**Linn Benton Lincoln Early Learning Hub**
**Strategic Planning Break-Out Sessions**
**Benton County Sunset Building, Corvallis**

April 24, 2014
8:30 a.m. – 5:00 p.m.

Welcome and Introductions – Tatiana Dierwechter, Benton County Public Health

- Goals for today
- Timeframe hand-outs of progress towards May 8th
- Reminder to check website for current information

## Session 1 – Developmental Screening

**Goal 5: Children are developmentally screened and referred**
**METRIC: ASQs for 2-60 month year old children**

### Strategies

- Inventory all places that do developmental screening to better understand opportunities for establishing consistent use of ASQs
- Promote a common message across the whole system
- Implement ASQ media campaign – "See How I Grow"
- Conduct workforce training for ASQ (Licensors, WIC, Food stamps, drug and alcohol counselors, family navigators, etc.)
- Trainings similar to Linn county could be system wide
- CCR & RS invite providers to learn more about screenings through community based trainings
- Increase parents knowledge - family training ASQ
- Need to create events for families to attend similar to Baby blast
- Information about ASQ in hospital birth packets
- Administer ASQ to siblings of children on waiting list for Head Start
- Identify opportunities in other venues – WIC, homeless shelters, home births, etc.
- Provide ASQ during intake at homeless shelters
- Link development screening with immunization to reach birth- 3 yr olds
- System to assure ASQs are sent to providers and providers are accurately referring children to services
- Develop referral pathways to CCO/ primary care providers
- Strengthen referral pathways from health providers to early intervention
- Insure early intervention referrals from ASQ
- Incentives for doctors to interpret ASQs
- Support health care professionals in administering and explaining ASQ to families and making referrals

**Opportunities**

- Inventory all venues/places that young families go to identify other natural opportunities to do outreach (e.g. schools, libraries, businesses, Boys and Girls Clubs, Parks and Recreation programs, Kindergarten Roundups, Living and Learning classes, Baby Blast events, county fair, religious organizations, farmers Market, Physician's Office, Prenatal care, School functions, Kindergarten in-take, hospitals, libraries, Wacky Bounce, Corvallis Sports Park, YMCA, USDA Home Visiting Program, doulas, La Leche League)
- Pediatricians and primary care physicians have the most access to children 0 to 3 years/ Electronic Medical Records
- Phone application for ASQ
- Kidco head start enroll children 2 months through Pre- K with ASQ
- Some CCOs are paying for completed ASQs to be turned in. Could we make that happen here?

**Gaps/Barriers**

- Access does not equal utilization
- Lots of duplication of effort – multiple screenings of some children, no screenings of others.
- Lots of duplication of ASQs, but not reported to doctor's offices, where it is reported to the State
- Some agencies using other screening methods, not ASQ.
- Existing service venues may not always screen, i.e. WIC, DHS, homeless shelters, childcare providers, Head Start waiting lists, all children on Waiting Lists
- Some agencies not trained in ASQ methodology
- Language and cultural barriers
- ASQs only available in English and Spanish
- Only 2 pediatricians in Lincoln County, and both are closed to OHP patients
- Confidentiality issues.
- Can't get screening records into medical records of child
- No wrap-around support before screenings.
- Referral pathways to CCO not clear.
- Not taking advantage of "low hanging fruit" – families with the knowledge and ability to navigate the system but don't know about the ASQs.
- ASQ is written in English and Spanish only, but our population is more diverse.
- Families don't always respond to ESD referral contacts.
- ASQ-SE also addresses Social and Emotional areas, but doctors don't use it because it's too "squishy". The SE version is a more thorough indicator, but not mandated by State.
- After diagnosis, losing a lot of families because they: a) don't want to deal with the results, b) don't know where to go to get the additional help.
- Families don't qualify when they apply, but they might in a year or two.
- Doctors want to "see how it goes" before diagnosing a child.

- Family Tree Relief Nurseries are required to do ASQ, but parent currently has to take the results to the doctor for it to "count". Not getting them to the doctor…
- CCO will be giving a baseline ASQ screenings number to the State that is way too low.
- Doctors MUST make referral to ESD or Home Visiting before anything else happens.
- Families that are "separate from the rhythm of community systems" don't participate.
- ASQs are on-line, but not as effective with parents – you get score results, but not printed results, and many families can't access technology.

