

JSI RESEARCH AND TRAINING INST

Moderator: Frances Marshman
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Operator: Good afternoon. My name is (Shawn), and I will be your conference operator today. At this time, I would like to welcome everyone to the ECCS Developmental Screening in Early Childhood Systems conference call. All lines have been placed on mute to prevent any background noise. If you would like to ask a question during the question and answer session, simply press star then the number one on your telephone keypad. To withdraw your question, press the pound key. Thank you. Ms. Marshman, you may begin your conference.

Frances Marshman: Thank you, (Shawn). Hi everybody. It's Frances Marshman at JSI in Boston, welcoming you to our third ECCS all-grantee conference call. Thank you so much for joining us this afternoon – or morning for some of you.

(Dena) is – (Dena Green) is also on the line. I don't know if you want to say hello as well, (Dena).

(Dena Green): Yes, hello and welcome, everyone. Glad to have you on, and I – we have a rich agenda today, and I'm not sure if your agendas reflect it, but we plan to talk about some of the questions that you've been e-mailing us in regards to – Joe and I will do an e-mail – an update at the end of this call – on the end of this call.

Frances Marshman: So (Dena) has hired me to be the hardnosed facilitator, and per usual, you've heard me in this role on the previous two conference calls. For starters, we have a surprise quick presentation from Leah Holmes-Bonilla,

who is a member of the communications team for the Caring for Every Child's Mental Health Campaign.

You all may recall that both Joe Zogby and I have sent you information related to the Early Childhood Mental Health Awareness Day that's to be held on May 6th, and Leah Holmes-Bonilla is going to give us a bit of information about that right now, and will be able to answer a couple of questions.

Then we want to go into the bulk of our call, which is devoted to developmental screening in early childhood systems, and then as (Dena) just referred, both she and Joe Zogby are on the line today to give some – answer questions and make some comments regarding continuation guidance electronic handbook, upcoming ECCS meeting, et cetera.

So Ms. Holmes-Bonilla is a Senior Account Supervisor at Vanguard Communications, based in Washington, D.C., and thank you so much for agreeing to give us a brief overview of the Early Childhood Mental Health Awareness Day, which is scheduled for May 6th.

Leah Holmes-Bonilla: Thank you so much. I really appreciate having a moment to speak with all of you, and when you think about Awareness Day, I want you to think about it in terms of not what you must do for National Children's Mental Health Awareness Day, but what National Children's Mental Health Awareness Day can do for you.

As many of you know – may know, it's May 6, 2010, and Awareness Day is a day for everyone to promote positive youth development, resilience, recovery, and the transformation of mental health services delivery for children and youth with serious mental health needs and their families. And this year, Awareness Day celebrates its fifth anniversary, as well as having its first-time focus on the topic of early childhood.

So communities across the country are going to be observing with events or youth demonstrations, social networking campaigns, all different ways that they have creatively come up with to look at how they can increase understanding of the mental health needs of children and families and bring awareness to the issue of children's mental health.

So with this key focus and the key message of positive mental health is essential to a child's healthy development from birth, there are three kind of major tenets of Awareness Day, and the web site is an easy one to remember. It's (samhsa.gov/children), and on the web site we have information about what we – I'm going to refer to as the Art Action.

And this is a really simple way that different communities can be involved in engaging young people in – and in art activity with the theme that "My Feelings Are a Work of Art," and there are folks all over the country who are partnering with the American Art Therapy Association that's engaging art therapists and Head Start programs around the country to participate in Art Action on May 6th.

We also have an initiative for young people who are a little bit older, who may want to write about their feelings, which is called, "When I Grow Up," and this'll – affords them an opportunity to write about who they are, how they describe themselves, how they see themselves, and what their aspirations are. Again, to be – that – to be shown on May 6th – to be held up as posters, to really identify them as young people with feelings and thoughts and ideas that go beyond their diagnoses.

And last but not least, we have a – an e-viral campaign called "Post Now," which you may have seen. It may have come to you, but you can certainly see it on the web site, which is really facts and information about early childhood mental health and how important it is to start early with an image. And this is an image of a young child holding up a message as well.

And these are things that different communities have used as either an e-mail signature, or they've taken the information and created posters, and used it as a way to spark dialog and conversation in their communities around early childhood mental health.

So I don't want to take up too much of your time. I wanted to give you a quick overview, and if anyone has burning questions, I'm more than happy to answer those. And again, thank you so much for the opportunity to speak with you.

Frances Marshman: Thank you, Leah. (Shawn), to confirm, if people do have questions about Early Childhood Mental Health Awareness Day, they could get in the queue, in the question and answer line by hitting star one, is that correct?

Operator: That's correct. You may press star one to ask a question at this time.

Frances Marshman: And we will just give anyone – a few people – the opportunity to ask questions of Leah Holmes-Bonilla, and then I just wanted to reiterate that there is a very comprehensive and helpful web site out there. Leah referred to it earlier. It's (www.samhsa.gov/children).

Are there any questions on the queue, operator.

Operator: There are no questions at this time.

Leah Holmes-Bonilla: OK. Well, thank you so much for the opportunity to speak with you, and if someone – you know, a question occurs or something comes up, since I won't be staying with you – I apologize – please let me know. I'd be happy to be back in touch with folks.

There is a list of wonderful partners – organizations from all over the country that are partnering for Awareness Day. So there are ways to see who's already engaged and what they're doing and how you might connect with them.

Frances Marshman: And all three activities are listed on the web site as well. And I think probably a good way to do this, Leah, is that if grantees or listeners out there have additional questions, you can e-mail them to me, and I'd be happy to forward them to Leah Holmes-Bonilla. That sound good?

Leah Holmes-Bonilla: That's wonderful. Thank you so much.

Frances Marshman: OK.

Leah Holmes-Bonilla: Take care.

Frances Marshman: Thank you very much for your time. Bye-bye.

Leah Holmes-Bonilla: Bye.

Frances Marshman: So I'm pleased to be able to introduce Jeanne Anderson, at the Healthy Child Care American initiative, part of the American Academy of Pediatrics. She works closely with Maternal and Child Health Bureau Project Officer Phyllis Stubbs-Wynn, and she will – Jeanne Anderson will be facilitating this call and introducing the other four speakers, who graciously offered their time and wherewithal to present on developmental screening in early childhood systems.

So Jeanne, are you there?

Jeanne Anderson: I am. Thank you, Frances. So as you know, Healthy Child Care America, the child care health partnership partners in providing technical assistance regarding health and safety to all of the ECCS system and the coordinators.

And on March 25th of 2009, the American Academy of Pediatrics Healthy Child Care America program hosted a summit on developmental screening in early childhood systems in Elk Grove Village. Recognizing that it's now possible to do high quality and low cost developmental screenings, we invited participants representing a full range of academic, government, health and education related professions from across the country.

We had ECCS coordinators, chapter childcare contacts, state administrators, as well as representation from mental health and other early childhood and early intervention related systems. They were given the opportunity to review the current recommendations in common language integral to the effective implementation of developmental screening.

They learned about existing approaches and efforts in several representative states, and then we discussed the challenges and barriers faced in this process. Today we're going to bring you the program quite similar to what we did that day. We're going to use system (inaudible) format, and we will highlight three state initiatives that have very different approaches to developmental screening initiatives.

And we will be sharing these in a condensed version. We have the same speakers. We are very lucky to have these same speakers, and we will be then summarizing this with Dr. Laura Jana, who will share excerpts from the summary report and some of our lessons learned from the day's events.

So Dr. Alderman, are you on the line?

Dr. Sherri Alderman: Yes, I am.

Jeanne Anderson: We will start with Dr. Alderman. I will have you go ahead and introduce yourself, and if you will tell us a little bit more about New Mexico's initiative.

Dr. Sherri Alderman: Well, thank you very much. It's a pleasure to be joining in on this conference – this phone conference. I have great memories of the original conference and what exciting work this is.

I speak as a prior Project Director for the Developmental Screening Initiative in New Mexico and am very pleased to be able to share with you the work that we have accomplished in New Mexico, which has put New Mexico fourth in the country in terms of developmental screening, along with many, many other local organizations in the state who have promoted developmental screening as well.

To start, I would like to recognize Envision New Mexico, the initiative for child health care quality, which is a division of the Pediatric Department at the University of New Mexico School of Medicine. There have been great components of the Developmental Screening Initiative that come directly from Envision New Mexico, one of which is a quality improvement process to implement practice change, and Dr. Jane McGrath has – had been hugely supportive and instrumental in the Developmental Screening Initiative in New Mexico.

