

Using Pediatric Care and Practitioners to Ensure Children are Ready to Learn

A *MAKING CONNECTIONS* PEER TECHNICAL ASSISTANCE MATCH BETWEEN
DES MOINES, IOWA AND HARTFORD, CONNECTICUT

PEER TECHNICAL ASSISTANCE LEADS TO ACTION

*Part of a Series from the
Technical Assistance Resource
Center of the Annie E. Casey
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Using Pediatric Care and Practitioners to Ensure Children are Ready to Learn

Des Moines and Hartford Peer Match

Des Moines, Iowa

February 22-24, 2006

INTRODUCTION

Through its *Making Connections* initiative, the Annie E. Casey Foundation is working with communities across the country to improve outcomes for children and families living in tough neighborhoods. One of the principal aims of *Making Connections* is to link residents to economic opportunities, social networks, and effective services that will improve the lives and well-being of children and their families. One core result sought by the *Making Connections* initiative is that all children are healthy and prepared to succeed in school.

As part of this initiative, the Foundation offers the participating communities access to technical assistance that will help them achieve their goals for strengthening families and neighborhoods. Peer technical assistance is a particularly valuable resource they can use to address issues and solve problems they have identified in their own contexts. Peer technical assistance allows sites to meet with innovators in other communities across the country who have successfully achieved similar goals and to capitalize on the practical knowledge gained from their experiences.

On February 22-24, 2006, a team from Hartford, Connecticut traveled to Des Moines, Iowa to participate in a peer technical assistance match focused on children's developmental health. Hartford and Des Moines have exemplary programs in broadening the scope of pediatric medical care to ensure more complete preventive and developmental health care: Connecticut's "Help Me Grow" program and Iowa's "Assuring Better Child Health and Development II" (ABCD II) initiative. Both of these efforts recognize that pediatric practitioners are in a key position to identify early issues that can affect child development and readiness to succeed in school, which include medical conditions but extend to social and developmental issues as well. The match was designed to help each of these exemplary efforts build upon its own successes and adapt practices from the other to strengthen the role of pediatric practice in ensuring children are healthy and ready to succeed in school.

This report is intended to capture information from the match so it can be referenced by those that participated in the meeting and shared with others who might be struggling with similar issues. Information has been organized and synthesized so the reader, whether they were present or not, can best find the answers to the questions posed in the teams' original learning objectives.

SETTING THE CONTEXT FOR THE MATCH

The goal of the peer match was to build upon Des Moines' and Hartford's exemplary and complementary efforts to strengthen the role of pediatric practice in the early identification of medical, social, and developmental issues that can impact school readiness. Pediatric practitioners see nearly all very young children ages 0 to 5, and Medicaid covers the majority of young children with developmental issues and concerns. Pediatric practitioners are therefore well-positioned to identify issues early-on that can affect a child's development and readiness to succeed in school. Strengthening both the establishment of medical homes and the effective use of those homes in identifying and addressing developmental health issues will significantly improve child safety, physical and mental health, and age-appropriate development. These ultimately lead to young children being healthy and ready for success in school.

Both Des Moines and Hartford have strong programs that have broadened pediatric medical care to ensure more complete preventive and developmental health care.

- Hartford's "Help Me Grow" program is part of a statewide effort to ensure that pediatric practitioners identify both child and family issues that can impact child development and refer the family to a care coordinator. Through a more detailed telephone discussion with the family, the care coordinator can identify specific needs and match the family with community resources, going beyond referrals to the actual scheduling of appointments or meetings. Included in the Help Me Grow program is a community liaison who is constantly investigating and updating resources for families in the community and linking providers with one another.
- The initiative in Des Moines is part of Iowa's "Assuring Better Child Health and Development II" (ABCD II) collaborative. In Des Moines, ABCD II has developed the EPSDT/Care for Kids program, which stands for early and periodic screening, diagnosis and treatment. Through this program, child health coordinators, who are financed under Medicaid, ensure that all children enrolled in Medicaid have a medical home that meets their health needs. These child health coordinators make contact with all parents of newly enrolled children, usually through a home visit, to identify specific health issues and establish a medical home for each child. The EPSDT/Care for Kids program is administered by Des Moines' Visiting Nurse Services (VSN).

