Joint ELC/OHPB Subcommittee Recommendations

Towards Collective Impact

Prepared for:
The Early Learning Council (ELC) and Oregon Health Policy Board (OHPB)

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Executive Summary

Under Governor Kitzhaber's leadership, Oregon has initiated simultaneous transformation of its health, education and human service systems. The opportunity to align these reform efforts will dramatically influence our ability to meet desired short and long-term outcomes and position Oregon for success in the global economy of the 21st century.

Based on the charge from the Oregon Health Policy Board and Early Learning Council, the goal of the Joint ELC/OHPB Subcommittee ("Joint Subcommittee") was to develop strategies, a policy framework and a timeline to ensure alignment and/or integration between health and early learning system transformation. After seven meetings and review of existing research, we make the following recommendations to achieve our desired outcomes. Our recommendations are based on a collective impact approach, whereby no single entity has the resources or authority to bring about the necessary change. It requires a systematic approach including disciplined and integrated relationships across health, early learning and human services that drive progress toward shared outcomes. The structure of this report and our recommendations reflect the five conditions of collective success as described by the authors of Collective Impact (Kania & Kramer, 2011): common agenda, shared measurement systems, mutually reinforcing activities, continuous communication and backbone support organizations.

The Joint Subcommittee imparts a sense of urgency to address the foundations of health and education outcomes and to meet the needs of Oregon's children. Many of the proposed recommendations can be implemented immediately. Where a step-wise approach is needed, a four year implementation timeline has been proposed.

Summary of straw proposal recommendations:

- *Adopt this collective impact framework to guide the joint work of the Early Learning Council and Oregon Health Policy Board.*
- *Designate kindergarten readiness as the common agenda for the Oregon Health Policy Board and Early Learning Council with a focus on equity.*
- *Adopt kindergarten readiness as a shared outcome with the included implementation timeline.*
- *Establish shared incentives linked to joint outcomes.*
- *Adopt the Child and Family Well-being measurement strategy and identify a technical advisory committee to support implementation.*
- *Identify additional resources to ensure capacity for cross-system learning and health information exchange dedicated to care coordination.*
- *Adopt and implement a statewide system of developmental screening including identified core components.*
- *Renew the Joint ELC/OHPB Subcommittee Charter with new deliverables focused on a shared measurement strategy, care coordination, information exchange and shared incentives.*
- *Designate the Transformation Center as the backbone structure for fostering shared learning and alignment at the local level.*
- *Implement shared communication strategies that facilitate local, cross-system learning between health and education.*

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Introduction

> Science tells us that meeting the developmental needs of young children is as much about building a strong foundation for lifelong physical and mental health as it is about enhancing readiness to succeed in school. (Center on the Developing Child at Harvard University, 2010)

The preconception, prenatal and early childhood periods are critical for long-term health and education outcomes (Shonkoff & Phillips, 2000). An extensive body of scientific evidence shows that the most common diseases in adults (hypertension, diabetes, cardiovascular disease and stroke) are linked to negative experiences during sensitive periods in brain and other organ development, such as stress and poor nutrition (Felitti et al., 1998; Barker, 2004). Physical and mental health problems in childhood are associated with poor adult health and also impact human capital development and long-term socioeconomic status (Delaney & Smith, 2012). Health outcomes are influenced by factors well beyond medical care, including genetic endowment, social circumstances, environmental conditions and behavioral choices (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2009).

High quality, early learning environments are essential for lifelong health and education outcomes. Home visiting programs for pregnant women, infants and young children have been shown to improve school performance, employment rates, and reductions in welfare use among participants (the PEW Center on the States, 2010). Two longitudinal, preschool studies- the High/Scope Perry and Abecedarian studies- have shown significant, long-term impacts from high quality early learning programs for socioeconomically at risk children. Outcomes from these programs were broad and sustained, including: reductions in special education, crime and need for welfare, as well as increases in employment and income (Knudsen, Heckman, Cameron & Shonkoff, 2006). Researchers for the High/Scope Perry program have estimated a public return on investment of $12.90 for every dollar spent on the program (Schweinart et al., 2005).