**State Wide Strategies**

- State registry similar to ALERT for immunization records
- Create a parallel system to the State's Immunization system.
- Tracking numbers for the children – Ex: Head Start uses their social security number
- Develop materials in other languages

**Touch Points/timeline**

- ASQ is done by many pediatricians, early interventions and early education, DHS for child welfare kids with founded disposition
- Baby story time 0-12 months at library /parents first outing with new baby
- Wobbler story time 12-18 months
- Toddler story time 18-36 months
- Preschool 36-48 months
- Maternal home visiting at 4 months
- NFP funded home visiting for 4 month-2 years
- Healthy families 4 months-age 3
- Babies first -4 years
- Gap in childcare for homeless families
- Gap in waitlist for healthy start siblings
- Touch points 0-1 health care system, healthy families, child care settings
- Touch points 1-2 early interventions in preschools and WIC, head start at 4 years
- Dulas- home births
- Relief nursery 6 weeks- 6 years
- Access at farmers markets and libraries, gleaners, thrift stores, churches, YMCA
- Mental health 0-5 years , early childhood services intensity instrument (ECSI)
- Indoor play parks, parks and recreations, boys and girls club
- 0-1 pediatric offices

**Session 2: Access to Patient Centered Primary Care Home (PCPCH)**
**Goal 3: Families are connecting to a Patient-centered Primary Care Home**
**Metric: Increase number of children enrolled in PCPCH**

What is a PCPCH and where are they currently located in LBL?

36 PCPCH facilities in LBL:

1. Level 1 – working on getting all medical/dental providers for complete service under one roof, or near each other.
2. Level 2 – majority of medical/dental providers are available under one roof, or nearby.
3. Level 3 – all medical/dental providers are on-site (Samaritan facilities, FQHCs mostly.)

**Strategies**

- Inventory primary care providers – location and which are certified PCPCHs
- Inventory who/where are CO outreach and enrollment workers and CO sites
- Workforce training for health care providers, DHS, etc.
- Hospitals assign pediatricians/primary care providers at birth
- Utilize maternity case managers
- Provide outreach in homes through home visiting
- Develop special access needs in Lincoln County
- All early childhood providers encourage families to access PCPCH
- Media campaign general outreach – (everyone needs a provider)
- Parent education/incentives on the importance of having a primary care provider
- Build the system around the client – traveling doctors, home visits, etc.
- Dental providers – First Tooth – CCO dentists
- DHS child welfare encourage families to go to PCPCH
- Healthy Families could support PCPCH enrollment

**Opportunities**

- Children enrolled in IHN CCO are assigned a primary care provider
- All children in foster care must have a PCPCH
- DHS – differential response case managers encourage PCPCH
- Required immunizations is a driver to accessing PCPCH
- CCO innovation perinatal pilot project(s) focusing on young children
- CCO non-emergency care transportation services and funding
- Lincoln County federal grant for home visiting
- Health care facilities are being located in high schools in Lincoln County
- School based health centers located at Lincoln and Monroe Elementary
- PCPCH are certified in 3 levels of care
- Healthy kids and expansion of CO has provided more opportunities for health coverage
- PCPCH's are certified and required to do ASQs at all well-baby visits
- School/Neighborhood Navigators are working with 501J to conduct ELL intakes/enroll new Kindergarteners.
- Where are dentists in our plan? Children should see a dentist before age 3.
- Dental van travels to schools throughout all three counties
- IHN-CCO dentists can't turn children away

- Great improvements due to HK expansion, CO expansion can close the gaps with their parents
- DHS trying a new "Differential Response" approach
- Family Support and Connections – home visits to support families on the edge of abuse.