While both Hartford's and Des Moines' efforts are exemplary in their outreach to and engagement of families and their attention to identifying health and development needs of children, they have different emphases and strengths. Hartford's particular strength is in developing strong linkages between pediatric practitioners and community resources to support families, creating both a more effective referral system and a stronger network of community services. Des Moines' particular strength is getting children into regular sources of pediatric care.

Learning Objectives

Each site had specific learning objectives.

- ❖ The Des Moines team wanted to:

- Learn how to strengthen ongoing pediatric referrals to community resources, including exploring expanding care coordination through Des Moines' First Call for Help (211), and
- Better understand Hartford's focus on creating both a more effective referral system from the pediatric practitioner's office-- for medical, social and development issues--and a stronger network of community services.

❖ The Hartford team wanted to:

- Better understand Des Moines's strategies for getting children and their families into regular sources of pediatric care and strengthening the establishment of medical homes for children, and
- Deepen its knowledge of Iowa's Medicaid care coordination system and how to secure Medicaid funding for the various services provided by the system.

STRUCTURE OF THE MATCH

Participants from both sites engaged in shaping the agenda in advance of their meeting in Des Moines. The match was designed to help each site build upon its own successes and adapt practices from the other to strengthen the role of pediatric practice in ensuring children are healthy and ready to succeed in school.

The match began with a dinner where the core planning team from Des Moines and the Hartford team had the opportunity to meet each other and spend some informal time together. An overview of the next two days was provided by the facilitator and both teams shared their hopes and expectations for the exchange.

On the first full-day of the match, the Hartford team presented the Help Me Grow program to Iowa and Des Moines stakeholders. This session was followed by presentations to the Hartford team about Iowa's ABCD II initiative, Medical Home program, and EPSDT/Care for Kids program. The remainder of the day was spent in small group discussions that focused on the "nuts and bolts" and how to incorporate specific features and key elements of these programs into existing efforts at each site. The match concluded the next morning with a planning session, where both sites had an opportunity to reflect on what they had learned and identify action steps they could take in their own communities.

The Hartford team was composed by representatives from child development infoline, the Children's Trust Fund, and outreach workers, public financing specialists, pediatric practitioners, early childhood program, technical and evaluation staff. The Des Moines team included pediatric practitioners from Des Moines and Iowa City, family support providers, state and local public health officials, representatives of the 211 program, Medicaid staff, mental health workers, the local United Way early childhood staff and other funders. The match was facilitated by Jean McIntosh, who is a senior associate with the Center for the Study of Social Policy in Washington, D.C., and

documented by Becky Miles-Polka, a Des Moines consultant who is the Making Connections Technical Assistance Resource Center (TARC) liaison.

LESSONS LEARNED

Help Me Grow

Des Moines was particularly interested to learn from Help Me Grow how to strengthen ongoing pediatric referrals to community resources and build that into its own efforts. This potentially includes incorporating care coordination into Des Moines' First Call for Help (211) that goes beyond referrals to actually scheduling appointments and creating a community liaison position to expand the knowledge of community referral resources and build a network of support. This would be an enhancement to Des Moines' already strong system of care coordination and is a logical next step for a more comprehensive and integrated system.

Help Me Grow is a program of the Connecticut Children's Trust Fund working in collaboration with The United Way of Connecticut/ Infoline, (the state's telephone information and referral service), the Connecticut Birth to Three System (through the Department of Mental Retardation), and the state's Department of Education Preschool Special Education Program. Through this collaboration, these organizations have developed a statewide network designed to help families and providers access appropriate services for young children from birth to age 5 who are at risk for developmental, health, or behavioral problems.

The program includes: a statewide toll-free telephone number for accessing needed care (the Child Development Infoline); partnerships with community-based agencies throughout the state; and child development community liaisons that serve as conduits between the community-based services and the telephone access point. Child development community liaisons also conduct regional Networking Breakfasts that bring together community-based agencies to share information and brainstorm solutions to challenging issues using case-specific presentations.