Finally, nurturing and stable relationships are crucial for ensuring optimal health and development. “A child’s environment of relationships can affect lifelong outcomes in emotional health, regulation of stress response systems, immune system competence and the early establishment of health-related behaviors” (Center on the Developing Child at Harvard University, 2010). The absence of these solid relationships and exposure to adverse childhood experiences (ACEs) are correlated with both academic failure and chronic disease (Felitti et al., 1998).

Long-term outcomes, such as those sought by Oregon’s health and education system reform, are reliant on secure attachments between children and the adults in their lives, early health, early learning, and the investments we choose to make during the most sensitive and optimally receptive periods. As stated by Gabriella Conti and James Heckman (2011), “The evidence is quite clear: Early health and early childhood development from birth to age 5 is a form of preventive health and economic investment that drives achievement and economic returns.”

The Joint Subcommittee

With knowledge of the evidence linking health and early learning, the Joint Subcommittee was chartered by the Oregon Health Policy Board (OHPB) and Early Learning Council (ELC) to develop strategies, a policy framework and a timeline to ensure alignment between health care and early learning system transformation. Specifically, the Joint Subcommittee was charged with the following deliverables: a strawperson proposal for alignment and/or integration of health and early learning

policy and service delivery, a proposal and timeline for establishing kindergarten readiness as a shared outcome, and a proposed system of screening across health and early learning. The Joint Subcommittee was convened in December 2012 and has met a total of seven times.

The Joint Subcommittee identified the following set of principles which have guided our work:

- *As shared as possible* (community culture and change; accountability; outcomes; coordination)
- *As simple as possible* (family experience; build on existing resources; common forms)
- *As straightforward as possible* (clear communication; family-centered; customer-driven)
- *As soon as possible* (urgency to address transformation opportunities, improve outcomes)

The Joint Subcommittee previously identified a set of initial recommendations to align early learning and health system transformation. The following is a summary of these recommendations already adopted by the Oregon Health Policy Board (3/5/13) and the Early Learning Council (3/14/13):

- *Joint Needs Assessment*: CCOs and Early Learning Hubs jointly develop a community needs assessment and community improvement plan.
- *Care Coordination/Case Management:* CCOs and Hubs identify best approaches to provide joint care coordination/case management for targeted children and families.
- *Cross Governance*: establish cross governance between CCOs and Early Learning Hubs.
- *Developmental Screening*: develop a statewide measure that accounts for developmental screening occurrences across early learning and health systems. The Early Learning Council adopts the Ages and Stages Questionnaire (ASQ) as the statewide general developmental screening tool for the early learning system.
- *Transformation Supports*: the Transformation Center serves as a resource for building alignment between health and early learning at the local level.

Concurrent System Transformation

Investments in early learning remain critical to meet the state's "40/40/20" educational goals: that 40 percent of adult Oregonians have earned a bachelor's degree or higher, that 40 percent have earned an associate's degree or post-secondary credential, and that the remaining 20 percent or less have earned a high school diploma or its equivalent by 2025. During the 2013 legislative session, critical steps were taken to ensure that children enter kindergarten ready to learn, including: 1) the creation of the Early Learning Division within the Department of Education and 2) the ELC charge to establish up to 16 Early Learning Hubs across the state during the next biennium. Early Learning Hubs are coordinating bodies that pull together resources for children and families in defined service areas while focused on achieving outcomes. They must work with all sectors that touch early childhood to produce desired outcomes, including health care, early childhood educators, human and social services, K-12 school districts, and the private sector.

Concurrently, health system transformation continues to move forward to meet the goals of the Triple Aim: Better Health, Better Care, and Lower Costs. Fifteen Coordinated Care Organizations (CCOs) have been established since 2012; certification of one additional CCO as well as dental care integration is underway. With approval from the Center for Medicare and Medicaid Services (CMS), a final agreement for the Oregon Healthy Authority's (OHA) Accountability Plan has been achieved, including the establishment of 17 incentive metrics and an overall Measurement Strategy. Quarterly progress towards defined benchmarks will be shared publicly. OHA has approved the CCOs' first transformation plans and community improvement plans are expected by July 2014. Recently created within OHA, the Transformation Center will support CCOs and the adoption of the coordinated care model through

technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices among CCOs and other health plans and payers.