**Gaps/Barriers**

- Access is not utilization
- New system confusing to healthcare workers/managers if not deeply involved in health care transformation in Oregon
- Children are assigned to a primary care provider, but there is no follow up
- Providers are unaware that the child has been assigned to them
- Usually not assigned a pediatrician at birth, unlike OHP
- Lincoln County only has two pediatricians and they are no longer taking IHN CCO clients (clients may be driving to Benton County for services) Shortage of medical personnel
- Shortage of medical personnel
- Difficulty finding doctors who accept IHN CCO clients
- Uninsured are going to Emergency Room or Immediate Care
- Only 3% of women who gave birth under the OHP receive home visiting services
- Don't know what children still need access to health insurance? 200+ kids in Benton County have no health insurance.
- Home Visits only reach 3% of patients in Linn County, and Linn County has 3 full-time Home Visit Nurses. Area is simply too large to cover with only 3 nurses.
- Undocumented families are often not identified until required to show proof of immunizations
- Health Fairs are not an evidence based strategy for getting people into primary care
- DHS works with abusive families, and has limited capacity to provide other prevention based child welfare services
- Patients don't always have a relationship with their provider.
- Physicians also need to change their thinking about team based care that includes community resources/referrals.
- Culture of poverty, social determinants of health

**Session 3: FAMILY RESOURCE MANAGERS**
**Goal 6: Child and family services are aligned and coordinating**
**Metric: Create Family Resource Managers to increase awareness of services**

**Role and function of Family Resource Managers (called many different things depending on service and setting)**

- Identifies at-risk children
- Conducts developmental screenings
- Attached to a medical home.

- Asks: what does the family want to happen?
- Creates bridge between agencies
- Once kids get to school, they are identified.
- Informs families about resources that are available to them, helps to meet their individual needs
- Coordinates across services
- Understands/knowledgeable of resources
- Helps families engage in their neighborhoods/communities
- Empowers families
- Connects to families
- Makes transitions more gentle for families
- Supports family through the journey of services
- Shares information about same families among agencies

**Strategies**

- Cross train all family resource managers so they have a clear understanding of resources/workforce training
- Better partner with the faith community, parish nurses, etc. Explore opportunities for embedding family resource managers in faith settings
- Promote a formal system for sharing information across agencies – release of information to addressing confidentiality while also increasing communication
- Develop common forms/intake templates
- Promote a unified approach around common themes, ex. “Everyone in the community is screening their kids. Would you like to be involved?”
- Develop MOUs/common agreements among agencies – for developmental screening, linkage to medical homes, etc.
- Inventory existing/create a new database of agencies and resources
- Identify a process for finding out who is serving families and where there is overlap
- Provide family resource manager services to people on waiting lists
- Place kiosks in early learning venues where parents can input ASQ information
- Prioritize evaluating progress against key metrics so that we know we’re doing a good job and where we can improve
- Continue to develop meaningful models for parent input into service delivery
- Parent Interest Surveys – ask them what they want. Incorporate common parent input questions across multiple agencies parent satisfaction surveys.
- Increase targeted recruitment strategies to employee diverse staff to reflect increasing diversity of our families

**Opportunities**

- Linn County service team, Benton County ACIST, Lincoln County Community Care Coordination
- School based health clinics in Lincoln city and Waldport, Corvallis and Monroe
- School based advocates in Lincoln county
- Kidco head start and early head start offer transportation and translation services

- Test out strategies – pilot programs to test our theories.
- Can 211 help us? Can we better partner to support 211 if we are underusing it?
- Faith-based communities are overlooked as a potential ally/resource.

**Barriers**

- Patient/family burnout from completing multiple forms
- Provider fatigue
- Challenging with clients needing multiple services
- Capacity challenges in some locations
- Families who don't qualify disappear from the system, but still need the services of a family resource manager/navigator
- Agencies often can't fund this role the revenue source prohibits it, or there is not enough staff capacity to provide this role.
- Families need to do this voluntarily.
- Access issue – not service gap.
- Need resources for incentives/supports (e.g. food, child care, transportation, etc.)
- Looking for more at-risk kids, but we already can't serve the families on current waiting lists
- Happening in little pockets, but not a primary/integrated model across the system so difficult to see longer term outcomes

**Session 4: Child Welfare System Metrics**
**Goal 4: Children are raised in stable and attached families.**
**METRIC: Decrease number of children/families involved in Child Welfare**
**METRIC: Decrease number of children entering Foster Care**
**METRIC: Decrease number of children re-entering Foster Care**

DHS Hand-Outs/Presentation of Current Situation (See handouts):

- 217 kids in foster care as of April 1, 2014 in Linn, Benton and Lincoln counties.
- DHS contracts additional services from local agencies.
- Need better support for families and linkages to prevention opportunities.
- Four indicators of potential problems: domestic violence, large number of children in family, drug and alcohol abuse, neglect.
- DHS tries to identify families on the edge of crisis to keep them out of DHS.