Help Me Grow

"Do you have questions about how your child is learning, behaving, or developing?"

Asked in the pediatric practitioner's office, that simple inquiry often elicits a flood of questions that parents want to ask about caring for their young child. Further, pediatric visits for young children (ages 0-5) often are the only place that parents may be asked this question by a professional who can follow-up with guidance and support.

The Connecticut Help Me Grow initiative has developed a structured program that increases the likelihood that pediatric practitioners will ask this question and that there will be effective follow-up and referral to community resources to match parents and their children with services that address their child's developmental needs.

Charlie Brunner
Child and Family Policy Center,
Des Moines, Iowa

To produce its desired results Help Me Grow has three core components:

1. *Training and support of child health providers in developmental surveillance.* One key to the success of Help Me Grow is that pediatric practitioners conduct "developmental surveillance" as a part of their practice. Asking the question, "Do you have questions about how your child is learning, behaving, or developing?" is one way to open discussions about a child's development. Getting practitioners to ask this question and follow-up on the responses parents give, however, requires both training and support. Help Me Grow has developed a short, but structured, training session for practitioners in private practices, clinics, and health centers that offers them a variety of tools to use in detecting potential developmental issues in the young children they serve. Along with this training, Help Me Grow also provides practitioners with other resources such as posters and brochures that describe the Help Me Grow program and how to contact it and a prescription pad on which to make referrals to Help Me Grow. Workshops on developmental surveillance are now also presented to child care providers and parents.
2. *Help Me Grow Care Coordinators.* The second core component of Help Me Grow is the care coordinator who follows-up on practitioner referrals or direct family contacts (often made as a result of practitioner referrals). These care coordinators talk by phone with parents to further determine parental concerns and needs and then draw upon a continuously developing database of community providers to match parents with the appropriate services. Clearly, the federal IDEA program, including Part C, represents one important referral and connection, but many children who may not be eligible for Part C because of age or identified concern still benefit from developmental health services. On average, care coordinators make up to a dozen calls following contact with the practitioner and family to find a service match. The amount of time in locating appropriate services is one reason that pediatric practitioners themselves do not generally do this work.

While referrals may be for additional medically-related services, many relate to parenting education and support services, including peer support and mutual assistance groups. Help Me Grow has found that, in most instances, there are services that parents can access that can provide real help, but finding them for an individual family takes initiative and time. The care coordinators also play the critically important role of providing information back to the pediatric practitioner on the services that have been matched (so practitioners have that record for the next pediatric visit), and conducting follow-up calls with the families to ensure that they have followed-up on the referral.

3. *Child Development Community Liaisons.* The third core component of Help Me Grow is the child development community liaison, who works closely with the care coordinators in identifying and matching services. The liaisons work to continuously build the comprehensive community resources inventory that care coordinators use in their work. They also serve as consultants to the care coordinators on specific cases to identify resources for specific needs. In addition, the liaisons are on-the-ground net workers across the service-providing community, hosting semi-monthly breakfasts for community providers to: receive guidance and specific information on selected developmental issues, broaden the Help Me Grow referral system, and identify and fill gaps in services identified both by Help Me Grow and by the community providers.

Keys to the success of Help Me Grow are:

- Strong connections to the pediatric practitioner community that are established by recognizing the constraints that practitioners face in their practice and the resources and information most helpful to them;
- Skilled care coordinators who are recruited, selected, and trained to be able to perform their roles effectively;
- Skilled child development community liaisons who are also recruited, selected, and trained to be able to perform their roles effectively; and
- Overall supervision and support from the Children's Trust Fund of Connecticut that has established a learning community across all parts of the Help Me Grow system.

The Help Me Grow program has a strong research and continuous learning component that also is fundamental to its success. Help Me Grow has found that most families can receive help to support their child's development. Its work with practitioners and parents has also led to identification of specific gaps in the current system that need to be filled. Help Me Grow has developed a strong, computerized data system that enables it to categorize developmental concerns and resources, provide for timely reporting back to practitioners and parents, and maintain a "tickler system" to ensure that referrals actually occur.