Strawperson Proposal and Recommendations

Collective Impact

As described by Kania & Kramer (2011), large-scale social change comes from better cross-sector coordination rather than isolated interventions of individual organizations or agencies:

> Collective impact is the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem… It requires a systemic approach to social impact that focuses on relationships between organizations and the progress toward shared objectives. (p. 36, 39)

The collective impact concept recognizes that no single entity or organization has sufficient power or resources to solve complex social problems alone. Ultimately, Oregon's achievements towards optimal health and early learning will be realized through local efforts across Oregon that address the unique needs of each community. Collective impact at the local level can serve as a helpful tool towards shared success across multiple community partners. However, in order to reduce unnecessary barriers and provide optimal support to local communities, state agencies must also break down existing silos and work collectively towards shared goals.

Recommendation 1:
Adopt this collective impact framework to guide the joint work of the Early Learning Council and Oregon Health Policy Board.

Common Agenda

According to Kania & Kramer (2011), collective impact requires that all participants have a shared vision for change, one that includes "a common understanding of the problem and a joint approach to solving it through agreed upon actions" (p 39). To optimize outcomes amidst health, human services and education reform, these systems must identify a common agenda. The ultimate goal of Oregon's broad transformation efforts is to position Oregon for success in the global economy of the 21st century and to ensure prosperity for all. For purposes of this collective impact initiative, however, the Joint Subcommittee has defined **Kindergarten Readiness** as the immediate common agenda.

What is kindergarten readiness? Kindergarten readiness means that a child enters school ready to succeed. It encompasses core areas of child development including social/emotional, physical, cognitive, and language development. Some of the most essential components of kindergarten readiness include: optimal health, a safe and nurturing environment, an eagerness to learn, the ability to follow direction, to work well with others, to recognize numbers and letters and to hold a pencil or crayon.

Kindergarten readiness is reliant on the critical role and responsibility of parents as their child's most important and life-long teachers. Kindergarten readiness is also a community issue that requires involvement of health, human service, and education supports for success. Finally, kindergarten readiness requires that communities are ready to support the needs of every child, including children with developmental delay, disability or other health care needs.

While pursuing a kindergarten readiness agenda in Oregon, attention to equity is paramount. The Oregon Education Investment Board (OEIB) and ELC recently adopted the *Equity Lens* (OEIB, 2013) which

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calls attention to the education achievement gap between communities of color, immigrants, migrants, and low income rural students compared to more affluent students. Similarly, these populations experience persistent and increasing disparities in health status (Health Affairs, 2013). To meet the goals of health and education system transformation, starting with kindergarten readiness, we must explicitly identify and address disparities to reverse these trends.

Until recently, Oregon lacked a uniform way to assess kindergarten readiness. Starting this fall, every Oregon child entering publicly-funded kindergarten will receive a composite assessment of kindergarten readiness using three validated and standardized tools: the Child Behavior Rating Scale (CBRS) and easy CBM Literacy and Math measures. This statewide kindergarten readiness assessment is completed by kindergarten teachers during the first six weeks of school. Results of this assessment will offer a snapshot of Oregon's children upon entry to kindergarten that allows 1) "a look forward" so that teachers and schools can tailor their instruction to the individual needs of children, and 2) "a look back" to assess whether community supports and services are meeting the needs of children and families.

Recommendation 2:
Jointly adopt kindergarten readiness as a common agenda for the Oregon Health Policy Board and Early Learning Council. Apply the OEIB *Equity Lens* to this joint work.