**Strategies**

- Promote general foundational education for everyone around child development and social and behavioral milestones
- Identify families early, families at risk or struggling and want to stay out of the child welfare system
- Promote linkage to more long term supports, such as alcohol and drug treatment mental health, employment, and transportation services, and affordable housing
- Pilot a strategy using indicators such as drug and alcohol use and domestic violence

- Better integrate A&D and domestic violence treatment into child welfare programs
- Develop a workforce of family navigators and family mentors that participate in shared learning/professional development
- Develop program that uses extended families and natural supports for at risk families - support the whole family
- Promote parent mentoring models that help families leaving the system. Pilot and evaluate promising practices.
- Ensure access to parenting classes that are long term (up to 1-2 years) in length and include case management services
- Establish faith based mentors for parents involved in the child welfare system
- Establish a relief nursery in Lincoln county and leverage knowledge from relief nurseries located in other counties
- Reduce duplication of ASQs conducted across multiple agencies/systems
- Coordinate with agencies to increase assignment of family to shared providers
- Inventory communities that also have lowest performing schools to identify available resources/services
- Promote team based problem solving models – eg. YST team
- Expand home visiting model used by health departments to families identified by DHS child welfare
- Integrate community mental health services into home visiting
- Provide parenting education to court ordered parents
- Use metrics that DHS is already tracking
- Advocate/expand class-based services for families that would like these services (more cost effective, allows families to build natural supports)
- Address the importance of fidelity to evidence based strategies, given funding often results in modifications to frequency of classes that reduces fidelity.
- Ensure that families that need more than a class can access more intensive services and supports
- Use an equity lens to assess if classes and opportunities equally distributed and make program modifications

**Opportunities**

- DHS – Differential Response - Senate bill 964 - multiple services provided, including contracting for case management and navigation services
- DHS self-sufficiency that provides family stability with TANF
- DHS routinely works to ensure families have access to PCPCH
- New funding available for Linn and Benton counties for targeted high risk parenting classes
- New OHA funding for mental health promotion, wrap-around, and housing services in all three counties (IHN-CCO/PH/MH grants)
- New Healthy Families programming at the Confederated Tribes of Siletz
- DHS self-sufficiency that provides family stability with TANF
- Relief Nurseries have a shared goal with DHS and child welfare
- Focus on Oregon safety model

**Barriers**

- DHS has limited/no capacity to follow up on referrals of families to other organizations (an issue not limited to just DHS)
- Additional services for tribal members are needed to address unique access needs
- Services not equitable for families speaking a language other than English
- Very few options for undocumented families to access health care insurance
- Undocumented families are very mobile
- DHS data shows that non-English speaking families come into the system much later when there are fewer options to avoid foster care placement
- Insufficient number of well trained, competent bilingual workers
- DHS is limited in their capacity to provide prevention and early intervention services
- Need mental health services that can address the language and cultural needs of Spanish speakers
- Poverty is not only about income, but how resources are allocated
- Families often need long-term assistance and their mental health and other social service needs are complex.
- Delicate balance of supporting not overwhelming families but also adhering to court mandates related to foster care.

**State Wide Strategies**

- DHS collects data on in home care, at risk, family homes and support services that can be used to inform regional and local programs. Recommend that LBL EL HUB Data and Evaluation team reviews this data and uses it for program development and evaluation.
- Review Oregon DHS's treatment recommendations to inform local gaps in program delivery

**Session 5 – KINDERGARTEN READINESS**

Goal 2: Kindergarten readiness
METRIC: Increase Kindergarten Readiness among incoming 5-year olds
METRIC: Increase test scores on assessment tests

**Strategies**

- Develop preschool - kindergarten transition process similar to model used in early intervention programming
- Survey kindergarten teachers and ask them what they would like for us to do?
- Develop an early registrations system, in conjunction with childcare providers or hospitals/pediatricians offices? To improve information sharing with schools so they already know about our children (high flyer kids who don't stay in the same daycare)?