Help Me Grow has developed a large variety of tools and resources for adaptation by other sites, including:

- A PowerPoint training presentation for pediatric practitioners, resource materials for pediatric offices, and prescription pads for referrals to Help Me Grow;
- Strategies, based on the taxonomy developed by the Infoline of Los Angeles, for categorizing and maintaining information about community service providers;
- Information on the client tracking system, including a forthcoming coding manual and a list of codes, used by staff to collect data on callers (the database, known as DOCS – Database of Children – is an access-based product);
- Job descriptions and work plans for both care coordinators and child developmental community liaisons; and
- Experience on developing a toll-free line that is integrated with 211 and other information services to create a seamless system for getting to the care coordinator for inquiries about developmental health concerns.

Many of the services that are identified and provided through Help Me Grow are eligible for funding under Medicaid, particularly under Medicaid's EPSDT provisions. This also may apply to the work of the care coordinators and even to some of the work of the community liaisons, although Help Me Grow has not sought Medicaid financial participation for this work. Help Me Grow also has found that many of the matches it makes for parents are with programs that exist in the community and do not charge fees (particularly those involving parent support groups) and with non-programmatic resources like faith institutions. In addition, there often are professional and Medicaid-eligible services that children need for their healthy development that can be accessed, and Medicaid funding helps to ensure parents can make use of these services and the services can continue to be offered. While this description has emphasized the pediatric practitioner as the starting point for

referrals, the Connecticut Help Me Grow program is also accessible to parents, other community resources such as child care providers, and child welfare workers.

The evaluation component includes a data collection system that identifies gaps in services and barriers to obtaining appropriate services. In addition detailed data is being collected on the time it takes to find an appropriate service, follow-up calls and hard-to- reach families. This information is being generated to help legislators understand the need for systems change involving prevention and the need for supporting services and resources for young children.

Assuring Better Child Health and Development (ABCD II)

The Hartford team was particularly interested to learn how to strengthen the establishment of medical homes for children and how to secure Medicaid funding for some of the Help Me Grow care coordination work already being conducted. Currently, Help Me Grow positions are funded through state appropriations and do not draw down federal Medicaid funding. Drawing down Medicaid funding could enable the program to expand, particularly in the area of earlier contact with children and families.

Over the last ten years, Iowa has engaged in a number of initiatives to improve the health and well-being of children and has made significant progress in building a strong system of care coordination. Among these are an existing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) collaborative, designated local empowerment areas that combine state and local funding to improve the well-being of families with young children, a Governor's Children's Cabinet, and a HRSA Early Childhood Comprehensive Systems Planning Grant. Furthermore, Iowa's Part C Early Intervention program (Early ACCESS) is focusing on improving the identification of eligible children from birth to age three and standardizing services and access across the state.

ABCD II is a collaborative initiative led by the Iowa Department of Human Services and funded through a grant from the National Academy of State Health Policy, with support from the Commonwealth Fund. ABCD II addresses three primary problems that Iowa has identified:

- Low rates of developmental/mental health screenings and anticipatory guidance;
- Difficulty in locating and connecting families with appropriate interventions; and
- Gaps and barriers in providing low-level intervention services for at-risk children and their families.

ABCD II is intended to:

- Build the capacity of Iowa primary health care providers to provide developmental surveillance and assessment, family risk assessment, and anticipatory guidance for the healthy mental development of all Medicaid eligible children from birth to age three;
- Build the capacity of Iowa's public and private health systems to promote healthy mental development through the enhancement of the delivery of Level Two services and improved linkages with Iowa hospitals and other service providers;

- Define clinical care standards for Level One and Level Two services, including surveillance, family risk assessment, and care coordination; and
- Conduct two pilot projects—one urban and one rural—to test the application of Level One system standards and linkages to Level Two services.

EPSDT/Care for Kids is developed through Iowa's ABCD II initiative. EPSDT/Care for Kids providers promotes healthy physical, mental, social, and emotional development of children from birth through age three. In 2005, Visiting Nurses Services served over 15,000 children in the program.

