeding the Institute of Medicine's call: "The time is long overdue for state and local decision makers to take bold actions to design and implement coordinated, functionally effective infrastructures to reduce the long-standing fragmentation of early childhood policies and programs."<sup>42</sup> However, these structures do not always include representatives from the health sector.

According to analysis of the ECCS initiatives, building a "system of systems" for early childhood requires governance and structural mechanisms to support and sustain integration.<sup>43</sup>

It is not uncommon for state executives to reorganize agencies and functions in an effort to improve service coordination. However, even without a coordinating structure among state-level agencies, state policies can encourage service integration. Project participants, drawn largely from state agencies with line authority over public health and insurance programs, expressed their belief that relationships, leadership, and intentional planning – not necessarily formal structure – are critical to successful service linkage. Some officials caution that overemphasis on structure and reorganization can result in more attention

to the process than the outcome. They generally believed that new departments and reorganized programs do not necessarily improve coordination. Evaluation of integration efforts shows that without the reordering of priorities, placing staff from different agencies in the same physical location and making policy and budget changes does not improve integration.<sup>44</sup> There also is concern that infrastructure reorganizations may be limited to the terms of the

governors who create them. Finally, participants noted that it is not realistic to create a comprehensive early childhood agency that spans multiple systems and programs. State agencies can address these challenges by developing memoranda of agreement (MOA) and interagency agreements without a formal umbrella structure. According to a review of the ECCS initiatives, 30 states have developed MOAs or similar arrangements.<sup>45</sup>

For states that are considering developing new governance structures, an analysis of such structures provides rules of thumb; it points to the importance of creating entities with the credibility, expertise, and authority to set cross-sector goals, measure progress, and redeploy funds to achieve common goals.<sup>46</sup>

### Public/private partnerships

There is growing recognition that ensuring children are healthy and ready for school requires a combined effort of government agencies, parents, community organizations, business, and philanthropy. Engaging private-sector medical providers is critical to ensuring that primary health care is part of an integrated system. Twenty-four state ECCS initiatives have public-private partnerships, some of which are incorporated and funded.<sup>47</sup>

#### Rhode Island

Rhode Island has a confidential, computerized health information system for children called KIDSNET. It was created to ensure all children receive appropriate and timely health screenings and preventive care. KIDSNET allows various sectors to collect and share health data; it connects families, pediatric providers, Early Intervention, public health programs such as the Immunization Program and WIC, and all programs involving preventive care screening. It provides real-time data access to doctors and school nurses, who use it for clinical visits, school entry information, and Head Start, among other things. Medical personnel can access data in nonmedical settings, such as child care centers, and the state may broaden access to other service providers. Access to this information helps ensure appropriate preventive services and follow-up are provided. KIDSNET began collecting information on all births in Rhode Island in 1997; in 2005 it began collecting data on immunizations given to children born prior to 1997, up through age 18. The system also includes information on children born out of state when the child sees a KIDSNET participating doctor or receives services at a participating program. As of April 2007, KIDSNET included information on more than 200,000 children.

KIDSNET works in part because its stakeholders value it. Health plans use KIDSNET because it helps them demonstrate high performance in meeting benchmarks. Providers use it because the state health department has linked vaccine availability to data participation.

Source: [www.health.state.ri.us/family/kidsnet/index.php](http://www.health.state.ri.us/family/kidsnet/index.php).

### Funding the systems and structures that promote integration

States have used a variety of mechanisms to fund early childhood infrastructure, including federal and state sources and private philanthropic support. States can develop budgets specific to early childhood initiatives by pooling or braiding various funding streams or creating new dedicated funding sources.

### POLICIES THAT PROMOTE DATA SHARING AND LINKAGE

Shared information and data tracking can help ensure that children experience coordinated services across multiple systems. Health data can provide information about well-child exams, follow-up referrals, and treatment services. Health providers must know what services and interventions are being provided in order to make relevant medical decisions. Health care encounter data are important not only to health care providers, but also to programs in other service sectors, such as school readiness and kindergarten assessment, quality child care, and Reach Out and Read. (The same is true for public health data and the analyses that result from epidemiological studies.) Linking databases across education, health, and human services departments can help case managers serving

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special-needs children communicate and coordinate services. Data sharing ensures that multiple sectors have access to the information they need.

Several states have linked databases across Medicaid and child welfare departments so they can quickly determine Medicaid eligibility, but linking across more than two sectors is less common. Some states are considering building data systems across medical, public health, education, and social service sectors for planning, coordination, and monitoring purposes.

Project participants noted that barriers to effective data sharing are both technological and policy related. State agencies and sectors have separate data systems with different users, elements, and structures – systems created for distinct and diverse purposes. Public health systems have surveillance and epidemiological data and client information, while Medicaid collects encounter and claims data; the Healthcare Effectiveness Data and Information Set (HEDIS) contains data used and reported largely by managed care plans. Other sectors may not understand how these data systems work or what information they collect. At the same time, states lack the resources to invest in interoperability and may encounter concerns about sharing information for fear of violating privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA)<sup>48</sup> and the Family Educational Rights and Privacy Act (FERPA).<sup>49</sup> For example, when integrating health components into education records, states must balance the need to protect a child's privacy with the desire to share critical health information with the child's teacher or school nurse. FERPA prohibits sharing educational information without express parental consent, but health providers need some of this information for the same reasons educators need health information relative to outcomes and coordination. Thus, appropriate releases for exchanges of information are necessary.

For the above reasons, crafting cross-sector data sharing agreements is a challenge. Participating states have found success by couching data sharing under school readiness and early learning because these topics are generating attention. Proponents of school readiness are interested in health sector data for kindergarten assessments. Data sharing must be done within the context of protecting the family's right to privacy and with appropriate releases and understanding from the family as to the benefits of such sharing. Benefits may include improved outcomes, minimized duplication, and decreased likelihood of missed critical information.

### **SETTING THE FRAMEWORK FOR LOCAL IMPLEMENTATION**

State agencies recognize that much of the cross-sector coordination and integration of services needs to take place at the community level. State policies can promote local integration by providing funding and technical assistance, setting a framework for local implementation that encourages or requires certain service components and accountability mechanisms for measuring progress, modeling integration at the state level, and incorporating local experience into suggestions for improving policy and practice. Thirty-eight state ECCS initiatives have developed, or are in the process of developing, structures to support local system integration by providing funding, technical assistance, or policy guidance.<sup>50</sup>

State-supported community-based initiatives can balance state requirements with local flexibility, allowing communities to address local needs, design appropriate programs, and allocate resources effectively, while holding communities accountable to state agencies for program outcomes. This approach may be particularly important in ensuring that strategies are culturally appropriate and address community needs and values. It also enables communities to address disparities and build on their assets, rather than focusing on their deficits.

Braided funding at the state level can help communities target their resources to achieve desired outcomes. States also can authorize counties to pool categorical funds. The states included in this report use strategies that provide incentives, technical assistance, and requirements to include the health sector in existing and new community early childhood initiatives. Some monitor health-sector initiatives through state-established indicators or provide

## Michigan

The Michigan Early Childhood Investment Corporation provides training and funding to community Great Start Collaboratives to improve the health, development, and learning of young children. Communities that are funded as local GSCs are required to address a series of issues, including access to health insurance and a medical home; mental health and social-emotional development; early care and education; parenting education and family support; infrastructure; and basic needs, economic security, and child safety. State policies provide the framework for local work. The program allows funded communities to meet their goals by finding the appropriate mechanisms to coordinate resources for young children. Community strategic plans include a specified scope of contractual work with a health component. Michigan uses state-established indicators as the basis for community engagement.

additional funding for projects that focus on the health sector. All but one of the states that participated in this project currently participate, or have previously participated, in an ABCD initiative. ABCD projects emphasize policy improvement at the state level and quality improvement at the primary care practice level. They encourage primary care providers to screen young children and develop referral and treatment pathways with community agencies.

In addition to local flexibility to meet community needs, project participants emphasized the need for states to help with long-term funding and capacity-building rather than relying on project support alone. Participants also stressed the need for training and technical assistance, support for development of IT tools, and a focus on building onto existing local systems rather than starting anew.

Table 2 provides examples from the 12 states explored for this report. It is organized by policies that:

- 1) encourage or require integration and/or coordination among state agencies and programs through cross-agency planning, policy development, and governance structures;
- 2) share or link data; and
- 3) set the framework for community-level service integration.

**TABLE 2: STATE POLICIES THAT SUPPORT INFRASTRUCTURE TO PROMOTE MULTI-SECTOR COORDINATION OF SERVICES, INCLUDING HEALTH**