Shared Measurement System
Shared Measurement Strategy: Oregon's Child and Family Well-being
In alignment with the collective impact approach, the Joint Committee recommends the adoption of a statewide, coordinated approach to measuring child and family well-being that transcends state agencies and traditional silos. The measures will be used to drive cross-sector strategic planning, mutually reinforcing actions, and policy decisions. This measurement approach will also provide local-level data to communities to help inform priorities and improvement plans. This measurement strategy will explicitly focus attention on identifying disparities in outcomes based on age, race, ethnicity, language, and geography and calls for uniform data collection on each of these parameters. The Joint Subcommittee has prioritized a set of measure categories and associated topic areas. With the support of a technical advisory committee and public input process, the Joint Subcommittee will adopt specific measures for each of these topic areas. To implement the measurement strategy, the Joint Subcommittee recommends:

- Appointment of a technical advisory committee (to include, at minimum, representation from the Metrics & Scoring Committee, CCOs, Hubs, governmental and tribal public health systems, and other state or local health, human services and education entities)
- Creation of a public, Oregon dashboard for shared child and family measures
- Adoption of a regular reporting timeline for measures
- Development of a state-level strategic plan driven by measures
- Use of the measurement strategy to design and assess quality improvement activities

The Joint Subcommittee recommends a combination of process and outcome measures to support the developmental progress towards achieving kindergarten readiness (see example dashboard below).

Recommendations 3:
Adopt the Child and Family Well-being measurement strategy and identify a technical advisory committee to support implementation in 2014.

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Example: Child and Family Well-being Dashboard

Family Stability

- Adverse childhood experiences (ACEs)
- Housing and food security
- Child maltreatment
- Domestic Violence
- Poverty
- Employment

Education

- Quality Childcare
- School Readiness
- 3rd Grade Math
- Absenteeism
- High School Graduation
- College Graduation

Prevention

- Screening , follow-up
- Immunization
- Unintentional injury
- Pregnancy intendedness
- Physical activity

Health Care and Access

- Insurance status
- Patient experience of care
- Mental health
- Preventive visits (prenatal, well child, adolescents)
- Alcohol and drug treatment