New Mexico is a somewhat unique state in several regards. It is a very sparsely populated state. Some of the areas of New Mexico are even classified as territories in the census, because there are less than one person per square mile in some parts of the state. It's a fairly large state, and it – half

of the population is located in a central corridor that includes Santa Fe and Albuquerque.

So we have issues in regard to how we reach out to the entire state, and we do fully embrace the philosophy that we – that we embrace the entire state. We also are a minority-majority state, meaning that greater than 50 percent of our population are federally recognized minorities. So we have diversity, we have great (expanses) of geographic area, all of which we actively embrace and use as a strength in any project that we are implementing in the state, and the Developmental Screening Initiative did that.

We also are challenged by a high poverty level, and a significant portion of that is a deep poverty. So those are challenges that we fully recognize, and one of the ways that we operationalize our recognition of that is New Mexico is an at-risk state, meaning that early intervention programs for birth to three years of age do – are provided for children who are at risk of developmental delays, even before they manifest those delays.

So screening is a logical step in the process, and talking with families and recognizing those children, not only the children who suggest there might be a delay, but children who are at risk, in order that those services can be proactively implemented in the families' homes to optimize early childhood development.

The roots of the Developmental Screening Initiative in New Mexico are very deep, going all the way to the level of the Children's Cabinet at the state government. Lieutenant Governor Diane Denish has been supportive of the Developmental Screening Initiative, and through the Children's Cabinet, the development of New Mexico's ECCS Early Childhood Action Network, was also very supportive of the Developmental Screening Initiative. In fact, much of the groundwork was in place through the actions of these players before the Developmental Screening Initiative was formed.

We also have a lot of stakeholders, ranging everywhere from the state, as already mentioned, to our professional organizations, and on into private foundations as well.

So the philosophy upon which the Developmental Screening Initiative in New Mexico is founded includes first and foremost a very broad definition of health that includes the capacity of the child to succeed in life well beyond any particular medical condition or any specific developmental delay.

We also recognize that children live in communities, and we know very well that those communities have resources and people working in early childhood that are fully dedicated and ready to work together to support developmental screening and appropriate follow-up to those screenings.

So those ideas and philosophies will pull together in what was a community organizing approach to developmental screening, meaning that going to the community where the child is, bringing together professionals who work with children in early childhood, and as a catalyst, promoting conversation and strategies for implementation of effective and seamless developmental screening and appropriate services for families in that community.

We had a pilot site in Roswell, New Mexico, and there we were able to pull together 26 professionals for an all-day training, representing 10 agencies, and through work groups during that day were able to formulate plans of action.

There were in fact some issues brought forth and in a very candid and transparent way that were addressed on site, and the agencies left that training with plans on how to promote further developmental screening, how to share resources with other agencies in their community, and those included child care, the child welfare system, the pediatric practitioners in the community, and a variety of other agencies, including the early intervention program agencies and home visitation nursing.

So we felt like this was very successful. We got positive feedback. It is an ongoing project as we continue to move out into other communities, and it was quite a pleasure for me to get to know a community at a much more intimate level and to act as a resource to them in order to increase their capacity for serving children in their community.

Thank you very much.

Jeanne Anderson: Thank you, Dr. Alderman. If there are questions for Dr. Alderman, it – we can take those now, and then we can take some questions at the end. (Shawn), are there any questions in queue at this time?

Operator: As a reminder, you may press star then the number one to ask a question at this time. And once again, that's star one to ask a question. And your first question comes from the line of (Cheryl Messid). (Cheryl), your line is open.

There is no response from that line. Your next question is from the line of (Heather Dubile).

(Heather Dubile): Can you explain when you said New Mexico is an at-risk state for early intervention, how that's determined – if you're an at-risk state?

Dr. Sherri Alderman: Yes, (Heather). Thank you very much for that question. It was a determination made at the state level that our resources would – for the early intervention program – would go to not only children who have a documented developmental delay in those first three years after birth, but to children who are also at risk.

And there is a definition for "at-risk" that is fairly comprehensive. There are, I believe, five or seven states who have made this policy decision that they will serve children who are at risk, in addition to those who have documented developmental delays, and that is how that process occurs.

(Heather Dubile): Thank you.

Operator: Your next question comes from (Martha Hyatt).

(Martha Hyatt): Hi. I'm from Arkansas, as we are really involved in several developmental screening initiatives in the state, having participated in the ABCD Screening Academy, and now it's an ABCD III state. So my question relates to standardized developmental screening tool, and if your state selected one, and if so, what is it and how are you promoting that and/or just that whole standardized tool situation in your state.

Dr. Sherri Alderman: Yes. Thank you, (Martha). We took on the approach that those agencies who choose to do developmental screening would learn first of all through the Developmental Screening Initiative training what considerations one considers before they make a decision as to which standardized tool would be the best tool for their practice.

So getting a little bit of a statistical background, a little bit of the public health background, we allowed our professionals to – in learning about the different tools that are standardized and any of which would be acceptable – we allowed our professionals to make that decision themselves.

From a practical perspective, those professionals who chose to do developmental screening ended up choosing the Ages and Stages Questionnaire, but only after considering all of the important considerations when you're picking a tool. New Mexico is – has a high-risk population, and the Ages and Stages Questionnaire is a standardized tool and is a standardized tool that is generally recommended for higher risk populations.

(Martha Hyatt): OK. Thank you. We've also – we selected ASQ in our state too. So that's great. Thank you.

Dr. Sherri Alderman: Oh, you're welcome.

Operator: Your next question is from (Judy Waldruff).

(Judy Waldruff): Good afternoon. I wondered if you had any feedback from particularly the pediatric or physician community that their – some concern about developmental screening being conducted outside of physicians' offices. We have noticed a little bit of that here and there. But I wondered if you had that experience and how you dealt with it.

Dr. Sherri Alderman: (Judy), that's a ...

Jeanne Anderson: Dr. Alderman, just so you know, (Judy Waldruff) is from the state of Arizona.

Dr. Sherri Alderman: Oh, OK. Yes and our neighbor.

(Judy Waldruff): (inaudible).

Dr. Sherri Alderman: (Judy), thank you very much for that question. You bring up a very important point on several levels. First, taking a community approach, what I found in the training with all of the community players there together is that there was a surprise outcome that was very exciting to see, and that was because each representative was allowed time during the agenda to present their own agency and the resources that they had, that an unexpected and very positive outcome was that there was a growth of increased confidence among all of the participants for each of the agencies that were represented there.

So as providers, we always want to be sure that where we are sending our families is a trusted place for them to go, we saw that that was one of the outcomes there. So there's increased trust.

The second issue that I see in regard to doing developmental screening outside of a medical office is that when a child does screen concerning for developmental delays and they are referred directly for developmental assessment and are truly diagnosed with a developmental delay, that really is the beginning of a journey for that child. And what that child needs is a medical workup for that developmental delay, in addition to developmentally appropriate services for that family.

Until that child has received that medical workup, there may be some underlying medical condition that would otherwise go unrecognized. And so as we spread out in all of the places where we're doing developmental screening, it's a very important message for people to hear that when the child is diagnosed with a developmental delay, they need a medical workup too.

(Judy Waldruff): Thank you so much.

Dr. Sherri Alderman: Thank you.

Jeanne Anderson: Thank you, Dr. Alderman. I really appreciate your sharing information from New Mexico. And now we're going to go ahead and move on. We need to move to our next speaker.

Chris Collins is from North Carolina, one of the original ABCD states, and so, Chris, if you will go ahead and talk about North Carolina's initiatives.

Chris Collins: OK. I'll be happy to share a little bit of where we've been and a little bit about where we're going, and I'll try and keep us on time here as well. (Inaudible) the fact that as you indicated, as an ABCD state, and so what really sort of spring boarded us in moving forward was that grant award from the Commonwealth, and having a strong physician champion in Dr. Marian Earls was really key, as she took that ABCD resource and began to work within her own practice and using the Community Care networks that we have in place here in North Carolina.

And what we have here is that our Community Care networks are Medicaid's managed care program so we have what's called a primary care case management model, in which both the medical home that the Medicaid recipient is assigned to receives a per member per month payment, but then there is also a CCNC network. So there are regional organizations that bring all those primary care providers together, and they receive funding and resources for infrastructure and staff that is shared among those primary care providers who participate in the networks.