<p><b>CROSS-AGENCY PLANNING, POLICY DEVELOPMENT, AND GOVERNANCE</b></p>	<ul style="list-style-type: none"> <li>• First 5 <b>California</b>, also known as the California Children and Families Commission, is dedicated to improving the lives of the state’s young children and their families through a comprehensive and integrated system of information and services promoting early childhood development and school readiness. It is funded through a 50-cent tax on cigarettes.</li> <li>• The <b>Kentucky</b> Office of Early Childhood Development coordinates efforts to support the state’s comprehensive system for young children through the Department of Education, the Department for Public Health, the Division of Child Care, state universities, local county health departments, and mental health centers.</li> <li>• KIDS NOW (<b>Kentucky</b> Invests in Developing Success) legislation dictates that 25 percent of Kentucky’s share of the master tobacco settlement goes toward the KIDS NOW early childhood initiative, which includes maternal and child health, family support, and early care and education programs. This money is used as a state match to draw down Medicaid funding for the Health Access Nurturing Development Services home visitation program and the early childhood mental health program.</li> <li>• <b>North Carolina’s</b> Smart Start early childhood initiative informally links to health sector innovations. Smart Start has a programmatic content specialist in each content area: early care and education; health; and family support. The health specialist’s role is to collaborate with various state projects that address health issues.</li> <li>• <b>Ohio</b> recently created an early childhood cabinet of six agencies with leverage to improve linkages.</li> <li>• The Child Development Division in <b>Vermont</b> integrates child care, prevention and early intervention, food and nutrition, communities, and partnerships.</li> <li>• Reorganization of <b>Vermont’s</b> Agency of Human Services brought together under one agency three core early childhood programs from various sectors: maternal child health services from the Department of Health; early childhood and family mental health services from the Department of Mental Health; and Part C/IDEA services from the Departments of Education and Health. These services are delivered via one Children’s Integrated Services Team at the regional level for pregnant/postpartum women, infants, and children from birth to school age and their families.</li> <li>• <b>Virginia’s</b> Plan for Smart Beginnings, developed through a partnership of the Governor’s Working Group and the Virginia Early Childhood Foundation, integrates the early childhood health, mental health, family support, and early learning sectors in an effort to meet certain goals. The new Office of Early Childhood Development has a joint staff position in the Departments of Social Service and Education and will be appointing a health liaison.</li> <li>• <b>Washington’s</b> Early Learning Advisory Council is composed of appointees from both the public and private sectors and is charged with making recommendations to the state’s Department of Early Learning. The State’s Office of Maternal Child Health, part of the Department of Health, coordinates the Early Childhood Comprehensive Systems grant and Kids Matter; it also encourages connections with the Department of Early Learning’s efforts to coordinate early learning services.</li> </ul>
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TABLE 2: CONTINUED

<p><b>PUBLIC/PRIVATE PARTNERSHIPS</b></p>	<ul style="list-style-type: none"> <li>• <b>Connecticut</b> Help Me Grow is a program of the Connecticut Children’s Trust Fund. It works with the United Way of Connecticut/Infoline; the Connecticut Birth to Three System (Part C in Connecticut); the Title V Children with Special Health Care Needs Program; and the Department of Education Preschool Special Education Program. It is supported by both state and private funding.</li> <li>• Health and early learning efforts in <b>Illinois</b> share a common vision. Advocates, policy makers, and primary health care providers have pursued school readiness and health policy efforts through the Birth to Five Project, the Illinois’ Build Initiative, and other collaborations that promote children’s physical, cognitive, social, and emotional development.</li> <li>• The <b>Michigan</b> Early Childhood Investment Corporation (ECIC) grew out of a strategic planning process led by the state Office of Maternal and Child Health and is financially supported by the ECCS initiative. The ECIC is a public, nonprofit corporation charged with implementing the Great Start System Blueprint (ECCS strategic plan). Key Blueprint goals include: establishing medical homes for all young children; creating a system of care for early childhood social and emotional health; improving child care quality; increasing capacity and coordination of parenting programs; and developing Great Start infrastructure at the state and local levels.</li> <li>• <b>North Carolina’s</b> multi-sector Smart Start initiative has received \$203.6 million in state funds and raised more than \$257 million in donations since it began.</li> <li>• Thrive by Five <b>Washington</b> was created by public and private funding, and key players from each sector serve on its board. It routinely coordinates initiatives with the Department of Early Learning, the Office of the Superintendent of Public Instruction, and other agencies such as the Department of Health and local health jurisdictions.</li> </ul>
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TABLE 2: CONTINUED

<p><b>DATA SHARING AND LINKAGE</b></p>	<ul style="list-style-type: none"> <li>• The <b>Connecticut</b> Help Me Grow program includes a data collection system that identifies service gaps and barriers to obtaining appropriate services. The program maintains data on the time it takes to find an appropriate service, the number of follow-up calls needed to connect families to services, and the number of families who have not been served. Since referrals to Help Me Grow, Part C services, Children with Special Health Care Needs, and Preschool Special Education all go through the Child Development Infoline, Connecticut is able to monitor utilization of a broad array of early childhood services. This combined referral database can be used to help legislators understand the demand for services and systems that ensure the needs of children are addressed. The Early Childhood Education Cabinet also has established a standing committee on accountability that will address the need for data system compatibility.</li> <li>• <b>Illinois</b> uses a data warehouse to provide data to medical homes, including data related to claims, involvement in early intervention services, and other sources (e.g., childhood immunizations).</li> <li>• The <b>Michigan</b> Department of Community Health operates the Michigan Care Improvement Registry, a secure electronic database that consolidates immunization information about adults and children from multiple providers. The MCIR is linked with vital records, Medicaid, Women, Infants, and Children, the Department of Education, and Lead Screening and is accessible to health care providers and schools. Tribal data also is included.</li> <li>• <b>Rhode Island's</b> KIDSNET enrolls every child at birth or first immunization; some teens also are enrolled. The system connects WIC, Early Intervention, screening, and all programs involving preventive care. It provides real-time data access to doctors and school nurses for clinical visits, school entry information, and Head Start. Funding for KIDSNET comes from the federal government (the Immunization Program, the U.S. Centers for Disease Control's Early Hearing Detection and Intervention, and the U.S. Department of Health and Human Services' State Systems Development Initiative), along with state vaccine accountability funds (assessed from insurers) and some state budget dollars.</li> <li>• <b>Vermont's</b> Bright Futures Information System is a Web-based data management and information system; it provides information for parents and child care providers on child care, early education, school-age care, and available services. The state plans to expand BFIS to include prevention and early intervention services, including direct services to children and families and consultation services to child care programs.</li> </ul>
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TABLE 2: CONTINUED

<p style="text-align: center;">SETTING THE FRAMEWORK FOR LOCAL IMPLEMENTATION</p>	<ul style="list-style-type: none"> <li>• <b>California, Michigan, and North Carolina</b> allow funded communities to meet their goals by finding the appropriate mechanisms to coordinate resources and services for young children. State policies provide the framework for local work. The states require that health services be included. Michigan and North Carolina require community strategic plans that include a specified scope of contractual work. All three states pay local communities to develop structures to coordinate resources and services for young children.</li> <li>• <b>Connecticut's</b> Early Childhood Education Cabinet is partnering with private philanthropy to provide grants for local communities to develop early childhood plans that address the comprehensive needs of children. The Children's Fund of Connecticut and the William Caspar Graustein Memorial Fund have provided additional incentive grants to ensure the inclusion of health partners and attention to health concerns. Eight communities have received these additional grants.</li> <li>• <b>Kentucky's</b> county-based Community Early Childhood Councils represent various agencies that are involved with early childhood services, including child care, mental health, early intervention, local health departments, education, county extension, child welfare, and families.</li> <li>• <b>Iowa's</b> Title V agency requires local health agencies to coordinate with Community Empowerment, a partnership between local communities and state government, to build a comprehensive and integrated system of supports and services for young children and their families.</li> <li>• <b>North Carolina's</b> multi-sector Smart Start initiative has reserved funding for local partnerships to pilot projects using two health models: ABCD (developmental screening in health settings) and NAP SACC (nutrition in child care centers). They chose these models because they are evidence-based and have clearly defined outcomes, potential to spread statewide, and evaluation plans.</li> <li>• <b>Vermont</b> has 12 Building Bright Futures (BBF) regional councils that mirror the state council and enable community-level systems building. Each BBF regional council brings together parents, providers, employers, and others at the community level to support creation of an integrated early childhood system; develop a regional plan; advise the state BBF state council; and monitor child and family outcomes.</li> <li>• In an effort to spread <b>Virginia's</b> collaborative early childhood model to local communities and share the lessons learned regarding braiding and blending of funding, referral systems, data collection, and screening, the Home Visiting Consortium will conduct workshops to encourage communities to operate across sectors.</li> <li>• <b>Washington</b> Kids Matter, a public-private partnership between the ECCS grant, the Head Start State Collaboration Office, the Foundation for Early Learning, and the Build Initiative, is focused on developing a statewide framework for thinking, planning, and acting strategically to promote a common vision and language across sectors. Many communities use the framework and have requested help with implementation. The Kids Matter framework is being used to organize and structure policy and funding discussions that cut across the critical sectors of comprehensive early childhood systems efforts. The Department of Early Learning is helping to fund early learning partnerships in local communities, and Thrive by Five Washington is supporting communities' efforts to expand public-private partnerships.</li> </ul>
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## OUTCOMES

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As states implement policies to support service linkages across multiple sectors, including health, they set goals and measure progress in order to determine outcomes for children and families. This evaluation process must be thoughtfully planned, executed, and re-examined. Some researchers have argued for a truly integrated system that optimizes development and health status, as opposed to moving from a fragmented system to a more coordinated one.<sup>51</sup> Additionally, funders of early childhood initiatives, including states, are increasingly emphasizing results-based accountability (RBA), which provides a clear framework from which to track and measure progress and outcomes over time; a minority of project participants report using RBA.<sup>52</sup> Several states point to initial success in improving child outcomes as a result of multi-sector linkages and integration of services.

### MEASURING PROGRESS

States need clear performance measures and program indicators to track progress, and they have different kinds of measures from which to choose: input measures (such as an increase in number of screens); process measures (such as better connection to referral); and outcome measures (such as timing of entry into Early Intervention or parent/patient satisfaction). In 2001, the School Readiness Indicators Initiative convened state policy and data experts from agencies in 17 states to develop measurable child outcome and system indicators focused on school readiness with strong health status and health systems components.<sup>53</sup> Other lists of suggested school-readiness outcomes have been developed, and one project participant recommended re-examining the usefulness of Healthy People 2010 and HEDIS measures in multi-sector initiatives.<sup>54</sup> However, a consensus list of indicators for early childhood systems and school readiness does not yet exist.<sup>55</sup>

Figuring out what data exist and how they can be accessed presents another hurdle. Sometimes the desired data simply do not exist. Some project participants assess coordination and duplication of various programs over time, as evidenced by joint agency efforts. Others focus on child development indicators, developing shared indicators across agencies, for example. Many states attempt to monitor performance using common quality standards to document improvement in child health indicators.