Systems of Care

- Care coordination
- Transitions of care
- Health home
- Data alignment

Kindergarten Readiness

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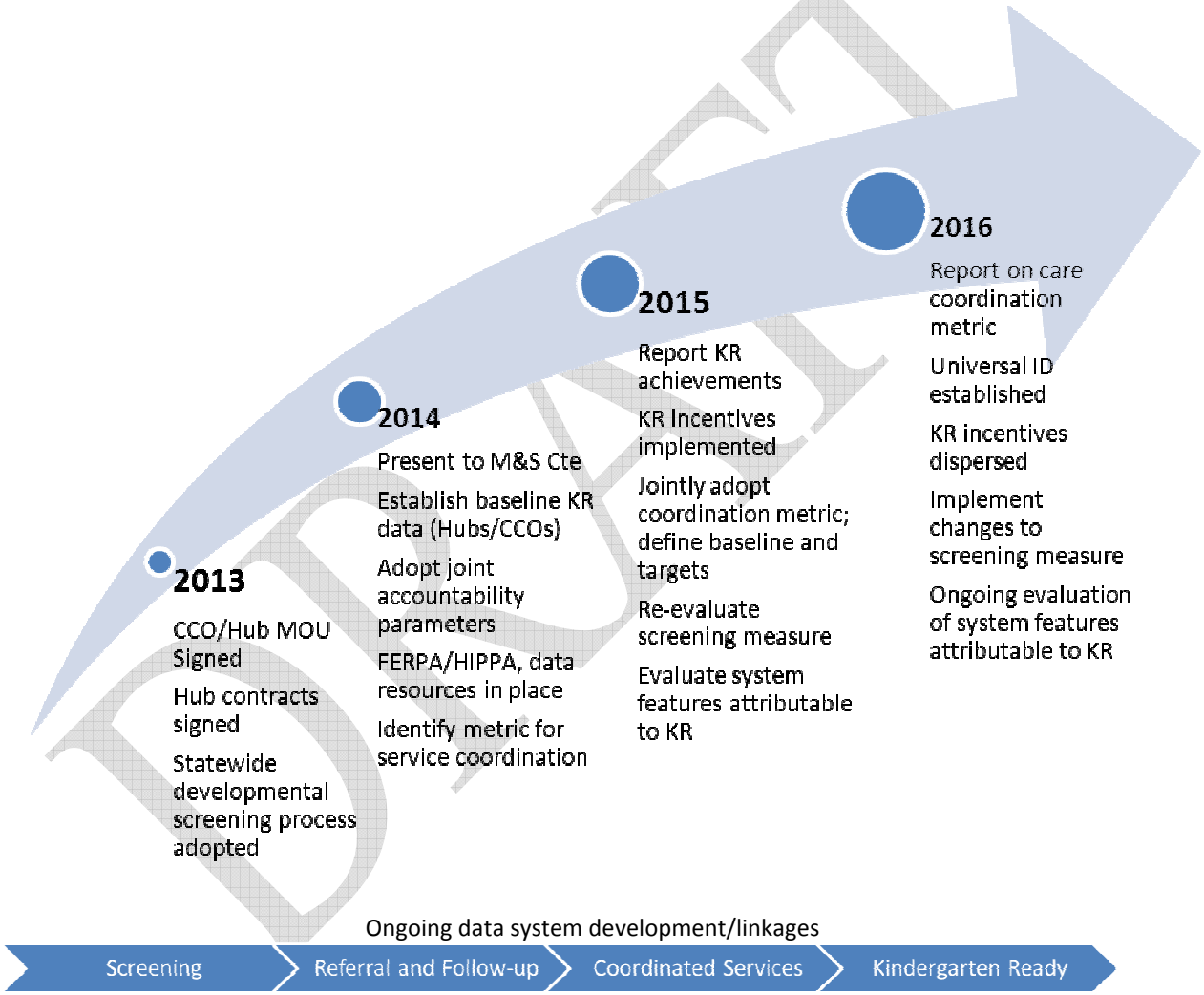
The Joint Subcommittee was charged with developing a proposal and timeline for establishing kindergarten readiness as a shared outcome for health and early learning systems. In developing this proposal, the Joint Committee has considered a variety of environmental and policy factors that impact this recommendation, including: statutory role of OHA's Metrics and Scoring Committee; capacity for information exchange, data linkage and reporting; privacy and security policies (e.g. FERPA/HIPAA); need for shared accountability and incentives; relationship of screening, coordinated services and kindergarten readiness; and differing stages of system transformation. The Joint Subcommittee recommends adoption of a four year timeline for establishing kindergarten readiness as a joint outcome, including the following implementation activities:

Figure 1. Kindergarten Readiness as a Shared Outcome: 4 Year Proposal



Recommendations:

4. Adopt kindergarten readiness as an urgent, shared outcome, including a maximum four year timeline for implementation of associated activities. The timeline shall be shortened where possible.

5. Establish shared incentives for achieving kindergarten readiness. The Joint Subcommittee shall identify an approach to shared incentives that recognizes the imbalance in financial resources across health and early learning.

Mutually Reinforcing Activities

It is expected that health, early learning and human service systems will each contribute unique activities and efforts towards the goal of kindergarten readiness. For optimal results, these activities must be mutually reinforcing and coordinated.

Shared Learning
Learning collaboratives represent a critical element for shared learning and spreading best practices. They can be employed in a collective impact approach to enhance mutually reinforcing activities towards a shared outcome. As previously agreed, the OHA and Early Learning Division will convene local leaders in health, education and human services to explore and spread opportunities for cross-system care coordination and case management for at-risk children. With initial seed funding through OHA's State Innovation Model (SIM) grant, additional opportunities to leverage these funds should be sought.

Recommendation 6:
Identify resources to build capacity for cross-system learning collaboratives dedicated to care coordination, including but not limited to: funding for shared learning, Health Information Exchange and Technology (HIE/HIT), and neutral skill sets (e.g. process engineers) to move this work forward.