EPSDT is the early periodic screening, diagnosis, and treatment program for children who are enrolled in Medicaid. Each letter of its acronym represents an important component of the program:

Early:	Children should receive quality health care beginning at birth and continuing throughout childhood and adolescence including the identification, diagnosis, and treatment of medical conditions as early as possible.
Periodic:	Children should receive well-child check-ups at regular intervals throughout childhood according to standards set by the American Academy of Pediatrics. Health care may be provided between regularly scheduled check-ups.
Screening:	Children should be screened for health and developmental problems. Services shall include health history, developmental assessment, physical exam, immunizations, lab tests, health education, dental exam, and vision and hearing screenings.
Diagnosis:	Children should receive further evaluation of health or developmental problems identified during check-ups that may require treatment.
Treatment:	Children should receive treatment for health or developmental problems identified during check-ups.

The focus of EPSDT/Care for Kids is to ensure that eligible children receive preventive health care services including oral health care. This program provides:

- An explanation of the benefits of well-child medical and oral health care
- Information about the services available through the EPSDT/Care for Kids program;
- An explanation of what to expect during a well-child check-up;
- Information about health resources in the community including how and where to find them;
- Assistance with locating providers for well-child check-ups and oral health care;

- Assistance with scheduling appointments for medical and oral health care;
- Assistance with finding transportation to medical and oral health services; and
- Assistance with other support services such as translation and child care.

In Iowa, Title V agencies are eligible to bill for the care coordination services provided under EPSDT. Services are free to Medicaid-enrolled children. Thirty-one percent of children from birth to age five have a well-child visit/EPSTDT screen funded by Medicaid.

LESSONS LEARNED

After the presentations and small group discussions, participants highlighted the following key lessons that surfaced during this exchange:

- *Health care has a unique role in preparing children to enter school ready to learn.* Participants found very useful the following “school readiness equation” that Dr. Brunner offered for understanding the critical role of health care services in school success:

The School Readiness Equation

Ready Families
+
Ready Communities
+
Ready Services (Health)
+
Ready Services (Early Childhood)
+
Ready Schools
=
Ready Children

- *Initiatives such as EPSDT provide unique, sustainable funding opportunities.* Many providers are not aware of the reimbursement available to them for EPSDT services. Iowa has harnessed EPSDT to provide funding for direct services as well as care coordination and created expectations for various components of children’s health and well-being. Among them are:
 - Physical Health and Development
 - No undetected hearing or vision problems
 - No undetected congenital abnormalities/birth defects
 - No chronic health problems without a management plan
 - Immunizations complete for age

- No undetected lead poisoning
- No untreated dental caries, good nutritional habits and no obesity
- No exposure to tobacco smoke
- Physically safe environment

- Emotional, Social, and Cognitive Development
 - No unrecognized or untreated developmental delays (social, cognitive, or communicative)
 - Good self-esteem
 - Positive social behaviors with peers and adults
 - Emerging literacy

- Family Capacity and Functioning
 - Parents knowledgeable about child's physical health status and needs
 - No unrecognized maternal depression, family violence, or family substance abuse
 - No undetected early warning signs of child abuse or neglect
 - Parents feel valued as child's primary caregiver and function in partnership with the child's health care provider
 - Parents understand and are able to use well-child care services fully
 - Parents read regularly to child
 - Parents knowledgeable and skilled to anticipate and meet a child's developmental needs
 - Parents have access to consistency sources of emotional support
 - Parents linked to all appropriate services

- *Framing programs as enhancements rather than "new" is an easier way to engage policymakers who have an important role to play in creating sustainable funding streams.* Both Iowa and Connecticut have been successful in securing state investment in early childhood services. Connecticut has established the Children's Trust Fund and Iowa has established the Empowerment funding stream. Iowa has also created a reimbursement mechanism for care coordination and medical home placement through the EPSDT program. The effective cross-departmental working relationships within Iowa have supported the implementation of this programming.

- *Early detection and referral can prevent the medicalization of non-medical issues.* Many issues identified and referred for service through the Help Me Grow Program could lead to medical issues if not supported early-on through community-based resources such as peer support and parenting education programs. Examples include:
 - Maternal isolation and depression leading to children's developmental issues
 - Parenting skills; and
 - Parent management of social-emotional problems.