A future option for states is a set of 36 early childhood indicators recently proposed for ECCS; the list includes outcome indicators as well as a variety of system, program, and process indicators related to population-based risk, health and medical homes, special needs, social-emotional development and mental health, and early care and education.<sup>56</sup> Fifty-state data exist for most of the performance measures, making them a possibility for all states.

Examples from the states included in this project include:

- Connecticut, Iowa, Michigan, and Vermont use results-based accountability.
- Michigan's Great Start Collaboratives (GSC) and the Early Childhood Investment Corporation use a common set of early childhood results and data indicators to determine current status, assess progress, and set targets for improvement. An annual report to the community on the status of young children is published by each GSC. In addition, the state Board of Education sponsored the creation of Early Childhood Standards of Quality for preschool and for infants and toddlers (ECSQ). The ECSQ were developed collaboratively by staff from state and local agencies as well as parents. The ECSQ define standards for early care and education programs and provide a framework for understanding and assessing children's development.
- North Carolina's Smart Start's Performance-Based Incentive System requires 3 percent of the total birth-to-5 population to be identified and receive early intervention services and 70 percent of Medicaid-eligible children to obtain well-child care. The state identifies data sources for measurement. Other health standards that local partnerships may choose for measurement relate to dental health, infant mortality, body mass index, elevated lead levels, and child abuse and neglect.

- Each of Vermont's Building Bright Futures regional councils has completed a draft plan that focuses on several priority areas. Key indicators include: child abuse and neglect; smoking during pregnancy; child care center quality; childhood obesity; and school readiness.

### **INITIAL SUCCESSES**

Despite challenges associated with establishing, implementing, and sustaining state policies to assure cross-sector service linkages or integrated services for young children, participating states shared many examples of initial success. In addition to anecdotal evidence about improved coordination among once-siloed departments and agencies, states shared specific achievements related to both processes and outcomes:

During the 2006-2007 program year, Connecticut's Help Me Grow program increased receipt of calls by 16 percent and referrals to community-based agencies by 60 percent. The program connected 86 percent of referred families to services. More than 3,000 families are enrolled in the Ages and Stages Monitoring System.<sup>57</sup>

Since incorporating developmental and social-emotional screening and referral into early childhood and health programs, Illinois has experienced a 30 percent increase in developmental screening for Medicaid-enrolled children, as well as a significant increase in children being screened and ultimately served by Early Intervention.

Kentucky's home visitation program, HANDS, intended to provide health and family support services that foster healthy child development, has documented a reduction in birth defects and significant differences in pre-term births, low birth weight, infant mortality, and abuse and neglect rates between HANDS enrollees and non-enrollees. As a result of a Health Resources and Services Administration (HRSA) perinatal depression grant, all HANDS participants are screened for perinatal depression, with appropriate referrals to the Early Childhood Mental Health Program.

In North Carolina, the ABCD and Smart Start initiatives have resulted in more children receiving quality well-child exams that promote health and school readiness. The number of referrals to Early Intervention has gone up dramatically, increasing 15 percent in the last year even as eligibility requirements tighten. Comprehensive medical care is provided through medical homes, which are required to coordinate referrals, and all recommended services are provided during well-child visits. Since the inception of Smart Start more than a decade ago, children in North Carolina are more likely to be immunized on time and have a regular source of health care. The coordination and effectiveness of local service agencies has greatly improved.

Rhode Island documented the effectiveness of integrating developmental screening into health and family support programs such as universal newborn risk assessments, home visiting, and Early Intervention, with a decline in the average age of enrollment in EI.

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## CONCLUSION

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To foster child health and development, states can implement a variety of policies to support service coordination across the many sectors that serve young children, including health. State health policies can coordinate services for young children by promoting streamlined policies and processes for program eligibility, screening and assessment, referral, training, and financing across multiple sectors and with primary health care providers. State policies also can create and sustain the systems and infrastructure needed for multi-sector coordination by promoting and funding cross-agency planning and governance structures, data sharing and linkages, and integration of services at the community level.

Although the initial intent of this project was to identify state health policies that promote service linkages across at least three sectors (e.g. health, early learning, family support, early intervention), such broad multi-sector linkages are difficult to identify; as a result, examples of two-sector linkages are included.

Participating states identified a number of success factors, barriers, and opportunities to implement policies that promote the health sector as a key component of multi-sector service linkages for children.

### CRITICAL SUCCESS FACTORS

- A public health approach to childhood health and development promotes the health sector as critical to broader early childhood initiatives. Such a framework recognizes the important role of social, economic, and political determinants of health, and it responds to the changing needs of children in order to support their continued health and development.
- Using early child development as an umbrella under which health, early learning, family support, and early intervention services fall helps create an inclusive framework for state planning and policy development. It is easier to promote multi-sector coordination that includes health to policy makers if its relationship to school readiness is made clear. However, when addressing primary care providers, focusing on health outcomes that are essential for school readiness proves more effective.
- There is much work to be done to integrate services even within the health sector. However, it is possible to promote multi-sector service linkages that include a health component while simultaneously addressing the need to better coordinate health sector services. Multi-sector linkage can lead to better linkages within the health sector, and vice versa.
- Much of the work toward service integration and coordination needs to occur at the community level. State-supported community-based initiatives can balance state requirements with local flexibility, allowing communities to address local needs, design appropriate programs, and allocate resources effectively while holding communities accountable to state agencies for program outcomes.
- Executive agency and legislative champions (such as governors, directors/deputy directors, legislators) at the state level are critical. Legislative and deputy-level champions can help promote continuity and momentum through changes in executive-level leadership.
- Cross-sector linkages are about relationships. Relationships among state agencies and private partners (including medical providers, the business sector, and foundations) at both the state and local levels are critical. A state's formal early childhood infrastructure may not be as important as the trust, commitment, and dedication required to link programs and services (e.g. using policy, grant, and contract language that encourages and promotes specific linkages).
- Federal health programs and policies can provide opportunities for multi-sector linkages (e.g. Medicaid EPSDT program, Medicaid/Title V agreements, ECCS program, Healthy ChildCare America).

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**BARRIERS**

- While recognizing the benefit of identifying and linking children and families to needed health services, states realize there is limited capacity to meet those needs. There are insufficient resources to address infant and early child mental health needs in many parts of the country, for example.
- Primary care providers and public health agencies and programs focus on broader health outcomes and thus do not always perceive themselves to be part of school readiness activities and care and support systems. At the same time, school systems and early learning programs do not always feel they are part of the system that promotes child health.
- Although federal health programs and policies can promote linkages, they also can create barriers (e.g. proposed Medicaid rule changes). Categorical funding also can lead to siloed programs.
- Technological and policy-related barriers to data sharing limit integration of health and other data sources.

**OPPORTUNITIES**

In order to move forward, states can adopt or adapt the examples from the 12 states featured in this project. These states have implemented policies and financing mechanisms that foster coordination and linkages, including the health sector, by:

- Coordinating eligibility policies or processes across multiple sectors so that families can more easily identify and access appropriate services;
- Coordinating cross-sector needs identification and assessment by promoting cross-sector screening;
- Establishing cross-sector communication or referral processes through centralized referral networks, case management services, and home visiting programs;
- Promoting or providing cross-sector consultation or training to link professionals and enhance skills;
- Supporting cross-agency and public/private planning, policy development, and governance by establishing or revamping state interagency structures or using less formal mechanisms;
- Sharing and linking data to coordinate services; and
- Promoting community-based cross-sector initiatives that balance state guidance and accountability with flexibility for local needs.

Identification of policies that support coordination of services for young children across multiple sectors, including health, can set the stage for broader linkages that better address the comprehensive health and development needs of young children. A multi-sector approach requires programs in health, early learning, family support, and early intervention to contribute their unique strengths while being flexible and willing to modify their approaches to promote integration. Although the goal of comprehensive multi-sector service coordination remains elusive, these states provide models that will guide further coordination so that children and families receive needed services and supports.