Developmental Screening
Developmental screening, core to both health and education, is a discrete example of a mutually reinforcing activity. Developmental screening using a validated and standardized screening tool can improve the identification of children at risk for a developmental delay or disorder. Developmental screening in the first three years of life represents one of Oregon's 17 incentive measures as adopted by the Metrics & Scoring Committee. Quality pool dollars will be distributed, in part, based on a CCO's ability to improve or meet a benchmark for this measure. Likewise, screening to identify children at risk for not being kindergarten ready at school entry is a statutory requirement of the early learning system. Funding from Oregon's Race to the Top grant is being used to build resources and professional training for early learning providers related to developmental screening. Ultimately, Early Learning Hubs will be required to work with CCOs to improve the local rate of developmental screening for young children.

To ensure that screening activities are mutually reinforcing and coordinated, a statewide system of screening is recommended (see Appendix A). The necessary system components include:

1. Accountability for screening should be held jointly across health and education.
2. Shared incentives should be established.
3. Training requirements should be set for participating providers.
4. Incentives for meeting training requirements should be established (e.g. participation in QRIS, future data exchange, and reimbursement or incentive decisions).
5. Opportunities for secure information exchange should be identified and implemented.
6. Shared messaging must be delivered regarding the importance of developmental screening.
7. Health, human services and early learning providers should identify best approaches to providing care coordination/case management for identified at-risk children and their families.
8. Strategies must be identified to address the unique screening considerations for specific child populations, such as children with existing intellectual or developmental disability and those served by Child Welfare

Recommendation 7:
Adopt and implement a statewide system of developmental screening including the core components listed above.

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Backbone Support Organization

The identification of a backbone support organization or entity to create and manage collective impact efforts has been hailed as one of the most critical elements for success. Essential functions of the backbone organization include: providing strategic direction, facilitating dialogue between partners, managing data collection and analysis, handling communication, coordinating community outreach, and mobilizing funding (Kania & Kramer, 2011). We recommend the following backbone support structures for our collective impact strategy towards statewide kindergarten readiness:

The Joint Subcommittee

We recommend that the ELC and OHPB carry forward the Joint Subcommittee charter to provide ongoing strategic direction and governance. With education and health system transformation efforts still in their infancy, it is too early to abandon alignment efforts until they are fundamentally incorporated into daily operations. The agenda for the Joint Committee's next phase of work should include: 1) implementing the shared measurement strategy, *Oregon's Child and Family Well-being*, 2) implementing policies and spread of best practices for cross-systems care coordination, 3) executing next steps for secure information exchange across health and early learning, and 4) identifying and implementing shared incentives. Representation from the Department of Human Services remains critical to this group's work. CCO and Hub representatives will be added to the Joint Subcommittee by 2014. Tribal representation will be included on the Advisory Committee.

The Transformation Center

The newly developed Transformation Center within the Oregon Health Authority and associated State Innovation Model (SIM) grant funding should be leveraged to serve as a backbone structure for transformation efforts across health and early learning. The Transformation Center will support the adoption of the coordinated care model throughout the health care system through technical assistance and learning collaboratives among CCOs. Similar strategies can be implemented to foster shared learning across CCOs and Hubs and to disseminate local best practices targeted at achieving kindergarten readiness. Economies of scale can be achieved through shared resources such as staffing and communication technology. The Transformation Center can provide the vehicle through which early learning and health staff can work together to support community-level transformation efforts and the spread of best practices across local health and early learning systems.

Recommendations:

8. Renew the Joint Subcommittee Charter with additional representation and deliverables focused on a shared measurement strategy, care coordination, information exchange and shared incentives.

9. Designate the Transformation Center as the backbone structure for fostering shared learning and alignment between health and early learning at the local level.

Continuous Communication

Organizational capacity and structure that promotes coordinated activities and continuous communication have begun to take shape at the state level. Oregon Health Authority representation has been included on the Early Learning Council and the Early Learning Division Cabinet. Likewise, a team of early learning focused staff are co-locating within OHA's Transformation Center to ensure alignment between health and early learning transformation efforts. This state-level coordination should be emphasized and can serve as an example of possible coordination at the local level.

Investments in communication technology are currently being explored to support CCO learning collaboratives and technical assistance within Oregon's Transformation Center. These technology

investments should be mirrored for early learning Hubs and can be used to support learning collaboratives between health and early learning at the local level.