So we really have the benefit here in North Carolina of having that infrastructure and being able to leverage it. So that was in place, and in those CCNC networks we have clinical directors who have experience in quality improvement protocols, so as Dr. Earls within Guilford Child Health began to pilot and introduce standardized validated developmental screening, she was able to share those results with the clinical directors in the other CCNC networks, who in turn were able to share it with their local primary care providers.

Our networks also have another key component in that they engage, in addition to the primary care providers, they bring to the table Departments of Social Services, Public Health, local hospitals, and increasingly local mental health entities that serve the mental health needs of our clients.

So some lessons learned, as Dr. Earls piloted this initiative, was that we really needed to take an office systems approach, so as part of that we created a organizational tool called "Getting Started." It included a worksheet that how are you going to integrate this developmental screen into your practice workflow. The trainings that we did across the state were multidisciplinary, so that involves the business office; it involves – you know, the nursing staff, as well as the physicians.

A DVD was created in which their colleagues – so you would hear a family practice doctor talk about his experience as well as a pediatrician to their peers. And the networks are used to working – and there's a very trusting relationship between our CCNC networks and the participating practices – so our networks are often that interface with the community and the linkage for those children.

So as a result of this, the clinical directors felt that the pilot really had merit, showed significant improvement, and because it's North Carolina's Medicaid managed care program, it has a very close partnership. In fact, my role is a joint role between the divisions of Medicaid assistance, which provides payment, and the Community Care networks, which are administered through the Office of Rural Health and Community Care.

So even here at the state level, it's very – those two entities are very closely integrated, and so it was not uncommon for the Community Care networks to make policy recommendations to the Division of Medical Assistance.

So the clinical directors made the recommendation that Medicaid change their EPSDT policy, and effective July of 2004, it included the requirement of a validated standardized developmental screening tool for children at – and this was before the Academy actually came out with their – with specific months that are recommended, but we recommended 6, 12, 18, or 24 months, three, four, and five years.

So it is a requirement when you submit your health check or your EPSDT well care visit that the claim contain a 96110 modifier. The primary care providers in our state did not ask for increased reimbursement for that, only that it be

placed as a requirement. Now if you do it independent of the well visit, our state does compensate you an additional \$10, if you were to do it as a sick visit.

At the same time that DMA was changing the policy and as the ABCD initiative was getting in place, we formed a state-wide advisory group that had key players – so including Medicaid, but also including Early Intervention Part C, Public Health, the Department of Public Instruction, Preschool Smart Start, Family Support Network, our Pediatric Society, and the North Carolina Academy of Family Practices, so that in addition to working at the local level and connecting the primary care provider with the early intervention services that were available locally, we were starting to address our processes at a statewide level about how do we streamline, or what messages can we push from our level down to our various local service agencies about how to better collaborate.

So from there, we did a series of health checks, seminars, surveys. We formed an ABCD quality improvement work group in addition to the advisory group. Our work group has since gone on to develop new kindergarten health assessment, we've expanded our partnership to include Smart Start. They are aligning some of their resources to support the ABCD initiative in currently 26 North Carolina counties.

We leveraged DMA's managed care consultants to begin to monitor the EPSDT requirements, so if a practice wasn't putting the required code on, what was preventing them from doing that – was it their billing software, was it denied claims, were they having any problems with regards to that. We increased processes for linkage and referral and communication. We started to standardize some of those things.

And we've since gone on to also – we have several co-location sites in which we are supporting mental health providers, integrating them into the primary care setting so that we can expand some developmental screening to also include screenings such as for maternal depression, and if we do the developmental screening with the ASQ and the social emotional domain is positive, to be able to go on and to the ASQ SE in the primary care setting.

So I've included in the – in what you received in one sample of the protocol that we developed with the preschool system, which was actually harder, because every county in our state, and in fact some cities, all have a different process. So the fact that our – this was one of our biggest successes – it was a little easier to standardize the process with Early Intervention.

But the fact that we've been able to standardize some processes, address issues of FERPA – which are different from issues of HIPAA – with our educational system really has been a huge success. But our processes have been more than with just the educational system.

And so what are the outcomes of some the work that we've been doing? So the number of children at risk to three referred to our North Carolina infant-toddler program by state fiscal year, as you can see, has drastically grown to now approximately 20,000 annually.

The primary source of referral used to be childcare, and as a result of this initiative, physicians are our top referral source into the North Carolina Early Intervention Toddler Program.

Our 96110, and this is derived from the administrative claims data, went from under 50,000 in 2004 to over 200,000 in 2008. We are currently running data on 2009. We have to wait a certain lag time for claims payment to process, but I suspect that will continue to rise.

The number of claims that are missing the required 96110, as you can see in the next slide, continues to decrease. So we have EPSDT report cards that we create, and our generated quarterly for our Division of Medical Assistance managed care consultants to work with local providers as well as our Community Care networks, greater than 90 percent of our primary care practices are screening; 84 percent of EPSDT exams for zero to five-year-olds include a developmental screen.

And some new things and where are we headed – again, the increased training for Smart Start ABCD staff, our quality improvement group is starting to work on autism screening, maternal depression screening. We've offered

CME sessions for both the Pediatric Society and the North Carolina Academy of Family Practice on autism screening and referral.

And this past year in January, we opened up new codes – our Medicaid program opened up the 99420, so that primary care practices, in addition to being able to screen for developmental screening, can do a secondary screen at the well visit – so for mental health or autism or even for adolescent mental health screening.

So those are some of the things that we continue to train providers on – of the availability to go on and do secondary screens, particularly if they have behavioral health providers nested in their primary care setting. So that's where we are.

Jeanne Anderson: Thank you, Chris. I appreciate that. For those of you on the call, you can see that we chose our initiatives to highlight, based on diversity. We really wanted to provide an opportunity for participants to be able to see various models, whether it be ones that targeted child care as the vehicle for disseminating information regarding developmental screening, or whether it be the pediatric side of things. And so we're seeing how this is all integrated together.

(Shawn), are there any questions in queue at this time?

Operator: As a reminder, you may press star one to ask a question at this time. And your next question is from the line of (Kelly Munson).

(Kelly Munson): Yes, Chris, Minnesota. Do you have electronic medical records? And then tied to that, do you have a way of tracking which developmental screening instruments primary care providers use?

Chris Collins: Some of our primary care providers have electronic health records, but our state is not connected with those electronic health records. So no. What we're using in terms of the data you're seeing is the administrative claims data.

Now, when our managed care consultants or one of our ABCD quality improvement specialists, Smart Start, or CCNC works with a practice, then

generally they have access to the electronic health record at that time. So it's something – our requirement is that they use the validated screen. Most use PEDS, or they use the ASQ, but not on – not at a statewide level, no.

(Kelly Munson): But you have no way of tracking for sure what they're using.

Chris Collins: No way to know for sure what they're tracking, but when our managed care consultant sees that someone is not following protocol, then they do actually go into the practices, and for the most part, both our CCNC network, our Smart Starts that do audits, and our managed care consultants report that they are generally using the ASQ and the PEDS as the two standard forms used.

We did a lot of statewide training around that and around the toolkit. I mean, we really did a traveling road show for quite some time, when we changed the policy.

(Kelly Munson): Thank you, Chris.

Chris Collins: Yes.

Operator: Your next question is from (Sandra Potter).

(Sandra Puttermer): Hello. This is (Sandra Puttermer) in Oregon, and I have a question about the maternal depression screening that you mentioned you were starting to do training. Can you tell me if any maternal depression screening is currently being done for this population, and if so, what tool is being used, and if in fact you've identified follow-up resources for these women, or parents.

Chris Collins: I can speak to it generally. The primary one that's being used is the Edinburgh. The resources that – where I see it happening, I – it's not widespread yet by any means. It tends to be the practices that have begun to collocate – behavior health providers in the primary care setting that are doing these screenings.

Our Medicaid program covers Medicaid women two months postpartum generally, if they are – if they're not – we have an MPW – medicine for pregnant women – so we're trying to identify them earlier and getting them at

least treatment initiated. We also – most of the practices that collocate behavioral health providers, we have – of the local management entity oversees mental health, and so they work closely with the LME, if they are uninsured, in terms of how to access services. But it's still very new.

(Sandra Puttermer): Great. Thank you.

Chris Collins: Yes.

Operator: There are no further questions at this time.

Jeanne Anderson: Thank you, (Shawn). And thank you, Chris.