- Proactively share information identified through early provider engagement with kindergarten teachers (i.e. teachers say that they can teach students math and reading concepts as long as the kids come in with social emotional skills to learn)
- Ready Together teaches social emotional skills, but is not high on the literacy. We need a system that teaches kids skills in communication, brain games, making them think, listen, and have flexibility, mentally.
- Explore ways to mandate schools to work with childcare centers for better communication
- Conduct a media/social marketing campaign around kindergarten readiness
- Promote a comprehensive strategy for imbedding literacy and math into all early learning opportunities (e.g. integrate math into Library story times, provide family STEM events, etc.)
- Use safe school grant model to promote common language across diverse sectors
- Support/train childcare providers in providing quality care
- Provide work force training/development in new, evidence based, and emerging best practice teaching strategies
- Engage parents in ESL classes
- Expand Even Start programs combined with ESL classes
- Provide parent training in dual-language immersion teaching strategies
- Provide parent training in social and emotional development
- Expand opportunities for preschool
- Targeted intervention for bilingual kids
- Locate preschools within K-12 buildings
- Design early learning space when building new elementary schools (e.g. new siting of Lincoln School in Benton County)
- Strengthen provider level partnerships with Confederated Tribe of Siletz
- Promote better linkages to Parks and Recreation and other enriching programs
- Assess kindergarten teachers' knowledge about early childhood literacy
- Use kindergarten registration days for ELL parents to identify younger siblings needing services
- Sponsor family activity nights that include a math component and promote opportunities for parents to connect with other parents.

**Opportunities**

- Kidco Head Start has 51 new slots
- OSU child development also has new slots
- ODE P-3 grants were recently awarded to partners in all 3 counties
- ODE kindergarten innovation grants are soon to be awarded (hopeful that our region will also pick up some of this funding)
- Linn County is hosting a social emotional training with K2 providers
- Parenting Success Network is offering Ready Together classes
- OSU School of Education is doing a great job at promoting math, integrating into the Head Start curricula
- Pediatricians office (reach out to read during well child checks )

- Kiwanis Service Club is a leader in raising funds and recruiting volunteers to support reading in our region
- School districts are mandated to work with early learning workers
- 0-3 programs in Bremerton, WA, have highest scores in the nation. Maybe invite them to provide technical assistance to us in implementing our EL Hub?

**Barriers**

- People do not see themselves as care takers, FFN (family, friends and neighbors). Don't understand the role they can play in providing support, especially those who are at-risk and non-English speakers.
- Latino parents want to know if their children are going to be tested and how they can help prepare their children
- Lack of Spanish speaking kindergarten programming
- Lack of available and appropriate space (Alsea preschool is an example of an embedded preschool. Lincoln Elementary in Corvallis previously had an Even Start program, but it was closed due to space limitations). These models promote better transitions for families and teachers/staff.
- The GAP assessment for numbers, letters and basic mathematic functions are not appropriate for all children (multiple choice test with requirements to pick answers).
- Parents are frustrated that they can't help their children with their homework because current teaching techniques are unintelligible to them.

Thank you's and Conclusion

Next Steps:

- Backbone Alliance Committee Meeting is scheduled for Tuesday, 4/29, from 8:30 -10:00 a.m. at the ESD building.
- LBCC has sent out survey asking you to vote for your preferences among four possible Mission Statements and Vision Statements. Please complete ASAP.
- Remember to review the website for all HUB information and documents.

Other:
Contacts for the Parenting Education office are Jerri Wolfe, Chair Parenting Education (541) 917-4891, jerri.wolfe@linnbenton.edu , Parenting Education Support Staff Marissa Balough, (541) 917-4908, marissa.balough@linnbenton.edu, and LeAnne Trask, (541) 917-4949, leanne.trask@linnbenton.edu.