Recommendation 10:
Implement shared communication technology and strategies that facilitate local, cross-system learning between health and education.

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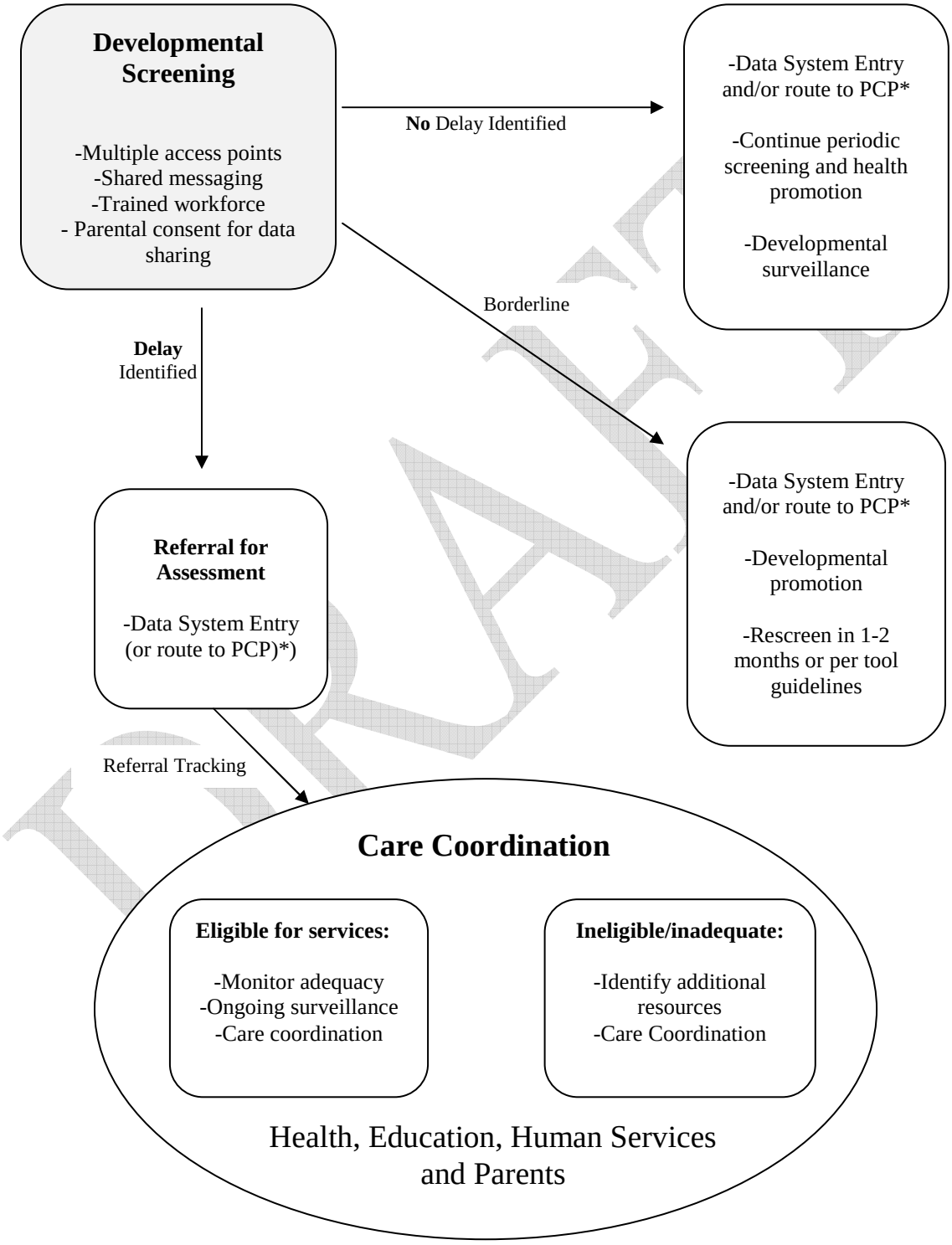
Appendix A: Statewide System of Screening

Example framework:



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