Chris Collins: Oh, you're welcome.

Jeanne Anderson: OK. So we're going to go ahead and move on to Rhode Island and Blythe Burger is going to present. Blythe?

Dr. Blythe Burger: Hi. Thank you. Can you hear me?

Jeanne Anderson: Yes.

Dr. Blythe Burger: OK. I think it's always challenging to follow North Carolina, because they do such a great job. But we're going to talk a little bit about Rhode Island's early childhood development screening services, and I'm going to give you a little background on how this started, because we really started with community interest that sort of came to us.

We had done a survey back in 2003 about children who were getting excused from childcare centers due to behavior problems, and we found a fairly high rate. When we went and talked to childcare providers about that, we heard a lot of language around, "Well, something's wrong, but we don't know what. We don't know how to talk to the parents."

When the parents go to the pediatricians, they don't know how to explain what's going on, and we don't go with them, and they don't want to talk to us. So this really started on sort of a small level and a geographic (attachment) area that asked us to come to them and talk about it.

And so what we were looking for was sort of a common language, and what we proposed to them was to help childcare providers learn to do developmental screening and then try to see if we could talk to the pediatric community – if we could share that information with them, either through the parents or send the screening tool directly to the provider, if they were interested in that.

And we started doing that, and what we did was we had somebody come and who had worked with childcare providers in the past, we picked the Ages and Stages. We did look at a lot of the different screening tools that were available on – and Ages and Stages was being used in other areas of the state, it had a fairly broad age range, and it coordinated well with what was being done at ages three and four.

So we set up a basically sort of a system, and then we had someone who was going to talk to providers and teaching them to set up a system to screen a child either right before their well child check or if there was an issue. And in the meantime, we had gone around to two of the large practices in the area, and because this was a geographically fairly cohesive area, a lot of the kids did go to the pediatricians – and asked if we could just have them get the screening tool faxed, and they said that was fine.

We also offered to train them to do the screening, but we did not get a lot of interest in that. So we started with the childcare providers, and then in 2006, we did a survey of pediatricians to find out how many were doing standardized developmental screening, how many were doing sort of general surveillance, and how many were really just having a conversation about it.

What we found out was that only 21 percent of the pediatricians who responded – we have – at that time we had 240 in the state – we got a 30 percent response rate. Only 21 percent were using a standardized tool. So we really felt like there was an opportunity there. We had worked through Healthy Child Care Rhode Island with the American Academy of Pediatrics.

So we got another staff person to help us who was already familiar with the pediatric community, and we sort of tried to develop a system. And in the

meantime Marian Earls had come and done ground rounds for us and talked to us about what a real system looked like, and we are still using the template that walks you through how you would implement this in a practice.

So we did start using it both with pediatricians – and at that time they were allowed to either choose the PEDS or the ASQ in Washington County and child care providers. And they were faxing information back and forth, and we found that they were starting to do referrals. And in the meantime, other community interest had sort of gotten generated.

Right Care was interested. We have a universal newborn screening, so we had some history around standardized screening. We have a statewide database that could capture the information, if we were available to get it in. And then as we developed our ECCS plan, it became part of that. So we had sort of a natural bridge to move forward.

So we looked at the resource in the state. At that time, the health plans were reimbursing 96110. We had some resources through a Healthy Tomorrows grant and our Early Childhood Comprehensive Systems grant. And then about two years ago, we applied for and were granted a launch grant from SAMHSA.

And we integrated developmental screening into that from the beginning. What we proposed was to do the developmental screening in pediatric offices and childcare centers and collocate mental health consultants in both of those places.

And when we started doing that about a year ago, it really took off. So currently we have about 50 child care centers who are doing developmental screenings, 84 physicians who are doing standardized developmental screening, and when we switched over to the Rhode Island launch activities, and we said, "We're going to place someone in the office with you," we wanted them to use something called the child wellness screen.

So what we use – it's on your slides – is we use the Ages and Stages, the Ages and Stages SE, and something called the EXA, which was developed in Rhode Island, and it has four questions that get at maternal depression as well.

So – and we (allowed) the time to switch over to childcare centers, so also using what we called a child wellness screen. So it really gets into more comprehensive looks. We have done ground rounds in all of the seven hospitals to try to really get the word out about this. We're implementing in addition to some private pediatric offices and the two very large clinics that serve high need populations, and that has proven to have been a very interesting experience.

We ended up having to get AmeriCorps volunteers to help us to have the parents complete the screen in the waiting room. What we're finding through these developmental screens is that a number of the issues that are highlighted that would have automatically gone as an early intervention referral are no longer going as an early intervention referral, because once a child has a red flag on the screen, if it's available, they are then sent to see the mental health consultant, and the mental health consultant does an additional evaluation.

And so what we're finding is that a lot of this is incredibly high parent stress, chaotic lifestyles, and if we are able to hook them up with a more appropriate system than early intervention, we do that.

Some of the challenges are obviously around, you know, getting the system in place, particularly in the busy pediatric practice. I think if we had 10 people doing the technical assistance that we currently have set up the physicians' offices, we could – we could use them full time. It's really something that they take advantage of, and need to keep doing it.

It's challenging to get the childcare providers, the physicians, the parents all to coordinate. Our referral processes right now aren't perfect, nor is our referral on end points, so although we know where we're referring, at this point we can't tell that we've completed that referral, which is something we'd really like to be able to do.

So we're actually looking to make some changes to our KIDSNET system, which would allow us to see more comprehensively once we recommended a child get into a certain sort of service system, did they actually get into that service system.

In addition to developmental screening that's going on in these childcare providers and the pediatric providers' offices, we are also running IYS – incredible years series – parent groups for parents of young children and something called the VIPP, which is a younger child diatic intervention, and that was largely in response to the physician saying, "All right. I've gone through this process, I've identified a child, I don't know what to do, and what if the IE is not an appropriate referral and we can't find something else."

So we're working with the offices to get together the parents who are interested or who clearly have an issue where they would benefit from this, to run the parenting education components. We're finding that that's a huge need in the state. And so we're hoping that – we're working with Medicaid to try to see if we can get some of that funded on a sustainability level.

So the outcomes that we're hoping to shift towards is a system more focused on prevention, that kids are getting the services at the earliest possible opportunity, that families are feeling like the care is coordinated and that they're not being asked to go to six offices to get six different types of services, that the care providers are really more of a resource.

Initially having mental health consultants linked with developmental screening seemed a little stressful for everybody, and at this point, I think they feel like they don't know what they would do without each other. So that's been sort of exciting.

And what we really – I think our biggest need is to be able to do a cost benefit analysis to show that getting children screened and into appropriate services as early as possible makes a lot of fiscal sense down the road. Thank you.

Jeanne Anderson: Thank you, Blythe. (Shawn), we have enough time for about two questions. Do we have anyone that has a question in queue?

Operator: Yes. Your next question is from the line of (Heather Dubile).

(Heather Dubile): So we're interested in – because we're kind of dabbling in that screening in the childcare sites here in Colorado, and we're interested in knowing what the

process was for screening in childcare sites, and how the centers sustained that. And who's completing the screening.

Dr. Blythe Burger: Well, if you send me that question via e-mail, we can send you part of the toolkit, but the way it's – so what we do when we go into centers, we provide them what the agent stated and allow them materials that they needed up front, which was sort of our carrot.

And then someone goes in and sort of says, "Here's how you want to implement this system in your site." And then for the most part, once we've done that, the actual screening, which is being done by the childcare providers and childcare sites, it is not that onerous, and they have pretty much sustained it on their own.

The biggest challenge is that we're trying to get data from them around the number of kids screened in the referrals, and sometimes that seems a little bit difficult. But they do tend to keep it up, because they find it to be a very helpful tool.

(Heather Dubile): Thanks.

Dr. Blythe Burger: Sure.

Operator: Your next question comes from (Kelly Munson).

(Kelly Munson): Blythe, thank you. Do you have childcare health consultants on network in Rhode Island?

Dr. Blythe Burger: We do have childcare health consultants in our network. We are working right now very hard to beef that up, and so in some – we have a requirement that sites that have infants have a childcare health consultant on site. Most of the other centers don't. So the places where they're on site, we have worked with the childcare health consultant to, you know, have them support the teachers through this process.

(Kelly Munson): How are the childcare health consultants paid, other than by the centers that need to have the reviews – the infant ones – but otherwise?