## NOTES

- <sup>1</sup> Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, D.C.: National Academy Press, 2000), p.5.
- <sup>2</sup> Institute of Medicine, *Reducing Risks for Mental Disorders: Frontiers for preventive intervention research* (Washington, DC: National Academy of Sciences, 1994); Carnegie Task Force on Meeting the Needs of Young Children. *Starting Points: Meeting the Needs of our Youngest Children* (New York, NY: Carnegie Corporation of New York, 1994).
- <sup>3</sup> Ibid.
- <sup>4</sup> Centers for Disease Control and Prevention; “National Center on Birth Defects and Developmental Disabilities (NCBDDD)” (11 June 2008); National Center on Birth Defects and Developmental Disabilities. Retrieved August 20, 2008. <http://www.cdc.gov/ncbddd>.
- <sup>5</sup> Framework developed by the Early Childhood Systems Working Group, a collaborative group of national organizations; Early Childhood Systems Working Group. Retrieved 20 August 2008. [http://www.zerotothree.org/site/DocServer/ECD\\_System\\_and\\_Core\\_Elements\\_Slides\\_Final.pdf?docID=3781](http://www.zerotothree.org/site/DocServer/ECD_System_and_Core_Elements_Slides_Final.pdf?docID=3781)
- <sup>6</sup> The W.K. Kellogg Foundation’s focus is on children from birth through age 8.
- <sup>7</sup> Linkages between the health care delivery system and the public health system were outside the scope of this study since both systems reside within the health sector.
- <sup>8</sup> Pediatric primary care and primary health care providers in this report refers to pediatricians, family practitioners, nurse practitioners, and physician assistants.
- <sup>9</sup> Charles Bruner, *Building Bright Futures: A Systematic Approach to School Readiness*. (Washington, DC: National Governors Association Center for Best Practices, forthcoming).
- <sup>10</sup> Rhode Island KIDS COUNT; *Getting Ready: Findings from the National School Readiness Indicators Initiative* (Providence, RI: Rhode Island KIDS COUNT, February 2005).
- <sup>11</sup> Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*.
- <sup>12</sup> Robin Peth-Pierce, *A Good Beginning* (Bethesda, MD: The Child Mental Health Foundations and Agencies Network, 2004). Retrieved 20 August 2008. <http://www.case1.org/downloads/goodbeginning.pdf>.
- <sup>13</sup> Helen Stebbins and Jane Knitzer, *State Early Childhood Policies* (National Center for Children in Poverty, Mailman School of Public Health at Columbia University, 2007), p. 2.
- <sup>14</sup> Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*.
- <sup>15</sup> Neal Halfon, Helen DuPlessis, and Moira Inkelas, “Transforming the U.S. Child Health System,” *Health Affairs* 26, no. 2, March/April 2007, 315-330.
- <sup>16</sup> Public health in this context does not refer only to formal public health agencies and programs, but rather to an approach that focuses on “fulfilling society’s interest in assuring conditions in which people can be healthy.” Institute of Medicine, Committee for the Study of the Future of Public Health, Division of Health Care Services. *The Future of Public Health* (Washington, DC: National Academy Press, 1988).
- <sup>17</sup> “Public health carries out its mission through organized, interdisciplinary efforts that address the physical, mental and environmental health concerns of communities and populations at risk for disease and injury,” Association of Schools of Public Health, <http://www.asph.org/document.cfm?page=300>.
- <sup>18</sup> Institute of Medicine, *From Neurons to Neighborhoods* (Washington, DC: National Academy of Sciences, 2000), p. 400.
- <sup>19</sup> Congress established the Program for Infants and Toddlers with Disabilities (Part C of IDEA) as a federal grant program to assist states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities and their families. Each state designates a lead agency to receive the grant and administer the program, which is often housed in Departments of Health, Education, or Rehabilitation Services. For more information, see U.S. Department of Education, “Building the Legacy: IDEA 2004: Part C – Infants and Toddlers with Disabilities.” retrieved 20 August 2008. <http://idea.ed.gov/explore/view/p/%2Croot%2Cstatute%2CI%2CC%2C>.
- <sup>20</sup> Neal Halfon, Helen DuPlessis, and Moira Inkelas, “Transforming the U.S. Child Health System.”
- <sup>21</sup> Reach Out and Read is a national organization that uses the link between pediatric providers and parents to promote school readiness and literacy, especially among children in poverty. Providers learn to give books to children at well-child visits and advise parents about the importance of reading aloud. See <http://www.reachoutandread.org/>.
- <sup>22</sup> Charles H. Bruner and Edward L. Schor, *Clinical Health Care Practice and Community Building: Addressing Racial Disparities in Healthy Child Development*, paper presented to the Institute of Medicine Roundtable on Racial and Ethnic Health Disparities Public Workshop, *Investing in Children’s Health: A Community Approach to Addressing Health Disparities* (Atlanta, GA: Morehouse School of Medicine, January 24, 2008).
- <sup>23</sup> Grantmakers in Health. *Erasing the Color Line: A Closer Look at Racial and Ethnic Health Disparities*. (November 2003). Retrieved 21 August 2008.

[www.gih.org/usr\\_doc/erasing\\_the\\_Color\\_Line\\_Report.pdf](http://www.gih.org/usr_doc/erasing_the_Color_Line_Report.pdf). Cited in Annie E Casey Foundation, *Race Matters: Unequal Opportunities for Health and Wellness*, (Baltimore, MD: Annie E. Casey Foundation, 2007). Retrieved 21 August 2008. [http://www.aecf.org/upload/publicationfiles/fact\\_sheet2.pdf](http://www.aecf.org/upload/publicationfiles/fact_sheet2.pdf).

<sup>24</sup> Ibid.

<sup>25</sup> Kay Johnson, *Building Comprehensive Early Childhood Systems*, presented at the Early Childhood System Change Meeting, Johns Hopkins Bloomberg School of Public Health, February 29, 2008.

<sup>26</sup> Joseph A. Zogby. State Early Childhood Comprehensive Systems Program Announcement Type: Competing Renewal HRSA-09-176: Program Guidance, Fiscal Year 2009 (Draft) (Washington, DC: U.S. Department of Health and Human Resources, Maternal and Child Health Bureau, Division of Child, Adolescent and Family Health, December 18, 2008) (CFDA) No. 93.110.

<sup>27</sup> Neva Kaye and Jill Rosenthal, *Improving the Delivery of Health Care that Supports Young Children's Healthy Mental Development: Update on Accomplishments and Lessons from a Five-state Consortium*, (Portland, ME: National Academy for State Health Policy, February 2008). Retrieved 21 August 2008. [http://www.nashp.org/Files/ABCD\\_II\\_Report.pdf](http://www.nashp.org/Files/ABCD_II_Report.pdf).

<sup>28</sup> Linkages are defined as connecting the child to needed services and supports while also staying connected to the child. Amy Fine and Rochelle Mayer, *Beyond Referral: Pediatric Care Linkages to Improve Developmental Health*, (New York, NY: The Commonwealth Fund, December 2006), page 2.

<sup>29</sup> Molly A. Hicks, *The Successful Integration of Health and Health Care into Broader Early Childhood Initiatives*, (Silver Spring, MD: Grantmakers for Children, Youth, and Families, April 2008). Retrieved 21 August 2008. [http://www.gcyf.org/usr\\_doc/GCYFinstIssueBrief4-08.pdf](http://www.gcyf.org/usr_doc/GCYFinstIssueBrief4-08.pdf).

<sup>30</sup> Catherine Hess et al, *State Health Policies Aimed at Promoting Excellent Systems: A Report on States' Roles in Health Systems Performance*, (Portland, ME: National Academy for State Health Policy, April 2008), p.18. Retrieved 21 August 2008. [http://www.nashp.org/Files/shapes\\_report.pdf](http://www.nashp.org/Files/shapes_report.pdf).

<sup>31</sup> Annie E Casey Foundation, *Race Matters: Unequal Opportunities for Health and Wellness*, (Baltimore, MD: Annie E. Casey Foundation, 2007). Retrieved 21 August 2008. [http://www.aecf.org/upload/publicationfiles/fact\\_sheet2.pdf](http://www.aecf.org/upload/publicationfiles/fact_sheet2.pdf).

<sup>32</sup> Ibid.

<sup>33</sup> Ibid.

<sup>34</sup> Neva Kaye and Jill Rosenthal, *Improving the Delivery of Health Care that Supports Young Children's Healthy Mental Development: Update on Accomplishments and Lessons from a Five-state Consortium*.

<sup>35</sup> Neva Kaye, Jennifer May, Andrew Snyder, *New Opportunities and Continuing Challenges: A Report from the NASHP EPSDT Forum* (Portland, ME: National Academy for State Health Policy, July 2008). Retrieved 21 August 2008. [http://www.nashp.org/Files/EPSDT\\_Forum.pdf](http://www.nashp.org/Files/EPSDT_Forum.pdf).

<sup>36</sup> The four major primary care physician groups (American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, American Osteopathic Association) have agreed on "Joint Principles of a Patient Centered Medical Home, March 2007." Retrieved 21 August 2008. <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>. However, different definitions of medical home exist, as do criteria for the types of health care providers and institutions (Federally Qualified Health Centers, local health departments, school based clinics, etc.) who can qualify as medical home providers.

<sup>37</sup> U.S. Department of Health and Human Services Administration for Children and Families, "Healthy Child Care America." Retrieved 21 August 2008. <http://nccic.org/hcca/index.html>.

<sup>38</sup> For a more detailed discussion see Cheryl D. Hayes, "Strategic Financing: Making the Most of State Early Childhood Comprehensive Systems Initiative," in Halfon, Rice, and Inkelas eds. *Building State Early Childhood Comprehensive Systems Series, No.5*. (Los Angeles, CA: National Center for Infant and Early Childhood Health Policy, January 2004). Retrieved 21 August 2008. [www.healthychild.ucla.edu/NationalCenter/FINANCE%20print%20copy%202.26.04.pdf](http://www.healthychild.ucla.edu/NationalCenter/FINANCE%20print%20copy%202.26.04.pdf).

<sup>39</sup> Sara Rosenbaum, *CMS' Medicaid Regulations: Implications for Children with Special Health Care Needs*, (Washington, DC: First Focus, March 2008). Retrieved 21 August 2008. <http://www.firstfocus.net/Download/CMS.pdf>.

<sup>40</sup> P.L. 110-252, Supplemental Appropriations Act of 2008, §7001.

<sup>41</sup> Sara Rosenbaum, *CMS' Medicaid Regulations: Implications for Children with Special Health Care Needs*.

<sup>42</sup> Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*, p. 12.