- *It is important to provide tailored or customized training strategies for health care practitioners.* Medical practitioners are working in an environment that is extremely demanding. This leaves very little time for new tools that are perceived to be complex and time-consuming. Both sites

have had success in the introduction of tools for practitioners that are both effective and simple. Messaging associated with the introduction of new screening tools must be short and ensure that the tool will make the provider's job easier. The training associated with the tools must be flexible and responsive. Scheduling the training can be challenging, so multiple opportunities must be created for practitioners to access training.

- *Data and evaluation are powerful levers of change.* Lessons identified on this topic include: 1) Data is a useful tool for educating policymakers. This is an iterative process. Relationships with legislators are key to presenting data that is understood and assimilated. 2) Often, children tend to get the services that are in place, not necessarily what they need. So documenting the gaps and barriers can be challenging. Connecticut noted that one of the barriers to engaging the resource provider community is being viewed as the "quality police", so they made a conscious decision early on to document what children received and not the quality of the services. 3) New models must be evaluated with a specific examination of cost effectiveness and return on investment. Connecticut has devoted significant resources to the evaluation of the Help Me Grow program.
- *To strengthen children's early health and development requires building on current efforts and creating stronger linkages across systems and resources serving young children and their families.* Connecticut built Help Me Grow by bringing together the pediatric health practitioner community, state agencies and funding streams, and local funders and community-based resource providers. In Iowa, there are a number of exemplary programs and services to identify and respond to children's developmental health needs. All these different efforts represent needed elements for 1) early identification of and response to young children's physical, developmental, behavioral and mental health needs, and 2) supporting families as their child's first teacher and respond to health and developmental concerns. At the same time, there is an opportunity, through modest additional investment, to help strengthen each of them through greater communication, coordination, feedback, and outreach.

In sum, this requires building on current efforts and creating stronger linkages across current systems and resources serving young children and their families. From the perspective of families and their young children, there should be "no wrong door" in getting what they need, and the number of steps required to get to what they need should be minimized. From the perspective of the service provider, there should be feedback on what happened to the children and families they refer to other services or supports so they can respond accordingly when they see the child or family again.

NEXT STEPS

At the end of the match, the Hartford and Des Moines teams worked on developing action plans for their respective sites based on the learning from the match that was applicable at the community and state levels.

Hartford's Plan

The Hartford team arrived in Des Moines with many questions about the funding and linking strategies used in Iowa to support children's development health. Specifically, they were interested in the role of the public health officials as champions and funders of those efforts. Their questions also focused on Iowa's concept of a "medical home" and the use of Title V agencies to link Medicaid-eligible families to health care providers—a key concept behind Iowa's definition of "care coordination."

The Hartford team identified the following set of goals for their action plan:

- Redefine care coordination as a central element within a medical home – this would broaden the medical home initiative;
- Create sustainable funding streams for care coordination through new financing models;
- Strengthen the primary care delivery system for children in Connecticut; and
- Strengthen the partnership between the Department of Public Health (DPH) and the Department of Social Services (DSS) in order to leverage Title V and Early Periodic Screening and Detection Testing (EPSDT) funding.

The Hartford team identified the following seven strategies for meeting these goals:

1. Work with senior leadership in DPH and recruit a champion.
 - Provide education.
 - Build on success of local and state programs (HOME and Help Me Grow).
2. Use the unique role of the Office of Program Management to support cross- departmental work.
3. Expose the leadership of DPH and DSS to Iowa's model of departments working together on programming and financing.
 - Conduct another peer match in Connecticut and include the following Iowa colleagues:
 - Jane Borst –Department of Public Health
 - Sally Nadolsky–Iowa Medicaid Enterprise
 - Carrie Fitzgerald–Department of Public Health
 - Susy Kell–Iowa Academy of Family Physicians
 - Andy Penziner–Child Health Specialty Clinics
 - Cheryl Jones–Child Health Specialty Clinics
4. Build or strengthen relationships among the following programs in Hartford: HOME, Child Development Infoline, and Help Me Grow.
5. Conduct a fiscal analysis of Medicaid, contracts with four managed care organizations, and EPSDT regarding financing opportunities for care coordination with credible partners.
6. HOME and Help Me Grow will meet to identify ways to support each other's programs

7. Children's Trust Fund will arrange a conference call to plan a presentation using Dr. Brunner's Children's Readiness Equation presentation at next cabinet meeting.