Dr. Blythe Burger: Mostly they're not paid, but we have – so we have two in the state right now that are funded through different federal funding streams, and as of July, we have promised that we will have a fee-for-service structure available. Stay tuned. I am behind.

(Kelly Munson): Thank you.

Dr. Blythe Burger: You're welcome.

Operator: Your next question is from (Martha Hyatt).

(Martha Hyatt): Thank you again. I'm in Arkansas, and I have two quick questions. First of all, would you clarify your statements regarding referrals that might be more appropriate than referring to early intervention, because we thought – I mean, we talked about the federal law that requires referral to early intervention. So we may have missed part of your statements there, and I apologize if we did. So that's my first question.

My second question is when a screening is done in a childcare center – because we're also piloting a program here in Arkansas – how – what process – how do you share the information, the results of the referral or whatever, with physicians – with the child's medical home – and you may have talked about that too, and if so, I apologize, but thanks.

Dr. Blythe Burger: OK. An example of the early intervention referral – so all of our pediatricians for the most part have said to us, "We are referring to EI, because that is what we know, and we don't know anything else."

A clinician saw a mother recently and the baby had a sleep problem, and the physician was ready to refer to EI, because the kid seemed so chaotic, and the way that the screening tool showed up – I was, you know, not there, but I heard about this. The mental health consultant spent about a half an hour with the mother, talking about different sorts of sleep practices, things to try – did not feel like this needed to go to early intervention – you know, said, "Why don't you come back in a month," and in fact, things were much better.

So the – a lot of it is because we don't have sufficient resources, or we don't publicize them sufficiently, around a lot of parent support. And because physicians know about EI, that's where they're going.

(Martha Hyatt): OK.

Dr. Blythe Burger: In terms of the childcare centers, what we did in the first area I talked about was that we contacted the physicians, and we told them that the childcare providers may be contacting them. The parents have to sign a release saying it's OK to share this information.

What we really did was encourage the parent to take it to the physician, but a lot of times they say, "Can you just fax it, because I don't think I'm going to remember, or I'm not going to get it."

So the parent had to sign a release in both places, saying, "I understand that this information may be shared."

(Martha Hyatt): So does the childcare program – then is there a requirement or something to help ensure that the childcare program shares it? Because here in Arkansas, we work very closely with our Academy of Pediatrics to set up this pilot program, and part of our protocol is that participating programs must share that information – of course with parental consent ...

Dr. Blythe Burger: Right.

(Martha Hyatt): ... with the physician – either fax, hand carry – in some small towns in Arkansas, that would be possible, mail or whatever. So do you really reinforce that? I mean, our pediatricians felt very strongly about that.

Dr. Blythe Burger: We really reinforce that. When you do the screen two weeks, three weeks, whatever it is, before the child's well child check, if the parent doesn't want to take it, please send it to the pediatrician. And it's – we have not heard that that's not happening.

(Martha Hyatt): Great. Thank you. That's real helpful.

Dr. Blythe Burger: (Inaudible).

Jeanne Anderson: Thank you very much, Blythe, for your presentation. And so in summary of our work on this day where we brought all these individuals together and we talked about developmental screenings, we had Dr. Jana work on a report for us, which will be available on our web site at the end of the month, and each of the ECCS coordinators will be receiving a copy in the mail.

So Dr. Jana, would you summarize what we found that day?

Dr. Laura Jana: Sure. And again, it's my pleasure not only to join you now, but it was actually great for me to get to participate at the summit with what was interestingly a lot of the same sorts of questions that are being asked on the call here around these presentations in a very rich discussion.

So the goal of writing up the report was to not only capture the presentations you've just heard, but also to capture those discussions and also some of the challenges that people have faced so that we could really pull together sort of next steps, say what has worked well, and what could you base, you know, your own efforts on, but also recognizing where those challenges may lie before you have to face them yourself.

So the beginning of the report – the goal also was to include some of the basics, so that it could function somewhat like a standalone report for anyone who's looking at implementing but hasn't gotten some of those basics in place yet – offering the overview that – similar to what Jean Anderson presented at the beginning of this call, looking at who all was involved – the multidisciplinary aspects of bringing people in and looking at all these aspects involved in developmental screening.

Also looking at some of the foundation that exists already, certainly in the context of the American Academy of Pediatrics and developmental screening initiatives that are in place, and also that fit in with what's been mentioned several times here, but the concept of the medical home.

So a review at the beginning of the report does include the AAP's developmental screening initiatives and medical home efforts, sort of by definition, and also what's there in the way of existing policy statements and

algorithms that people can follow for developmental screening and surveillance.

And then went on with a presentation from Dr. (Donahue), who's not on the call today. But looking at some of the things we're addressing, each of the presentations you just heard but in a more general way so that people could apply it to their own circumstances regarding implementation in early childhood settings. And I believe I just heard some of the questions that were asked were specific to these sorts of things.

First of all, looking at the need for clarifying the rationale for developmental screening in the first place – and then it's very important to emphasize why it's important, identifying – making note of the fact that early identification does in fact prove to be critical to the well being of children and their families.

And then also looking at how few children actually are currently being identified who would qualify for services, and therefore making a rationale for implementation.

The next step was looking at the – defining the common terminology, because again, some of the resistance when you talk about whether this is done in the doctor's office versus in the childcare setting or in other areas in the community often stems from concerns that may not be justified because everybody uses different terminology.

In fact, even the words developmental screening are often misunderstood to mean more than just the administration of a brief tool to identify possible developmental delays – and again, the perception may be more of a – somebody's making a diagnosis labeling a child or confusing it with evaluation, which again is a much further along the process step than the simple screening process.

So those things – the delays, the disorders, surveillance, screening, and evaluation – all need to be defined so that everybody's using the same language.

The next part of that section looks at the goals of the screening, and somebody early on in the call here asked about which – you know, which tools and how do you decide which is the appropriate tool. Addressing that during the summit, it was mentioned that there needs to be careful consideration of what the goals are for any given implementation project, given that the tools would relate to whether you're looking for a general developmental delay, if you're looking at autism specifically, et cetera.

And there is information on the different tools and in fact definitions and abbreviations are all kind of listed out at the end of the report here so that people look at some of the available tools, but also what specifically they screen for.

And then the last part of that section was the planning for the implementation process. And that addresses not only the last stage of, you know, when you're implementing it, how those results are going to be conveyed and shared. Again, how do you get it from the childcare center, for example, to the physician's office and vice versa.

But even earlier on in the process determining where the screening results are going to be documented – if that involves putting them in the children's files, if they're being entered into a registry, and all of these who-what-when-where – all of those aspects that often stand to get overlooked in establishing the process.

The other thing that was very clearly identified as something not to be overlooked is the need to consider how the results are going to be delivered to the family. And that often meant additional training for staff. A lot of staff weren't comfortable with the aspects of delivering what may be – especially when you're delivering positive results or concerns about developmental delays – delivering those in a way that is both useful to the family, but also that the staff are comfortable with.

And then lastly, which we have already touched on is the referral procedures – what's going to be done with that information, how's it going to be conveyed, and also ensuring that you know what referral options there are in any given

community, since just defining the results is clearly not enough, but knowing what to do with them as an end point.

And then for assessment, we included a structure of the very standard PDSA formative evaluation – the P standing for the planning out the process, which we've just discussed. The Do, which is the implementation of the plan, but then also adding on the taking the time to study, so PDS, and the S being study – taking the time to assess if the stated goals are being met, and then how to act on anything that may not be, so that you can improve it and improve your results.

And again, what you've just heard in the three presentations that were given, are ways that each implementation process was customized for any given, I guess, circumstances in each of those states.

So having kind of summarized that actually in the report prior to the presentation of the three state examples that you just heard, each of the three states' implementation plans were presented somewhat in a standardized way, so that it gave you very different – I mean, gave the same aspects, but very different ways in which each of those – of those implementation processes were put in place.

And then at the end again there was a very rich discussion, which was – I think everybody agreed very important to include in the report, which was again, exemplified in each of the specific state reports, but was a discussion of what those challenges were and then what next steps needed to be taken to be successful in implementing developmental screening in early childhood systems.

The four questions that everybody was asked to consider after the initial presentations were number one, what are the challenges your state faces in the implementation of a statewide developmental screening initiative; number two, what are ways that your state can overcome these challenges; number three, what are the next steps for your state; and number four, what lessons learned do you have to share with the group.