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APPENDICES

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APPENDIX A: ADVISORY GROUP MEMBERS

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<p><b>M. Jane Borst, R.N., M.A.</b>  <i>Bureau Chief</i>  Family Health Bureau  Family Services Division  Iowa Department  of Public Health</p>	<p><b>Glenace Edwall, Psy.D, Ph.D</b>  <i>Director</i>  Children’s Mental  Health Division  Minnesota Department  of Human Services</p>	<p><b>Nan Streeter, R.N., M.S.</b>  <i>Director</i>  Maternal and Child  Health Bureau  Utah Department  of Health</p>
<p><b>Rose Ciarcia, M.S.W.</b>  <i>Director, Managed Care / HUSKY</i>  Managed Care Division  Connecticut Department  of Social Services</p>	<p><b>Sally Fogerty</b>  <i>Assistant Commissioner</i>  Center for Community Health  Bureau of Family and  Community Health  Massachusetts Department  of Public Health</p>	<p><b>Justine Strickland</b>  <i>Assistant Commissioner of</i>  <i>Child Care Policy</i>  Georgia Department of  Early Care and Learning  Bright from the Start</p>
<p><b>Lesley Cummings, M.P.A.</b>  <i>Executive Director</i>  California Managed Risk  Medical Insurance Board</p>	<p><b>Martha Hiatt</b>  <i>Health/Special Projects Director</i>  Division of Child Care  Arkansas Department of Health  and Human Services</p>	<p><b>Kathy C. Vincent, L.C.S.W.</b>  <i>Staff Assistant to the</i>  <i>State Health Officer</i>  Bureau of Administration  Alabama Department  of Public Health</p>
<p><b>Paul Choquette</b>  <i>Senior Health Care Delivery</i>  <i>Systems Specialist</i>  Rhode Island Department  of Human Services</p>	<p><b>Christopher A. Kus, M.D., M.P.H.</b>  <i>Pediatric Director</i>  Division of Family and  Local Health  New York State Department  of Health</p>	

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 APPENDIX B: MEETING PARTICIPANTS
 

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**THE ROLE OF STATE HEALTH POLICY IN MULTI-SECTOR SERVICE LINKAGES  
FOR YOUNG CHILDREN, MAY 28, 2008**
**M. Jane Borst**

*Bureau Chief*  
Family Health Bureau  
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Iowa Department of Public Health

**Chris Collins**

*Program Consultant*  
Community Care of North Carolina

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Bureau of Maternal and Child Health Promotion  
State of Illinois, Healthcare and Family Services

**Ed Schor**

*Vice President*  
The Commonwealth Fund

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## APPENDIX C: STATE SUMMARIES

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**T**his appendix provides a one- to two-page summary of key information for each of the twelve states referenced in the main report. The state summaries include background information, examples of multi-sector systems and service linkages including health for young children, and, where applicable, examples of outcomes related to multi-sector system and service coordination.

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## CALIFORNIA

### Background

First 5 California, also known as the California Children and Families Commission, is dedicated to improving the lives of California's youngest children and their families through a comprehensive and integrated system of information and services to promote early childhood development and school readiness. Originally a ballot initiative passed by voters, First 5 created children and families commissions at the state and local level. A 50 cent tax on tobacco products provides funds for the state and each of the state's 58 counties to develop infrastructure, coordinate resources, and provide direct services for young children. This funding structure, in which 80 percent of the total revenue goes directly to the counties, provides local flexibility. At the same time, First 5 California uses the other 20 percent to fund programs statewide, developing policies that provide the framework for local level activity. The School Readiness Program, First 5 California's largest statewide program, includes health as one of four results-based areas (along with parenting/family support, early care and education, and improved systems of care). Additionally, other First 5 California programs include health as a component, including preschool and programs for children with disabilities. These programs fund services for children 0-5 including health and developmental screening and referrals to other state programs such as Medi-Cal and WIC. First 5's funding assists in filling service gaps and coordinating programs, including health services.

### Linkages

First 5 California partners with state and county agencies, including local First 5 county commissions, to expand access to health care by providing support for the local Children's Health Initiatives, which operate in about half of the counties.

In addition to First 5, the California Department of Health Care Services coordinates eligibility across sectors with its One-e-App web tool ([www.oneeapp.org](http://www.oneeapp.org)). This tool streamlines enrollment and retention in an array of health and social service programs, which can include health care coverage programs, WIC, Earned Income Tax Credit (EITC), food stamps, and Temporary Assistance for Needy Families (TANF). One-e-App can provide access to a multitude of health and social services programs based on county preferences. Currently, ten counties are using One-e-App. Two counties' use of One-e-App Express Lane Eligibility (ELE) in school districts is an effort to enroll children in the Medicaid program by linking enrollment to other programs with similar eligibility rules, such as Food Stamps and the school lunch program.

Additionally, the state's EPSDT program policies help promote cross-sector consultation. California EPSDT reimburses for observation of children in the preschool setting if the child is a Medicaid beneficiary and a mental health client. The observation is billable if it meets the following requirements: 1) related to psychiatric diagnosis or treatment planning, 2) delivered by a county mental health professional, or by an agency contracting with a county mental health professional that has an EPSDT contract agreement.

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## CONNECTICUT

### Background

Connecticut's Early Childhood Education (ECE) Cabinet – established in 2005 – has a set of goals and objectives designed to promote the development of all of the state's young children. The Cabinet's goals are linked to school readiness and academic performance. In 2006, the Cabinet agreed on ten priority areas of action related to school readiness. Two of these ten goals relate to the role of the health care system: 1) children enrolled in HUSKY (the Medicaid program) receive scheduled well-child visits and an annual developmental assessment; 2) there is an integrated approach to health, mental health, and education consultation to early care and education programs. In addition, a task force of the Cabinet has developed a plan for children from birth to 3 (First Words, First Steps) with action items for a variety of sectors and programs. Policy recommendations within the plan pertain to maternal health; early screening and developmental assessment; developing integrated systems of services and supports at the state and local levels; early care and education; and family support.

### Linkages

Connecticut has several innovative programs that provide linkages across service sectors, including Help Me Grow, grants to communities to integrate health into early childhood plans, Medicaid enhancements that promote service linkages, and a system of health and mental health consultation to child care settings.

Connecticut Help Me Grow is a program of the Connecticut Children's Trust Fund. It works in collaboration with The United Way of Connecticut/ Infoline, the Connecticut Birth to Three System (Part C in Connecticut), the Title V Children with Special Health Care Needs Program, and the Department of Education Preschool Special Education Program.<sup>1</sup> Help Me Grow has developed a statewide network of early childhood services to help families and providers access appropriate services for young children (birth to 8) who are at-risk for developmental, health, or behavioral problems. Program components include the Child Development Infoline, a statewide toll-free telephone number that provides centralized care coordination for developmental services, partnerships with community-based agencies throughout the state as referral resources, and child development community liaisons that serve as a conduit between the community-based services and the telephone access point. Infoline care coordinators conduct assessments and connect children to appropriate programs and services. Families are connected to community-based services and supports. Follow up is provided to ensure successful linkages. In addition to information on healthy development and care coordination, Help Me Grow provides referral feedback to providers. The Infoline is funded as a collaboration of four state agencies to serve as a single point of access for services provided by these four agencies.

A community grant program operated through the ECE Cabinet and funded through a public/private partnership, has been developed, based on the prior demonstration program funded by several foundations called Promoting Health and Learning. State and foundation funds are pooled to provide grants to support communities to develop comprehensive early childhood plans, with additional incentive grants to specifically address health as part of their school readiness initiatives. The ECE Cabinet has a Standing Committee on State-Local Partnerships that oversees the community grant program and will help ensure that the work is multi-sectoral.

Building on the earlier work of Healthy Childcare Connecticut and the ECCS grant program, Connecticut has developed its Early Childhood Consultation Program (ECCP) to support 20 mental health consultants who work with early care and education programs throughout the state. Connecticut also has a regulatory requirement that ECE programs have regular visits from a health consultant. Through the ECE Cabinet, the state is working on developing an integrated approach to health, mental health, and education consultation to early care and education settings,

building on the strengths of each of the existing consultation programs to provide an integrated approach to training and service delivery.

## **Outcomes**

Evaluations and process documentation of several Connecticut cross-sector programs have been completed: Notable results to date include:

- Twenty mental health consultants have provided services to hundreds of classrooms and served more than 2,000 children. A rigorous evaluation shows significant changes in teacher perceptions of children with challenging behaviors.
- Two Promoting Early Health and Learning community-based collaboratives have documented the feasibility of sustained involvement by child health providers in school readiness initiatives.
- Help Me Grow has enrolled more than 3,000 children in the Ages and Stages monitoring system.
- Help Me Grow has experienced double digit annual percentage increases in the number of referrals of children at-risk for developmental delay.

In addition to several program evaluations, Connecticut is also one of several states that uses results-based accountability.

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## ILLINOIS

### Background

Advocates and policy makers in Illinois have pursued school readiness efforts through the Birth to Five Project, Illinois' Build Initiative. A focus on health and early care and education improvements and partnerships has occurred under the umbrella of this project. Illinois has used a variety of health strategies to improve children's access to services and the quality of services connected to school readiness. These strategies include: enhancing maternal health through perinatal care; improving access to health care; eligibility expansions; broadening well-child care beyond physical health; promoting children's social-emotional health, and addressing children's oral health. With the help of a Perinatal Task Force, Illinois has raised awareness about maternal health, its connection to young children's development, and the need to improve access to perinatal care. Other initiatives that focus on improving the health outcomes of young children include the Illinois Children's Mental Health Partnership, Early Childhood Committee; ABCD II: Healthy Beginnings; Early Learning Council; and Enhancing Developmentally Oriented Primary Care. Illinois implemented All Kids to ensure all uninsured children under 18, regardless of income, health status, or immigration status, have access to health insurance. Illinois uses the comprehensive EPSDT benefit package for all children, regardless of eligibility enrollment (e.g., Title XIX, Title XXI, or state-funded). It is the first state to provide affordable, comprehensive health insurance for every child, as well as preschool for all.

### Linkages

The Illinois Medical Assistance program, operated by Healthcare and Family Services (HFS), emphasizes the interrelated nature of child and family health and well being by enhancing maternal health through perinatal care and broadening well-child care beyond physical health to promote children's social-emotional health. The program reimburses primary care providers for using a validated screening tool to screen all pregnant and postpartum women for perinatal depression, including mothers of all infants up to age one, covered by the Medical Assistance Program. In an effort to connect services across sectors, infants whose mothers are diagnosed with postpartum depression are eligible for Part C Early Intervention services.