Des Moines' Plan

The Des Moines team initiated the match with Hartford with the specific intent of importing critical elements of Hartford's Help Me Grow program into their care coordination system for young children and their families. They wanted to learn additional strategies for helping pediatricians and primary care health professionals in Iowa inquire about the developmental health of their young patients. They also examined Help Me Grow's care coordination system—including phone consultations and referrals as well as extensive community resource outreach—to gather new ideas Iowa's ABCD II and medical home models.

The Des Moines team identified the following six strategies with multiple action steps that they want to pursue:

1. Utilize strategies and lessons learned from ABCD II pilot sites.
 - Arrange a peer match between the Dubuque, Iowa ABCD II pilot site and Polk County to spread lessons learned around care coordination to promote children's developmental health.
 - Start with the physicians and health care professionals in attendance at the peer match and use them as champions to enlist their colleagues.
 - Identify other potential champions among Polk County pediatricians, family practice and primary care physicians so that peers work to enlist their colleagues.
 - Utilize effective screening tools and "message" statement to enlist the interest of physicians and their practice colleagues.
 - Ensure that health care practitioners have a single number to call for assistance on children's developmental health and that information is relayed back to them regarding actions taken by/with the family.
 - Extract strengths of the ABCD II and medical home initiatives to frame key child developmental health messages. One idea for further consideration is to take the "CJ Story" from the Help Me Grow presentation and frame the optimal roles for physicians, Visiting Nurse Services, 211 call line, and care coordinators as examples.
 - Evaluate opportunities for integrating ABCD II and Help Me Grow practices into the medical home initiative.
2. Convene 211 and Healthy Families Information Line to better structure interface and to identify mutual training needs.
 - Assess whether it is possible to route families to one place for care coordination/resources.
 - Utilize the same format statewide for resource listings.
 - Expand the resource scan to enrich the resource base and devise better strategies to keep listings current, especially regarding family/parent support resources. Utilize information from care coordinators as part of the scan.

- Designate the Healthy Families Information Line as the primary contact for health care professionals.
 - Be prepared for budgetary and workload impacts as referrals to care coordinators increase.
 - Ensure there are no “wrong numbers” for health care professionals calling in, and develop a strategy for “closing the loop” with physicians who call in a way that minimizes “call backs” from physicians.
3. Plug the gaps for non-Medicaid eligible children and families.
- Determine who does what in both Title V and Information and Referral.
 - Explore the point(s) of access for Pact C children.
 - Assess the role and expectations of Iowa Health and Community Empowerment. Can it help with:
 - Resource development through Community Development Liaisons?
 - Training for practitioners?
 - Added care coordination capacity around linking to community resources?
 - Explore the role and expectations of FQHC.
4. Harness and align the multiple care coordination functions and programs in Iowa more effectively.
- Develop a common platform/protocol for action.
 - Explore a generalist approach (like Help Me Grow) that employs joint problem-solving between care coordinators and Information and Referral.
 - Identify strategies to support care coordinators to accomplish their goals.
5. Capture maternal depression issues alongside children’s developmental health indicators.
- Explore using the Visiting Nurse Services screening tool.
 - Identify strategies to persuade physicians to address this issue with families. For example, develop a “magic question” for the physician to ask that might open the conversation.
 - Link potential strategies to uncover maternal depression to Strategies 1 and 6 (Polk County pilot) and employ a physician champion.
 - When a child is referred for behavioral health screening, also screen the mother. One issue raised was to employ this strategy carefully as there is potential to over-medicalize situations that would benefit more from parent support.
 - Ensure exploration of home health resources.
6. To spur statewide action, engage Polk County in advocacy for ABCD II (advocacy to focus on both Medicaid eligible and non-eligible children and families).
- Plan and build statewide infrastructure to support enhancement of children’s developmental health care coordination throughout the state.
 - Utilize university expertise to engage the various professional peer groups to support statewide enhancement.