And again, a lot of what I've just mentioned, which I included in the initial part of the report, was emphasized and reinforced in this discussion. That – the fact that developmental screening in early childhood systems involves interdisciplinary coordination and cooperation seems to pose probably what was considered to be the most significant challenge to implementation, because it really does require thinking outside of the traditional silos of the, you know, medical office, of childcare, and of all the other agencies involved in this sort of a community approach to implementation.

The – again, the resistance – and sometimes it was framed as resistance, not just a challenge – but resistance to implementation is sometimes based on first of all the need for a health care professional champion – somebody who's going to champion the cause, because without that, everybody seemed to agree that implementation was not as likely to be successful.

And that champion had to be somebody not necessarily in a clearly defined – one particular field or professional background, but somebody who could effectively interface with all of the key components to implementation. And that was the ECCS programs with the medical professionals, the childcare professionals, et cetera.

And it was suggested that might be an AAP – American Academy of Pediatrics childcare contact, which I guess has been effective in some of the states.

The second aspect for resistance was in training, as I mentioned earlier, and that there's a definite need for additional and adequate training for whoever's going to be participating in the screening process and the exchange of information. And some of that training may be as basic as what is defined as normal and abnormal development, since the goal is to use sort of the uniformly accepted and defined definitions, and not peoples' kind of arbitrary decisions, and also the need to take into account cultural differences, which clearly vary from state to state and area to area.

The next one was addressing specifically childcare agencies and organizations, and some of the resistance being very focused on limited

financial resources, staff time, education levels, and a potential lack of understanding as to the benefits of screening.

Again, looking at reimbursement issues, which often gets brought up and for coding purposes for the medical office, hold as true in the childcare setting and the childcare consultant, who also looking at how do you afford or how do you make it feasible for them to be available at the level we're talking about, implementing more widespread programs. For the next point was reimbursement, and again that's tied in with it.

And then finally, the inadequate connections, which brings us back to what people considered to be the primary challenge, but one that was very worth taking, and clearly evidenced in the three programs you heard, when it's done successfully, and that is making adequate connections and the sharing of information across what is considered to be a traditional silos that we're dealing with.

So in closing, both the report and I guess my summary of the report, it basically resulted in the fact – stating the fact that there are clearly recognized benefits for the children and families impacted by early developmental screening, that subsequent referral and early intervention are important, and that a coordinated approach to facilitating those services within a well established medical home really is what we are all striving for.

And the last thing as promised to conclude the report was the summary of important next steps. And again, there was a lot of detailed information and suggestions presented, which I tried to distill into the following eight next steps.

Number one was to commit to better and earlier intervention – or earlier evaluation of children with developmental disabilities, both developmentally and medically.

Number two is to be prepared to work together across disciplines, identifying and bringing together key stakeholders.

The third is address potential shortages or lack of availability of early intervention resources.

The fourth is to seek out reliable and valid screening tools, looking for consistency.

Number five is identify optimal times and locations for screening, which may vary greatly from one state to the next and one program to the next.

Number six is plan and provide professional training and education.

Number seven is ensure appropriate payment for surveillance, screening, and evaluation.

And then the last one is expand evidence on the effectiveness of developmental surveillance.

And that is my summary of the report.

Jeanne Anderson: Thank you, Dr. Jana. And so, you know, as we conclude our presentation on developmental screening, we have enough time for maybe one or two more questions, but certainly it was a very rich opportunity that day to share information, and I hope that as you have questions, you will bring those forth, if not – you know, to your program officers, you know, that can forward them to Healthy Child Care America, please send them to me.

My information is on the agenda, and we will certainly get those answered for you. (Shawn), do we have a couple of questions in queue right now?

Operator: Yes. Your next question is from (Shirley Pitt). (Shirley), your line is open.

(Shirley Pitt): Hello. I was wondering when you did the report – actually my question was for an earlier speaker, but since I have you, I was wondering – when you did the report, did you have a sense of how many states were billing 96110 the same day or time that they billed for an EPSDT exam?

Dr. Laura Jana: I – this is Dr. Jana – I don't have that information. I don't know if Jeanne can comment on it, because I really again was focused on what was presented at the – at the summit itself. Jeanne, do you know the answer to that?

Jeanne Anderson: No, I don't know the answer to that, but I certainly – Chris might know, or if I can't answer that today, I certainly can look into that for you, (Shirley).

(Shirley Pitt): That'd be great. Thank you.

Chris Collins: This is Chris. If you send me specifically what you're looking for, I can see if we can run the data real quick and get it back to you.

(Shirley Pitt): OK.

Operator: Your next question is from the line of (Kelly Munson).

(Kelly Munson): Yes. You know, I'm from Minnesota, and we're interested in – maybe it was you, Dr. Jana, with the Academy – is what's being done – for example, we've heard many states using ASQ, and – you know, we use it here in Minnesota. Is Brooks Publishing is working and – I don't know if it's released yet – a web based version and a whole system around that.

But the challenge is those electronic medical records. There's like 20 different types of that in there, and what we're seeing is not a net – a lack of national support and leadership and actually money to help move this forward of linking, like, web based ASQ to electronic medical records. Anybody want to comment on that?

Chris Collins: This is Chris from North Carolina, and it's something I've heard from some of our pediatric practices that in fact some of the EHRs for pediatric practices as a general rule are sorely lacking. Some don't have (growth) charts. Some don't have validated developmental screening tools. In them I think our state's pretty sensitive to it.

And so as these vendors are coming and demoing, you know our providers are saying, "I can't use what you have in there." So not only are they not coming

with anything in it, in fact what they're coming with is not even validated tool. So I agree it's a significant issue.

Operator: Your next question is from the line of (Martha Hyatt).

(Martha Hyatt): This is not so much a question as it is a comment, because all of this discussion and the report is great, and I know the summit in 2009 was excellent, but as several states have referenced the National Academy of State Health Policy and the Commonwealth Fund, and because several of us – a lot of us probably – have participated at one time or another as ABCD states, (NASHP)'s web site – they have done a tremendous amount of work on developmental screening, the 96110 code and the use of it, and so I would just encourage everyone, and I know Joe and (Dena) have sent out and through various ways we've gotten information on (NASHP) and ABCD, but that has been a really major focus of their initiative.

And I know they've worked with you all at the Academy of Pediatrics, so I'm just suggesting that that's another resource that you might could use without someone having to collect a lot of information that may already be at one web site.

Jeanne Anderson: Thank you, (Martha). I appreciate that very much.

Dr. Laura Jana: And I will just – this is Dr. Jana again – I will just chime in. I did not go through every bit of the report, but there actually is a section in here as well that does review and discuss some of the national activities and trends. That includes not only some of the – of additional initiatives that the AAP has, but also the ones with the Commonwealth Fund and sort of a summary of the ABCD efforts as well.

I don't remember if we included that as a web resource at the end of the report, but we did try also to include several articles, web resources, and a – and a book or two, and some articles that all would again get people kind of to more focused information where they wouldn't have to pull it from lots of different sources.

Jeanne Anderson: Thank you, Dr. Jana. And so that concludes our portion of today's call. I really appreciate the opportunity to share this information with all of you. And Frances, I will turn it back over to you.

Frances Marshman: Jeanne, and everybody else, thank you so much. That was really wonderful. And I want to reiterate that contact information for the speakers is at the bottom of the agenda, as well as I believe Dr. Jana promised that the report will be posted on the American Academy of Pediatrics web site soon. And I would just ask you Jeanne Anderson if, when that day comes, you could make an announcement to the ECCS Listserv, that would be really wonderful, and alert all of our listeners to being able to go to the web site.

Jeanne Anderson: Absolutely.

Frances Marshman: OK. And so without further ado, I – we do have sixteen more minutes. And as you all noticed on your agenda, we've left it for other ECCS business, and I'm going to hand over the call to both (Dena Green) and Joe Zogby, who – I apologize, I didn't introduce you earlier.

Joe is on the call as well as Phyllis Stubbs-Wynn, to get us up-to-date on a few ECCS related activities. (Dena)? Joe? I'm not sure who wants to start.

Joe Zogby: Oh, I'll start.

Frances Marshman: Hi, Joe. Great.

Joe Zogby: Hi. A couple of (comments) that the guidance has not been approved yet by HRSA. It's – I think it's in the end stages there. But you can get a head start by using the draft that I had sent out.

Now, you cannot open up the electronic handbook until the guidance goes out officially. Now it's my understanding in conversation with higher-ups that the due date is not going to be hard and fast cut in stone, such that if you're five minutes late with it or a couple of days late with it even, that you're not going to get an award.