Legislation in 2008, intended to increase awareness and to promote early detection and treatment of perinatal depression, requires health care professionals and hospitals that provide prenatal, postnatal, labor and delivery, and infant care services to provide education to women and their families about perinatal mental health disorders. HFS also requires providers participating in its new primary care case management (PCCM) program to include an objective developmental screening as part of an EPSDT visit for children under age three. HFS monitors and provides feedback to individual providers on performance in this area. Family Case Management agencies, generally local health departments, that are enrolled as medical providers are required to conduct objective developmental screenings for all infants and risk assessment for pregnant women who are beneficiaries of HFS' medical programs. Children in foster care state custody are assessed on social-emotional development. Child care providers are trained on all aspects of social-emotional health as well as applicable changes to HFS policies. Developmental screenings are conducted for all Preschool for All children (funded with education dollars), and referrals are made to health and other needed services. These efforts to increase screening are the first steps in connecting women and children to resources and services that can assist in promoting healthy child development.

Illinois' comprehensive perinatal depression initiative is a multi-faceted approach, consisting of provider training and a consultation line, a client crisis intervention toll-free line with expertise on community resources and triage referrals to those resources, and HFS monitoring and tracking with ongoing provider feedback. The perinatal depression initiative included a collaborative performance improvement project (PIP) in HFS' managed care program to strengthen early screening, identification, and referral for assessment and treatment as needed. Additionally, HFS strengthened its contract with MCOs, specifying required content of care for perinatal women and young children.

Illinois' policies establish referral networks and promote cross-sector consultation. Illinois' PCCM program supports a medical home model. Within this reimbursement system, primary care providers take responsibility for care coordination. Enrolled Medical Home providers receive a per member per month (PMPM) care management fee. Providers can also call a provider helpline to access a referral resource directory to identify medical professionals and community-based agencies that can help address patients' medical and other (e.g., WIC, transportation) needs.

Through a public/private partnership, Illinois has implemented the Enhancing Developmentally Oriented Primary Care (EDOPC) project. Grant dollars received from private agencies allow the state to increase developmentally oriented primary care and thus, assist HFS enrolled providers in complying with comprehensive well-child exams and needed follow-up as federally required under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program.

Illinois is using a data warehouse to provide data to medical homes, including data related to claims, involvement in early intervention services, and other sources (e.g., childhood immunizations).

### **Outcomes**

Since incorporating developmental and social-emotional screening and referral into key early childhood and health programs, Illinois has experienced a 30 percent increase in developmental screening for HFS enrolled children. This finding has proven significant, resulting in subsequent early intervention services, where needed.

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## Iowa

### Background<sup>2</sup>

In 1998, the Iowa Legislature created Iowa Community Empowerment, a collaboration of local communities and state government to help build a comprehensive and integrated system of supports and services for young children (ages 0-5) and their families. Community Empowerment is also a key partner in Iowa's 1st Five Healthy Mental Development Initiative, which teams up with community health providers to improve developmental screening for young children. The 1st Five Healthy Mental Development Initiative builds upon lessons learned from Iowa's Assuring Better Child Health and Development Initiative.

Community Empowerment is led by the Iowa Empowerment Board, which makes recommendations to the legislature and is itself supported by an interagency group of six departments called the State Empowerment Team.<sup>3</sup> Below these governing structures are county-level entities (Community Empowerment Areas), each with a local Community Empowerment Board made up of an array of community members, such as citizens, service providers, and elected officials. Financial support comes from TANF funded community grants and School Ready grants funded by the state general fund.

### Linkages

The Medicaid and Title V agencies in Iowa play a key role in supporting the coordination of services for young children across multiple sectors. Iowa's Title V agency requires local health agencies to coordinate with Community Empowerment. Iowa's Medicaid agency contracts with the Title V agency to provide consultation, technical assistance, and training pertaining to the EPSDT program including outreach, informing services, care coordination services, and/or screening services for Medicaid eligible infants, children, and youth. The Medicaid agency provides a daily list of names, addresses, and phone numbers of Medicaid clients who are eligible for EPSDT informing and care coordination services so the local contract agencies can explain the benefits of preventive health care and other services available to Medicaid families. Expenditures for the services described in this agreement are eligible for federal match through the Medicaid Program. Iowa's agreement between Medicaid and Title V makes Title V providers eligible as Medicaid providers for wraparound services such as transportation. Title V providers notify newly eligible Medicaid recipients of covered services, ask if they need help accessing services (e.g. dental, immunization, screening), and help connect them to services.

There are additional efforts related to EPSDT in Iowa that help coordinate care across sectors. The state's insurance code requires insurers who sell health insurance in Iowa to provide access to preventive health services consistent with EPSDT, which provides the opportunity to coordinate health and related community services for enrollees. Iowa uses EPSDT local care coordinators to support families and providers and help link them to community resources.

### Outcomes

Iowa is one of several states included in this project that uses results-based accountability. Local Community Empowerment Boards assess community needs, develop and implement plans, determine the use of funds, and evaluate program effectiveness. Each community must demonstrate its capacity and commitment for achieving healthy children, children ready to succeed in school, safe and supportive communities, secure and nurturing families, and secure, nurturing child care environments.

## **KENTUCKY**

### **Background**

In 2000, Kentucky passed the KIDS NOW (Kentucky Invests in Developing Success) legislation, the backbone for the state's early childhood initiative. The KIDS NOW legislation dictates that 25 percent of the state's share of the master tobacco settlement funds the KIDS NOW initiative. Programs crossing multiple sectors comprise KIDS NOW, including: home visiting, immunization, child care, mental health, and Early Intervention. Additionally, the Kentucky Office of Early Childhood Development coordinates efforts of the health, education, and social services cabinets, two university medical centers, local county health departments, and mental health centers.

### **Linkages**

KIDS Now includes the Kentucky Healthy Start in Childcare program which provides consultants to work with centers on early child development and early intervention, safety, nutrition, health, and social-emotional well being. Another component of KIDS NOW is the Early Childhood Mental Health Program, which has trained mental health specialists located regionally throughout the state to work with private practices and child care centers to help them recognize behavioral health issues and to help those with identified problems navigate the system. Kentucky's county-based Early Intervention Councils represent many agencies that are involved with early intervention services, including child care, mental health, and Early Intervention consultants.

### **Outcomes**

Kentucky's home visiting program, intended to provide health and family support services that foster healthy child development, has documented numerous positive outcomes. Kentucky has experienced a reduction in neural tube defects and significant difference in pre-term births, low weight births, immunization rate, and abuse rate between home visiting program enrollees and non-enrollees.

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## MICHIGAN

### Background

There is a strong history of interdepartmental collaboration between the Michigan Department of Community Health (MDCH), which incorporates Medicaid, Public Health, and Mental Health/Substance Abuse into a single agency, the Michigan Department of Education, and the Department of Human Services. Michigan has achieved multi-agency administration in several initiatives, for example, early intervention and abuse/neglect prevention. Coordination and collaboration is supported by the Children's Cabinet, comprised of the directors of the above agencies, plus the Department of Labor and Economic Growth. Working in conjunction with the Children's Cabinet, the Interagency Planning Team (IAPT) meets regularly to review and assist implementation of interdepartmental collaborative projects. Local counterparts to the state agencies ensure the delivery of coordinated services to children and families; community collaborative bodies support the local coordination and collaboration efforts.

The Early Childhood Investment Corporation was created in 2005 as the result of a strategic planning process led by the MDCH, which was financially supported by the federal ECCS initiative.<sup>4</sup> A public, non-profit corporation, the ECIC is able to bring state and local leaders together and solicit and receive funds from both public and private sources. The ECIC supports local Great Start Collaboratives and Great Start Parent Coalitions through the provision of funding, training, and consultation with the purpose of developing the local component of the Great Start system throughout Michigan.

### Linkages

The Michigan Care Improvement Registry (MCIR) is a secure electronic database operated by MDCH that consolidates information about immunizations and other key health indicators from multiple sources.<sup>5</sup> The MCIR is linked with the MDCH data warehouse which includes Medicaid data, and can be viewed by health care providers and schools in order to access information related to meeting their program requirements. Tribal data is also included. As the utility of MCIR is realized, other key health indicators are being added (hearing, vision, newborn screening, etc.)

Michigan formed a state level social and emotional training committee involving early childhood partners, including mental health, public health, early intervention, and Head Start. The committee is promoting common definitions and social-emotional development milestones for use across early childhood systems.

The Part C Early Intervention system, Early On, is collaboratively administered and staffed by the Departments of Education, Human Services, Public Health, and Mental Health. Staff are analyzing state-level policy in each agency to identify opportunities to better coordinate and reduce duplication of services across systems, while recognizing the need to meet outcomes in each system.

Michigan is participating in the Assuring Better Child Health & Development (ABCD) initiative, working with Medicaid, primary care providers, early intervention, and state agency and university partners to expand developmental screening and linkage to helpful services. Understanding of the early childhood system is increasing, as are referrals to Early On. The absence of a feedback loop to inform the primary care provider regarding the disposition of the referral is an outstanding issue.

Michigan has a long established, collaboratively funded and administered 0-3 Secondary Prevention initiative, designed to reduce abuse and neglect in at-risk families, while incorporating important indicators related to physical health, mental health, and early care and education. Funding from Human Services, Education, and Community Health is granted to local agencies to implement evidence-based home visitation programs in communities with high need.

Vital Records, within MDCH, is piloting a project with Public Health and Early On to link families reported to the state Birth Defects Registry with helpful early childhood services. Based on pilot results, the partners will review strategies for implementing more broadly.

Medicaid and Public Health are working with Head Start and federally qualified health centers serving migrant families to ensure that migrant children have access to health care, immunizations, hearing and vision screening within Head Start programs, and referral for other needed services.

Great Start Collaboratives (GSCs) have been established in 32 local communities. They are required to complete a results-based, data-driven community assessment process that examines assets, needs, and concerns for all components of the Great Start Initiative (pediatric and family health; early childhood social and emotional health; child care and early education; family support; economic stability; and child safety). The outcomes of the community assessment are a comprehensive, community specific strategic plan and annual Early Childhood Action Agenda. The GSCs have leveraged nearly \$3 million in new private investment for their communities. Additional funding has been designated in the budget for this next fiscal year to establish these collaboratives nearly statewide.

