



NATIONAL CENTER ON

Early Childhood Health and Wellness

Early Care and Education/Medical Home Learning Collaborative APPLICATION OVERVIEW

Introduction

For over 50 years, the American Academy of Pediatrics (AAP) has promoted the medical home model as the ideal method for delivering health care to children. For equally as long, early childhood educators have been providing high quality education and child care, with an emphasis on keeping children healthy so they are better able to learn and succeed. There are many success stories involving these two systems working together effectively to the benefit of the children and families they serve. In spite of this and despite each entity's commitment to high quality programs and practices, challenges still exist in ensuring all children receive services that are comprehensive and well-coordinated.

To help meet this challenge, the National Center on Early Childhood Health and Wellness (NCECHW) has made a commitment to support a learning collaborative that will give several teams the opportunity to strengthen the partnership between their Early Care and Education (ECE) program(s) and the medical home.

One of the biggest threats to children's health today is exposure to toxic stress in early childhood. Toxic stress involves the experience of traumatic events in the absence of protective factors, particularly supportive and loving relationships with parents and other adults in the child's life. Toxic stress disrupts healthy brain development, which can lead to increased physical and mental illness, high risk behaviors, and other psychosocial implications. Given the potential impact of toxic stress on child's lifelong health and ability to learn, the teams selected for this learning collaborative will be asked to incorporate the issue of toxic stress throughout their general collaboration activities.

Learning Collaborative Teams

The learning collaborative teams will have 2 representatives from the ECE program and 2 representatives from the medical home or health care system. Teams should include a mental health professional such as a licensed clinical social worker, early childhood mental health consultant, psychologist, or behavioral health clinic.

Because both the medical home model and ECE programs strongly value family involvement, a successful application will include a description of how the family perspective will be integrated into the collaborative. Families may be included on the Learning Collaborative team or engaged in other meaningful ways. Examples for Head Start can include engaging the parent committee, health services advisory committee, or policy council. Medical homes could consider focus groups with parents,

establishing a family advisory committee, or could incorporate this project within existing quality improvement systems that include parental representation.

There would also be flexibility to recruit additional community members such as mental health professionals, Women, Infants and Children office, local health department, if the most appropriate people aren't already participating. We hope for pediatrician participation on the health care teams, but understand other health care professionals may be taking the lead for that team, depending on the circumstances.

The Work

Teams will gain understanding of each other's role and use quality improvement strategies to improve collaboration among medical homes, ECE programs, and other community partners. Partners will jointly host at least one event appropriate for their community that features education about risks and/or protective factors for toxic stress.

Menu of possible activities:

- Using community data to assess needs and determine strategies in relation to access to healthcare, risk of toxic stress, and supportive mechanisms to building protective factors in children. Sources of community data can include a community needs assessment (accessible via local or state health department, local Head Start office) program self-assessment, focus groups, and listening sessions with community leaders and family representatives. Listening sessions or focus groups can include existing groups such as a Head Start health services advisory committee (HSAC), program and medical staff, and Parent Committee or Policy Council.
- Joint educational offerings
- Reviewing Caring for Our Children or Head Start Program Performance Standards with health care team members to identify opportunities for collaboration.
- Identifying appropriate measures related to objectives of the collaborative.
- Addressing a mutually identified challenge to communication (eg, a form that could be standardized to be more effective)
- Developing tools to build collaborative or support services between collaborative or other community partners such as WIC clinic, local health department, home visiting program, Early Interventions, SNAP.
- Establishing a measure of protective factor(s) that build resiliency in children and a strategy for improvement. Consider strategies related to access to healthcare, food insecurity, prenatal nutrition, parental depression or Adverse Childhood Experiences, addressing gaps in supportive relationships with ECE program, staff, medical providers, and families.
- Identifying gaps in care coordination and identifying ways to resolve. Could include other partners, like WIC, Early Intervention, Early Childhood Comprehensive Systems (see [Building Bridges speaker's kit](#))
- Incorporating information on ECE programs into local health care training. Examples can include training of staff at medical home partner or local residency program.
- Joint advocacy efforts (eg, presentation to rotary, chamber, etc)
- Enhancing care coordination such as aligning services with the Family Partnership Agreement, engaging a home visiting program, building regular care coordination meetings.
- Addressing staff wellness with emphasis on their own trauma

- Developing a local referral network for services related to supporting families such as mental health services, WIC office, SNAP, food pantries, Cooperative Extension program, parenting education, etc.
- Integrating of opportunities to strengthen child’s adaptive skills and self-regulatory capacity into the daily curricula.
- Developing family education strategy or activities that support connection to the medical home, or facilitate supportive family-child relationships
- Developing a method for identifying parent relationships as a vital sign in the medical home.
- Evaluating the continuity of care for children
- Defining a strategy to support parents and children affected by toxic stress
 - How will families be identified
 - What resources are available – therapy, parenting support
- Identifying methods for addressing one particular area of risk (eg, addiction, child abuse and neglect, unemployment, parental incarceration, food insecurity, parental depression, intimate partner violence)

The Outcomes

The goal would be to develop or strengthen processes that facilitate collaboration. We will be documenting what is working well within these partnerships and share that information with others who are seeking to increase collaboration.

Outcomes will be demonstrated using structured measures. Measures will be customized to the context of the teams and will likely include:

1. *Strength of collaboration among the team of MH, ECE and parents as measured by the Wilder Collaboration Factors inventory over time.*
2. *Communication system effectiveness and efficiency between MH and ECE over time – measures will be individualized to the intervention chosen by teams*
3. *Team member, staff and targeted community member awareness or knowledge of toxic stress or protective factors pre and post event*
4. *Evidence of community partner engagement*

The Application Process

Teams will have until **Saturday, April 30th 2016** to submit their applications. In addition to the application itself, we suggest submitting letters of support from organizations the team may be affiliated, such as the AAP chapter, the State Collaboration or Regional Office, child care health consultant, local health department, home visiting program, or Women, Infants, and Children clinic, etc.

If awarded, each partnership would receive \$7,500 to assist with the costs of building the partnership. This will be designated to the health care partner involved with the partnership. Acceptable expenses include securing meeting space, staff time to facilitate collaboration, stipends for subject matter experts to present, general meeting supplies, etc. Applicants are asked to provide a breakdown of how the funds will be used, along with a brief budget narrative.

Applications will be reviewed by experts who served on the planning team for the learning collaborative. Once applications are scored and selections finalized, all applicants will be notified of the final decision.

Summary of Requirements

Applicants will be asked to participate in and/or complete the activities as outlined below. Travel for the learning sessions will be arranged and expenses covered by the AAP. Each team will also commit monthly 30 minute update calls with our Improvement Advisor to monitor progress, assess TA needs, and facilitate success. Periodic data submission to the Improvement Advisor will also be required.

April 30th	Applications submitted (Includes: Application form, Budget, Brief Budget Narrative, Letters of Support)
May 6th	Applicants are all notified
May 16th	Kick-off virtual meeting for learning collaborative
June 2-3	1st in-person learning session (held at AAP headquarters in Elk Grove Village, IL)
July 11th	2nd virtual meeting with participants
August 9-10th	2nd in-person learning session (held at AAP headquarters in Elk Grove Village, IL)
September 9th	Annual reports due
October 2016- August 2017	Quarterly virtual meetings and TA
September 2017	Final report due