You have to consider that grants management needs time to process the award, so that if you could have your non-competing application in by early May or a little earlier, then we'll be able to deal with it. That's one item.

Next item – we tried to bring everybody up to \$140,000, and the notices of grant award have been going out. Yes, that is in this year's budget, and you will not be able to use it after May 31st, unless it's obligated. That is, that you have made a commitment – a legal commitment on the use of the money, such as a contract.

If you are doing some kind of a project that requires a contract, and you obligate the contract before May 31st, you are able to continue to operate that contract through the next budget year. The key thing is that your grant is still active.

Now the length of the contract is determined by your own state rules. Your procurement office will tell you how long you can run the contract. As far as the carryover of that money, hypothetically, it can become available again next year – what you don't spend or obligate. But I cannot promise how much of the carryover, or if carryover requests are going to be possible next year.

It all depends on how much money is available to us – the ECCS program. We may have to rely on carryover in order to keep the program funded at the highest level possible.

I also want to note that there are six grantees that have not gotten their financial status reports in yet. I can't say 100 percent that you won't get an award if you don't have the financial status report in, but you never know. It might complicate the picture, so please get it in.

But furthermore on that, we are converting over to a new reporting procedure called the FFR, which you've probably heard about. And that is the 1st of April. And there are training materials – there have been training sessions on that. After April 1st, you will have to do the FFR procedure.

Let's see if there's anything else.

Frances Marshman: Joe, would it be OK – this is Frances Marshman – if I summarize what I heard you telling everybody, before we take questions?

Joe Zogby: But let me finish one more thing.

Frances Marshman: OK. Certainly.

Joe Zogby: There were questions on the page limit. At one point in the guidance, it says 50 pages. At another it says 80 pages. We feel that 50 pages should be enough. However, if you go over 50 – of course, we're not wanting you to go very far over 50 – but if you creep over 50, you're not going to be in trouble. But 50 should be enough. All right. That's what I've got, Frances.

(Dena Green): Joe, this is (Dena).

Frances Marshman: (inaudible).

(Dena Green): Frances, could I just say something too?

Frances Marshman: Absolutely.

(Dena Green): All I wanted to do was again – I don't know if the speakers are still on, but I wanted to thank the speakers, because I thought it was a very rich discussion, especially since a lot of our grantees are working with and have been struggling with the issues of developmental screening, so I just wanted again to say thank you.

On the agenda, we did have some information about the August meeting, and I know Frances will be giving everyone further information, and she's also – I don't know if you were going to mention it or let them read it – that we are going to be looking for grantees who may be interested in being on a planning committee for our ECCS meeting.

And with the EHB, the last thing is I know a lot of people have had a lot of questions about how to enter their reports into the EHB, and there is new training that's going to be coming up soon. Project officers will first be trained in how to use the new system, and then you should be getting something in your e-mail in regards to this training.

We'll also have a web site that should be up and live in another month or so. Frances and her staff are working on that. And on this web site, we plan to post all of the information that we've ever sent you and that you also see in the back of the guidance in terms of how to access the EHB.

We also may, if we can squeeze it into our calendars, have another all-grantee call, where we'll have hopefully the people from Grants Management and possibly the people that monitor or manage the EHB when it's time for you to do your end year reporting, and also when you submit your applications.

I just heard Joe say something about the page limits, and I think that's good, because since you have to submit your applications electronically, I thought in the past that the computer would determine if you had too many pages. But hopefully, you won't have that problem, and we'll also be able to have this training prior to everyone submitting their applications.

So keep watching your e-mail. Look out for the training that I just mentioned and the new FFR form that Joe mentioned and that (Karen) spoke about in our last all-grantee call. And also information about the guidance.

And remember also, if you're having problems – and I don't think anybody will – but in case you're having problems with your applications, that JSI and all of the regional TA coordinators are available to help you with your applications. And that's about it for me.

Joe Zogby: Frances, I didn't mention the meeting in August. We're having a grantee meeting, and then we're also going to have a joint meeting of a very large nature – multiple agencies – even more than the last time – the March of 2008.

You'll hear more about this, but our grantee meeting will be starting on August 2nd, which is the Monday, and it will be all day Monday. Then the next day, August 3rd, will be the joint meeting all day Tuesday and half of Wednesday.

Then Wednesday afternoon, we're going to resume the grantee meeting. We're going to ask you in your new budget to have money set aside for three

people to come in – that is yourself, if you so choose, another ECCS staff person, and the third one will be the state early childhood advisory council representative.

We are asking you to pay for their coming in, because they're a very key player who is going to be working with us in the future. That's all I've got now. Frances.

Frances Marshman: Thank you, Joe. I think maybe we should. I could recap what both you and (Dena) have said, but maybe we should open the lines up for questions.

Phyllis Stubbs-Wynn: (If I can) say something. Hello, Frances. This is Phyllis, and I couldn't let the call end without personally thanking our presenters today – Jeanne Anderson and our presenters from New Mexico, North Carolina, and Rhode Island, as well as Dr. Jana and that excellent summary.

If you would remember about a year ago when we asked what do we need to do in terms of to support the ECCS work, one of the responses that we got quite often was we need to do and get a little more assistance with the whole idea of developmental assessments and strengthening the medical home.

So all of our presenters did a wonderful job, and I – as you do – look forward to the report that Dr. Jana referenced and that you can review it, look at it, and also find ways that it can help you specifically in your needs. Thank you.

Frances Marshman: Thanks, Phyllis. Operator? (Shawn), I think we should open up the line for questions.

Operator: Yes. Your next question is from the line of Phyllis Stubbs.

Frances Marshman: I believe she just spoke. So maybe we could move on to the next question on the line please?

Operator: Your next question is from (Jamie Anderson).

(Jamie Anderson): Hi, this is (Jamie) from New Jersey. I did not receive the e-mail, or I guess I missed it or whatever it might be, that Joe mentioned that he had sent out an e-mail with a potential draft for ...

Frances Marshman: It was sent on March 4th in the Listserv – by the Listserv.

(Dena Green): This is (Dena). I just got three e-mails from people who also said that they didn't get a copy of it, so I'm sending another copy. The copy is coming through Joe's e-mail list, and my e-mail list, so instead of saying ECCS in the header, it'll say "Joe's List" or "(Dena)'s ECCS List."

(Jamie Anderson): OK, thank you.

(Dena Green): You're welcome. So I'm sending out another copy as we speak.

(Jamie Anderson): Now, I have another question in terms of the – this year's grant money – that's expected. I've been on hold with a contract for a long period of time, because this money has not yet come in. I – because of that, I'm not quite sure. Maybe (Dena), this would be something to just discuss in – you know, just one-to-one. I don't know if this affects other states – territories as well.

But because we haven't had the money, I haven't really been able to – you know, sign off on a contract. So the contract has been waiting. And we've been waiting to sign off what's going to happen, based on how much money – if that \$35,000 came in or not. So I've been in a holding pattern.

So from what Joe said, I'm not really sure yet if I can even still move forward with this \$35,000, because at this point the contractor has told me they can't even finish the work if we don't even have guarantee of the money up for them to even start yet.

Joe Zogby: Who is this?

(Jamie Anderson): New Jersey.

Joe Zogby: New Jersey.

(Jamie Anderson): So they said if we can extend it through to next year, it would be fine. But if we can't, we – you know, I'm sort of betwixt and between a contract issue here. So can I just call you personally to kind of work out how ...

(Dena Green): Whoa, whoa, whoa – I'm – I think this is a question that several people wanted to know.

(Jamie Anderson): OK.

(Dena Green): When is their (NGA) going to arrive, and most of you know – if not all of you – that Joe and I cannot guarantee that it's going to come at a certain time. But we have – Joe has done the work for that to happen, and it – the (NGA) itself does not come from us. It comes from the Grants Management people.

(Doesn't) – it's not an (addressed) specification, but it's to say that are working on the (NGA)s. I've gotten some out already that she sent to – she sent out, and I send them again to the grantees. But we hope that you'll be getting them in the next couple of days.

Now, if you're having a particular problem – as one grantee told me that their state won't even allow them to even recognize the money until they get the NGA, and there's some paperwork that has to be done in order for the state to accept the money. If you have some concern like that, maybe you could send an e-mail to Joe and I, whoever your project officer is, and then we can take those particular letters maybe to the Grants Management and ask them if they could do them a little faster.