As the peer match drew to a close, participants agreed that the peer exchange had not only met but exceeded their expectations, and both teams expressed interest in continuing their dialogue as they work on next steps. Participants one-word check-out capturing this experience included words such as sharing, encouragement, inspiration, re-energizing, validation, clarity, openness, new tools, and program enhancement.

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WHAT IS *MAKING CONNECTIONS*?

Making Connections is the Annie E. Casey Foundation's initiative to improve outcomes for some of the nation's most vulnerable children and families. The initiative is conducted through deep and durable partnerships with selected cities and neighborhoods across the United States (for more information, visit www.acef.org/mc). Several core ideas underlie *Making Connections*:

- *Making Connections* is based on the recognition that the greatest numbers of American children who suffer from "rotten outcomes" live in city neighborhoods that are in many ways cut off – disconnected – from the mainstream opportunities of American life. Thus, *Making Connections* is "place-based" – it focuses on specific neighborhoods in specific cities.
- *Making Connections* has a simple theory: children do better when they grow up in strong families, and families do better when they live in supportive neighborhoods. Thus, *Making Connections* strategies are aimed at helping families obtain what they need to be strong and helping neighborhoods gain the resources they need in order to support families well.
- *Making Connections* focuses on three major types of "connections" that help families grow stronger and achieve what they want for their children. The first of these is helping families connect to economic opportunities and to jobs that provide income, assets, and an economic future. Research and experience suggest that this type of connection is unlikely without two others: strong connections to the social networks of kin, neighborhood groups, and other informal ties that sustain families when times get tough and connections to high-quality, effective services and supports that help families reach their goals.

Making Connections focuses on improving results for children and families in tough neighborhoods. The initiative aims for the following core results:

- Families have increased earnings and income;
- Families have increased levels of assets;
- Families, youth, and neighborhoods increase their participation in civic life;
- Families and neighborhoods have strong informal supports and networks;
- Families have access to quality services and supports; and
- Children are healthy and ready to succeed in school.

A key task in ensuring the success of *Making Connections* is making available learning and technical assistance that the participating sites need to move forward with their work. One of the ways that the Foundation provides this kind of support is by making peer matches available to the sites.

WHAT ARE PEER MATCHES?

Since 1995, as part of a broader effort to rely more intentionally on the experience of people working in the field, the Center for the Study of Social Policy began working with several partners and funders to develop and offer a rather intensive form of peer technical assistance known as peer matches. Peer matches are structured opportunities for teams of people from two or more jurisdictions who are working on a similar issue to exchange experiences and practical knowledge toward resolving a particular challenge that has been identified in advance.

The rationale behind peer matches is straightforward. Often, the people best able to provide hands-on help are the “doers” themselves – people from states and communities who have successfully addressed a problem or created an effective new policy or strategy. These are the people who have an acute sense of what has and hasn’t worked and why or why not. They have developed good tools and strategies they can share. And they are usually eager to help others because of a strong sense of shared mission. But while good peer matches are informal, they are never casual they use a carefully designed process and structure to focus the common interests, roles, and goodwill that exist between peers on producing meaningful change for a community.

Peer matches are a resource- and time-intensive strategy. Careful consideration of when, where, and how to use this approach is therefore always warranted. Experience has shown that careful preparation and execution of the matches are critical factors for their success. This approach tends to work best when the following conditions are in place:

- A specific problem or issue has been identified, and the people looking for help are at a key decision point with respect to the design or implementation of a state or community strategy;
- Stakeholders are invested in and have a high degree of ownership in solving a problem;
- The timing is right – e.g., a decision or action that will affect the community’s family strengthening agenda is going to be taken, and/or someone needs to be convinced to take action; and
- A reasonably small number of people have the authority and ability to act on what they learn in the match.

To date, the Center has brokered over 60 peer matches on topics ranging from creating resident-led community development corporations and governance structures to establishing multilingual homeownership assistance centers to building integrated services models. As illustrated in the case summaries that are part of this series, peer matches help spread good policies and practice, build relationships among different stakeholders who may not always have a chance to work together, and enable people to put changes in place that improve results for children, families, and neighborhoods.



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