### **Outcomes**

The GSCs and the ECIC use a common set of early childhood results and data indicators to determine current status, assess progress, and set targets for improvement. An annual report to the community on the status of young children is published by each GSC. In addition, the State Board of Education sponsored the creation of Early Childhood Standards of Quality for Preschool, and for Infants & Toddlers (ECSQ). The ECSQ were developed collaboratively, including staff from across state and local agencies as well as parents. The ECSQ define standards for early care and education programs, and provide a framework for understanding and assessing children's development.

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## NORTH CAROLINA

### Background

North Carolina uses community care networks – networks of health care providers that deliver community directed care – to promote medical homes and care coordination. Primary care providers are paid one dollar per member per month (PMPM) to participate in Carolina ACCESS, North Carolina’s primary care case management program intended to link patients to a medical home. Network members are required to coordinate referrals to specialists and provide 24-hour coverage. Providers who choose to join a Community Care of North Carolina (CCNC) network also receive an additional PMPM fee of \$1.50 to implement a disease management process for the Carolina ACCESS patients assigned to their primary care practice. The networks receive an additional PMPM fee of \$3 to hire case managers and conduct case management, disease management, and quality improvement activities. A central data repository allows the state to set benchmarks and action plans and review data by network. The community care network structure enables all network members to have access to data in the network in one place.

Networks that expressed interest focused on healthy child development by implementing an ABCD initiative (developmental screening in health settings) to improve the rates of developmental screening and referral as part of their disease management activities. In addition to improving local linkages, outcomes were reported to the CCNC clinical directors who endorsed changes to the State Medicaid reimbursement policies, which have been changed as a direct result. An evidenced-based screening tool is now a required component of specific well visits.

Smart Start is a public-private initiative that provides early education funding to all 100 counties in North Carolina. Smart Start funds, including state funding and donations, are used to improve child care quality, make child care more affordable and accessible, provide access to health services, and offer family support. Local nonprofit organizations administer Smart Start funds. The North Carolina Partnership for Children, Inc. (NCPC), a statewide nonprofit organization, provides oversight and technical assistance for local partnerships. Smart Start is considered a model for comprehensive early childhood education initiatives, and in 2001 the NCPC established a National Technical Assistance Center to aid other states in developing an early education initiative. Funding for Smart Start is currently at \$203.6 million in state funds. Smart Start has raised more than \$257 million in donations since it began.

### Linkages

North Carolina is creating synergy among its early care and education and primary care initiatives at the state and local level. The Smart Start initiative includes health as a program area, and has a programmatic content specialist in each content area (early care and education, health, and family support). The health specialist’s role, for instance, is to interface with various state projects that address health issues.

Smart Start funds local communities to develop structures to coordinate resources and services for young children, allowing flexibility for communities to find the appropriate mechanisms to meet their goals. Community strategic plans must include a specified scope of contractual work with a health component. North Carolina’s Performance-Based Incentive System requires three percent of the total birth-to-five population to be identified and to receive early intervention services and 70 percent of Medicaid-eligible children enrolled in Medicaid to access well-child care. The state identifies data sources for measurement. Other health standards that local partnerships may choose for measurement relate to dental health, infant mortality, body mass index, elevated lead levels, and child abuse and neglect. Smart Start is now incorporating the ABCD approach by funding five new ABCD projects and is funding 10 Health Check (Medicaid) coordinators (in addition to 90 funded by Medicaid) to identify income eligible children for enrollment and increase utilization of Medicaid services, particularly preventive health services. Smart Start has reserved a pot of funding for local partnerships to pilot projects using two health models – (ABCD and NAP SACC (nutrition in child care centers). In some cases, Smart Start is funding the position within the CCNC networks.

In all counties the state programs work to bring together the CCNC Network, Smart Start, and Health Check Coordinators to maximize relationships and create efficiencies across the various agencies.

North Carolina Smart Start funds about 70 of 100 child care health consultants. The University of North Carolina at Chapel Hill functions as a training center for a mandatory state training course (as well as the National Training Institute for Child Care Health Consultants). North Carolina is considering Medicaid reimbursement for child care health consultants who participate in this state training. Smart Start also funds 25-30 child inclusion and behavior specialists who provide referrals to community resources and services.

## **Outcomes**

Comprehensive medical care is provided through a medical home, and all recommended services are provided during well-child visits. CCNC and the Division of Medical Assistance (Medicaid) continue to monitor the rate of claims submitted that are missing a required 96110 code (developmental screening). Statewide, the rate of missing 96110 codes continues to decrease, demonstrating improvements in screening rates.

The number of referrals to EI has increased from 4,719 in SFY 03/04 to an anticipated 20,000 in SFY 07/08. Physicians are now the primary referral source for early intervention services.

Since inception of Smart Start more than a decade ago, children in North Carolina are now more likely to be immunized on time and have a regular source of health care. The coordination and effectiveness of local service agencies is now greatly improved.

North Carolina has also developed a Kindergarten Health Assessment Report that is approved by the North Carolina Division of Public Instruction and the Department of Health and Human Services. The report requires developmental, hearing, and vision screening results.

## OHIO

### Background

Ohio recently created an early childhood cabinet of six agencies with leverage to improve linkages. The Early Childhood Cabinet was created by the Governor and is composed of directors from an array of agencies serving young children (ages 0-6), including the Departments of Education, Health, Alcohol and Drug Addiction Services, Mental Health, Mental Retardation and Developmental Disabilities, as well as Job and Family Services/Medicaid. The Cabinet meets regularly and is charged with promoting school readiness by improving policy across agencies, decreasing duplication.

Ohio also has a birth to 3 system, Help Me Grow, which provides funds to county Family and Children First Councils to promote a coordinated, community-based infrastructure of services for expectant parents, newborns, infants and toddlers and their families. Help Me Grow is administered by the state Department of Health's Bureau of Early Intervention Services.<sup>6</sup> Help Me Grow targets at-risk children and newborns via home visits. Help Me Grow referrals also go into Part C.

Additionally, Ohio is a VCHIP grant recipient and a Build state (Build Ohio). Build Ohio is an interagency group that convenes periodically to address early childhood health. Ohio is participating in the ABCD initiative, working with Medicaid, primary care providers, and state agency partners to expand developmental screening and linkage to referral services. Physician education is planned on billing, improving referrals for care, and ensuring feedback from referral programs.

### Linkages

Ohio's Early Childhood Cabinet is exploring ways to implement the recommendations of a state school readiness group and reviewing the state's Help Me Grow program.

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## RHODE ISLAND

### Background

Rhode Island's Department of Health administers two important projects that facilitate multi-sector service linkages for young children. The first project is KIDSNET, Rhode Island's confidential, computerized child health information system, created to help ensure all children receive appropriate and timely health screenings and preventive care.<sup>7</sup> The Department of Health also administers Successful Start, Rhode Island's Early Childhood Comprehensive Systems Initiative, which began in 2003.<sup>8</sup> Successful Start partners include community-based agencies, child care providers, and health care and mental health professionals, as well as all state departments that administer programs for young children. These partners use Rhode Island's Early Childhood Systems Plan to ensure that all young children reach their full potential through a system of services that promotes healthy social-emotional development, quality early care and education, coordinated medical homes, and effective parent education and family support services.

### Linkages

KIDSNET serves and connects families, pediatric providers, Early Intervention, public health programs (such as the Immunization Program and WIC), and all programs involving preventive care. It provides real-time data access to doctors and school nurses for a variety of uses, including clinical visits, school entry information, and Head Start. Access to this information helps ensure appropriate preventive and follow-up services are provided. KIDSNET began collecting information from all births in Rhode Island in 1997. KIDSNET also obtains information about children born out of state if they see a Rhode Island participating doctor or receive services at a KIDSNET participating program. In 2005, KIDSNET began collecting data on immunizations given to children born before 1997, up through age 18. As of April 2007, KIDSNET included information from more than 200,000 children. KIDSNET funding comes from the federal government (the Immunization Program, U.S. Centers for Disease Control's Early Hearing Detection and Intervention, U.S. Department of Health and Human Services State Systems Development Initiative) along with state vaccine accountability funds (assessed from insurers), and some state budget dollars.

Additionally, Rhode Island has integrated developmental screening into universal newborn risk assessment with follow up through its home visiting program, linked to Early Intervention. Sponsored by Successful Start, child care centers and medical homes are piloting developmental screening that will link both settings. The Rhode Island EPSDT standards have been revised, and commercial coverage is also rapidly moving to include evidence-based developmental screening.

### Outcomes

In the 1990s, Rhode Island was able to document the effectiveness of integrating developmental screening into universal newborn risk assessments, home visiting, and Early Intervention. The average age of enrollment in EI has declined dramatically as a result. Watch Me Grow Rhode Island, which provides training and technical assistance to child care providers and health care providers on developmental screening and related topics, is configured to recognize and respond to child development risks beyond infancy, including Autism Spectrum Disorders, and other significant socio-behavioral problems.

## VERMONT

### Background

Vermont's Early Childhood Comprehensive Systems (ECCS) program and Building Bright Futures (BBF)<sup>9</sup> are working together to create a statewide comprehensive plan for early care, health, and education. BBF, which is guided by a public-private State Council, was created via Executive Order by Governor Jim Douglas. Community-level systems building is provided by BBF Regional Councils in each of Vermont's twelve districts. BBF Regional Directors have been hired in each region and are mandated to expand the BBF councils where necessary to include additional partners and stakeholders to mirror as closely as possible the public/private membership of the BBF State Council.