(Jamie Anderson): I think at this point it's been – we've been on hold to cut back the type of work we were going to do ...

(Dena Green): (I understand).

(Jamie Anderson): ... because we haven't gotten the money, and now we're being told the money might be there. So now I'm thinking, "Wow, we can do the whole big potato, like we wanted to do."

(Dena Green): And it still might be, but what you have to have is that NGA for your – your fiscal folks, to say that the government does intend or has awarded you this money, and that's probably what they're waiting for.

(Jamie Anderson): OK. I think I'll need to follow up with you, (Dena).

(Dena Green): OK. On Monday.

(Jamie Anderson): On Monday? OK. Thank you.

(Dena Green): You're welcome.

Frances Marshman: I'm aware of the time, so I think we should take a few more questions.
Was there another one in the queue, operator?

Operator: Yes. Your next question is from (Helen Arthur).

(Helen Arthur): Hi, everyone. I think that I just may need to do this off this call, but a lot of my questions have been answered already, so thank you. But as far as the FSR is concerned, Delaware is probably one of those grantees probably holding this process up. But I am completely out of options on how to fix this. And I have been working with Miss (Thorne), and it is not getting resolved, and I'm really getting worried, because we are down to the wire for receiving the next NGA. And I am not sure what to do about that, (Dena).

(Dena Green): I'm sorry. Could you repeat the – who is this on the phone?

(Helen Arthur): This is (Helen Arthur) from Delaware.

(Dena Green): OK. And you're having a problem with your FSR.

(Helen Arthur): Yes. We have been working on this for the entire project period, and I have followed up with Miss (Thorne) many, many, many times, and she told me that this was kind of on a supervisor's desk, waiting to be finalized. It was reconciled, but – you know, I'm really at my wit's end.

It had to do with a problem I believe with the transfer into the electronic handbook of information, and so Delaware – we've done every – I just don't know what to do about this.

(Dena Green): Well, it does end at (Karen Thorne)'s office. But if you send me another e-mail, I'll re-send the – and cc to me – to (Karen) and I, and I'll send her to remind her that this is something that we're working on ...

(Helen Arthur): Thank you.

(Dena Green): ... that you need to have done.

(Helen Arthur): All right. Thank you.

(Dena Green): Anybody that's having an FSR problem. Now, I just sent the e-mail out for the guidance to all of my grantees on a separate list. We didn't want to put it on the big list, because there are people on the big list that shouldn't have the guidance at this point. So if there's anyone that did not receive it that's one of my project officers – and then I'll also send it again with Joe's name on it too – then send us another e-mail, and we'll send it to you individually.

Frances Marshman: And please know that this is draft guidance ...

(Dena Green): That's right.

Frances Marshman: ... with a draft deadline of April 1st.

(Dena Green): Thank you, Frances.

Frances Marshman: And as Joe has said, that will change. Let's take one – let's take two more questions. (Shawn), are there more in the queue?

Operator: Yes. Your next question is from (Linda Gramblin).

(Linda Gramblin): Yes.

Frances Marshman: Hi, (Linda).

(Linda Gramblin): I have a couple of questions. Are we required to submit a revised budget for this current year with the \$35,000 increase?

(Dena Green): No.

(Linda Gramblin): OK. I didn't think so. And ...

(Dena Green): At least today, no, I should say.

(Linda Gramblin): At least today? OK.

(Dena Green): (inaudible) changes, let you know. But right now, no.

(Linda Gramblin): OK. Thank you.

(Dena Green): You're welcome.

(Linda Gramblin): And for our new application process, I'm a little confused, I guess, as far as when we go into the new application process. Are we needing to submit an entire application along with new letters of support and the whole – the whole process? Or are we really more doing just an update of our program activity?

(Dena Green): Joe, you want to answer that?

Joe Zogby: Well, there should be no need for you to include in that application things that have been sent in already.

(Linda Gramblin): OK. Thank you. So just whatever – if we have, like, revisions of staff working, or staff percentages – that kind of thing – we will include that, but any letters of support or anything like that that's been included before, we will not do again.

Joe Zogby: No, you don't need to send the same letters of support again.

(Linda Gramblin): OK. Thank you. I appreciate it.

(Dena Green): Frances, I have two questions that came up on the e-mail also having to do with the FSR. People asking are they late, or is theirs due. If you haven't gotten a letter from someone saying that your FSR is due, it should not be due. But I want to remind folks that you have access to your EHB folder, and you can see in your folder, if you go in there under your grants number, you can see if your FSR has been submitted.

That's something that comes from your office and goes to (Karen Thorne's) office. We only find out about it if they tell us that yours is still outstanding. So please check your folder to see if yours has been sent. If you haven't heard anything, then it means more or less that it has been received.

OK. And I didn't get any e-mails from anyone saying that they didn't get the re-send that I did of the guidance. If there's anyone still on the phone that's not near a computer, and you haven't gotten the copies that I just sent out, please send Joe or I an e-mail, and we will re-send it to you.

Frances Marshman: Operator, I think we have time for one more question.

Operator: Yes, your next question is from (Shirley Pitt).

(Shirley Pitt): Hi. I just wanted to clarify, Frances, you made a comment – and Joe probably covered this. The April 1st deadline may change?

Frances Marshman: The guidance which (Dena) is referring to that she's just re-sent out on e-mail that Joe did send originally on March 1st is draft guidance. So the deadline on the draft guidance is April 1st. It's more than likely that the deadline will change, once the guidance goes from draft to final.

(Shirley Pitt): OK.

Frances Marshman: As time – as time passes – however, you heard both Joe and (Dena) talk about the contents of it – of your re-application, and that it should hover around 50 pages and that you don't need to include a lot of things that you included in your original application. So I encourage you and everybody else to start pulling together all the pieces now, because I wouldn't want – we don't know for sure, but I wouldn't want you to be surprised if the deadline does stay at near or on April 1st.

(Dena Green): Great. Oh, hey – Joe could probably talk about this better than I could, but – so understand that it's a continuation guidance, so it's not as extensive as the original guidance, and it should be more or less clear in terms of what you usually do for continuation guidance, you know, with an updated progress report, where you look at what you've accomplished and what was not accomplished, and what you plan to do in the next year. That's essentially what the guidance covers.

Joe Zogby: Also, be aware – and it does say it in the guidance – that the OMB forms – standard forms – do not count toward the 50 pages.

Frances Marshman: Thank you, Joe, for that clarification. It sounds to me that there might be other questions that come along, and I would like to offer JSIT coordinators as resources for both sending questions or CC'ing on e-mail to (Dena) and Joe, if you want to write them directly, and we will help facilitate getting answers for you.

There's certainly been patterns to the questions that have been asked thus far. I want to reiterate that we are starting to plan for the (ECF) meeting, which is being held in conjunction with the first ever Early Childhood 2010 Innovations for the Next Generation – a summit of other early childhood agencies in D.C. from August 2nd through August 5th.

We're starting to plan our meeting, and if any grantees are interested in planning with us, we'd love it. It would make it a lot more fun and a lot more interesting and for a better meeting for all of us. So please e-mail me of your interest, and we'll include you in the planning committee.

I'm sorry we've gone over. It's 20 of 5:00, and (Dena) and Joe and Phyllis, if you don't have anything else to add, I think we should – would – should end our call.

(Dena Green): I – one thing – I'm sorry. But this just seems to happen. We just talked about the dates again. Someone just asked me about the date on the guidance. It says the release date I think is February 26th. So understand that again it's because of a in house kind of issue. Even though it's March 11th, I think Joe talked about the dates. You know, try to get it out as soon as you can, or completed as soon as you can, not submitted, and we will let you know – watch your e-mails – when the final is – when your applications are actually due.

But we're hoping that April 1st is not the date. And I only have to say that again, because even though we just had the conversation, I just got an e-mail about the dates.

Frances Marshman: And again, JSI's available, if people have additional questions. Thank you once more to Sherri Alderman, Chris Collins, Blythe Burger, Laura Jana, Jeanne Anderson facilitating our developmental screening portion of this call, and I'm glad so many of you were able to attend our third all-grantee conference call today.

Take care, everybody.

(Dena Green): Thank you, everyone. Good-bye. Thank you, Frances.

Frances Marshman: You're welcome, (Dena). Bye-bye.

Operator: Thank you all for participating in today's conference call. You may now disconnect.

Frances Marshman: Thank you very much, (Shawn).

Operator: Thank you. Have a great day.

Frances Marshman: OK. Take care.

END