The Vermont Agency of Human Services' (AHS) Child Development Division (CDD) is charged with improving the well-being of Vermont's children by ensuring that safe, accessible, and high quality child development services are available for every child.<sup>10</sup> CDD's work spans the following: child care; prevention and early intervention; food and nutrition; and communities and partnerships. CDD is responsible for several aspects of child care in Vermont ranging from provider licensing, tuition assistance for families, and the SStep Ahead Recognition System (STARS) that rewards child care providers for improving the quality of their programs. CDD is responsible for prevention and early intervention programs, including early childhood and family mental health, Part C, and maternal-child health services. CDD brings together funds and services that are designed to establish and support statewide, regional, and local partnerships that assist children and their families. These funds and services include Parent-Child Centers, Head Start State Collaboration, Healthy Child Care Vermont, and ECCS. CDD assists partnerships and programs through policy direction, licensing regulation, monitoring and evaluation, and technical assistance.

### Linkages

Each BBF Regional Council brings together parents, providers, employers, and others at the community level to: support creation of an integrated early childhood system; develop a regional plan; advise the state BBF State Council; and monitor child and family outcomes. State technical assistance and resources from ECCS support community planning efforts; however, the BBF funding given to local communities primarily supports administration and the regional BBF staff.

Vermont's Bright Futures Information System (BFIS) is a web-based data management and information system; it provides information for parents and child care providers about child care, early education, school age care, and the services available to ensure high quality child care. The state plans to expand BFIS to include prevention and early intervention services, including direct services to children and families and consultation services to child care programs.

The Vermont AHS offers a wide variety of services to meet family needs, such as for food and nutrition, health, mental health, family support, etc. Eligibility and contact information is available via an interactive website ([www.screendoor.vermont.gov](http://www.screendoor.vermont.gov)).

AHS reorganization in 2004 brought three early childhood prevention and early intervention programs from various sectors together into the CDD:

- Healthy Babies, Kids and Families (HBKF) with its maternal-child health services from the Department of Health,
- Children's UPstream Services (CUPS) with its early childhood and family mental health services from the Department of Mental Health, and
- Family, Infant, Toddler Program with its early intervention services for Part C/IDEA from the Departments of Education and Health (co-leads).

These services are now delivered via one Children's Integrated Services (CIS) Team at the regional level. The Regional CIS Teams function as a referral hub for access to a continuum of prevention, early intervention, and therapeutic services for pregnant/postpartum women, infants, and children birth to school-age and their families. Referrals flow to CIS from a variety of providers, including mental health, child protection agencies, schools, WIC, parent-child centers, and other community support agencies. CIS activities include: outreach; early identification and referral; multidisciplinary assessment and evaluation; individualized child and family outcomes planning; service delivery; and transition.<sup>11</sup>

Connections between the child and family's medical home and CIS providers are a critical part of the CIS structure. Efforts are underway to link the American Academy of Pediatrics 2008 Bright Futures Guidelines with regional CIS teams as a common framework for assuring the healthy development of infants, children, and their families. In state fiscal year 2010, a new performance-based financing structure will further support the CIS Team by blending funding from Medicaid, general funds, and Part C. This funding will enable CIS systems to provide cross-sector screening, referral, and assessment for individuals with a suspected developmental delay, condition, or risk in a more efficient and effective manner.

### **Outcomes**

The ECCS Coordinator and other state staff provide technical assistance to the BBF Regional Councils to develop early childhood systems plans using a results-based accountability approach. Each region has completed a draft plan focusing on three or four priority areas. Some of the indicators that are central to the plans include: child abuse and neglect; women smoking during pregnancy; quality out-of-home environments (child care); childhood obesity; and school readiness. The twelve regional plans inform the BBF State Council about common barriers to providing needed programs or services and include recommendations to the Council for changes in policies or programs to better serve young children and their families.

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## VIRGINIA

### Background

Gubernatorial leadership has been a driving force in efforts to coordinate multi-sector service linkages for young children in Virginia. In 2005, then Governor Mark R. Warner created the Virginia Early Learning Council, a public/private task force of leaders, to make recommendations for improving the state's early learning system. The Council focused on health, education, child care, family support (such as home visiting and parent education), the Virginia Preschool Initiative, and Head Start. The Council released a report in 2005 with key recommendations and five goal areas, each with measurable outcomes, to promote and ensure school readiness.<sup>12</sup> A priority recommendation to Governor Warner was to create a non-profit, public-private partnership, critically important in a state with a one-term Governor rule. As a result, the Virginia Early Childhood Foundation (VECF) was launched in December of 2005.

Current Governor Kaine implemented the Start Strong initiative. This initiative created a council that studied and (with others) produced a set of recommendations for a comprehensive, high quality early childhood development system.<sup>13</sup> Governor Kaine also created the Working Group on Early Childhood Initiatives in 2006, which provides a mechanism for multiple agencies to convene to coordinate services for children and families. Governor Kaine formed the Office of Early Childhood Development in 2008, a governance structure that spans the Departments of Education, Health, and Social Services, to ensure that young children (ages 0-5) and their families have access to "a seamless continuum of services and education."<sup>14</sup> The Working Group and the VECF co-lead Virginia's Plan for Smart Beginnings, a statewide comprehensive strategic plan built from the ECCS initiative. The plan provides a framework of five goals with measurable objectives and outcomes related to governance/financing, family support and parent education, early childhood education, health, and public engagement.<sup>15</sup> The comprehensive work of each goal group is led by a public and private leader, shepherding the efforts of many organizations and coalitions. The Milestones for Child Development created by state and local early child professionals<sup>16</sup> and the Bright Futures Guidelines will serve as useful tools for identifying the role health plays in school readiness and how programs can collaborate to support families.

The state is in the process of identifying efficiencies in collaborative training efforts, maximizing funding streams, effective local referral practices, and new data links that will assess needs and outcomes. The transfer of Part C program administration from the state's mental health agency to the Virginia Department of Health has been announced; transition will be completed by June 2009. This change in state structure reflects and will continue to stimulate alignment in training, data collection, and services for health care providers, home visitors and child care staff.

### Linkages

Virginia's local communities collaborate and connect to state-level activity through VECF and other grant opportunities, and are developing and implementing strategies of single-point-of-entry delivery, joint training, integrated data collection, and comprehensive assessment and evaluation.

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## WASHINGTON

### Background<sup>17</sup>

Washington State's Office of Maternal Child Health in the Department of Health coordinates the ECCS grant and Kids Matter. Kids Matter is a public-private partnership developed through a planning process that included the ECCS grant, the Build Initiative, the Foundation for Early Learning, and the Head Start-State Collaboration Office. Kids Matter represents a collaborative and comprehensive strategic framework for building the early childhood system in Washington State in order to improve outcomes for children. Kids Matter offers a framework that supports the efforts of local and state stakeholders to coordinate, collaborate, and integrate efforts that will lead to children being healthy and ready for school. The framework defines a common vision and language across sectors, which many communities use to aid in the implementation process.

Kids Matter identifies specific achievable outcomes within four goal areas: access to health insurance and medical homes; mental health and social-emotional development; early care and education/child care; and parenting information and support. Cutting across and integrated within each of these is a family support approach to achieving outcomes within the four goal areas. Kids Matter was developed with the participation of early childhood stakeholders at the community, regional, and state levels from 2003-2005. The Kids Matter Framework is being used to organize and structure policy and funding discussions that cut across the critical sectors of comprehensive early childhood systems efforts.

The Department of Early Learning (DEL) was created in 2006 as part of the recommendations of Washington Learns, an effort led by Governor Chris Gregoire to build a premier, seamless education system in Washington. It brought together: the Division of Child Care and Early Learning, formerly part of the Department of Social and Health Services (DSHS); the Early Childhood Education and Assistance Program (ECEAP), formerly with the Department of Community Trade and Economic Development (CTED); and the Early Reading Initiatives, formerly of the Office of the Superintendent of Public Instruction (OSPI). DEL coordinates state-funded early learning programs and focuses on children's earliest years of life. It also offers information and resources for parents and others who care for and teach young children.

In 2006, as momentum was building to create DEL, public and private funding partners joined to create Thrive by Five Washington, an organization to serve as a catalyst for improvements to parenting education and support, child care, preschool, and other early learning environments. A nonprofit corporation, Thrive By Five is governed by a board of directors consisting of funding partners. Early steering committee members have formed the core of an advisory committee that helps guide Thrive by Five's strategic efforts.

The public sector offers experience, considerable public resources and infrastructure, and political legitimacy. Private organizations, such as foundations and businesses, bring expertise, credibility, nimbleness, rigor, and flexible funding to an issue. Thrive by Five Washington champions positive early learning opportunities for every child, from birth to age five, so that they are ready to succeed in school and thrive in life. Thrive by Five partners with parents, early learning professionals, communities, philanthropic organizations, businesses, and government to develop a sustainable system for statewide early learning improvement—strengthening families and ensuring that all children in Washington experience positive, early learning environments.

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## Linkages

Examples of policies that support multi-sector service coordination for children in Washington State are:

- Washington State legislation that created the Department of Early Learning identified the important collaboration and coordination needed between the new department and the public-private partnership, Thrive by Five Washington.
- Through the Council on Children and Families Washington State issued an RFP for communities to integrate the state's home visiting programs, which provide health and family support services.
- Since 1995, Washington State's Child Care Health Consultation (CCHC) program has used public health nurses specially trained in children's health, child development, social-emotional development, infant/toddler care, and special health care needs in each county to provide consultation services to licensed child care settings. This is modeled off of the federal Healthy Child Care America Initiative. CCHC is funded through the federal child care block grant.
- 2008 legislation created three mental health consultation pilot programs through the Department of Early Learning, to provide mental health consultation in child care centers. The pilot programs being implemented are to demonstrate how they will support the five protective factors as identified in the national Strengthening Families through Early Care and Education Initiative.
- Washington has a web-based parent line called ParentHelp123 that includes child care, health, and food security programs. Parents enter basic information, and then staff determine eligibility. ParentHelp123.org helps Washington families apply for health and food programs online, and locate resources in their local communities. The website has health information for pregnant women, parents of new babies, and families with children. There is high satisfaction among families.

## APPENDIX C NOTES

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