NEW YORK CITY

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

NYC LOCAL EARLY INTERVENTION COORDINATING COUNCIL (LEICC)

BOARD MEETING

November 10, 2015

Transcribed by: Geneva Worldwide, Inc.

A P P E A R A N C E S:

Christopher Treiber, LMSW, MS, SAS, LEICC Chair

Kelvin Chen, Director of Health and Development at the Bureau of Childcare.

Marie B. Casalino, MD, MPH, Assistant Commissioner, Bureau of Early Intervention

Catherine Warkala, MS, SAS, Coordinator, Queens Early Childhood Direction Center

Kathleen Hoskins, Esq., MPA, Director, Administration for Children's Services, Office of Education Support and Policy Planning

Linda Silver, Program Director, Village Child Development; Chair of New York City Coalition

Cindy Lin Chau, BS, MAEd, Parent

Cynthia Winograd, Director of Jumpstart; Early Intervention Program; Women's League Community Residences

Tracy LeBright, LMSW, Public Health Solutions, LEICC Policy Review Committee

Mary DeBey, Ph.D., Early Childhood/Art Education Dept., Brooklyn College

Rosalba Maistoru, MA, SDL, BCBA, Lic. BA, Program Director, Little Wonders

Toni Rodriguez, parent, Bureau of Child Care, New York City Health Department

Nora Puffett, Director of Administration and Data Management, NYC DOHMH

Lisa Shulman, MD, Albert Einstein College of Medicine, Montefiore

Kaiya Dudal, Early Learn, representing ACS Associate Commissioner, Vidia Cordero

Jeanette Gong, PhD, Director of Intervention Quality Initiatives, NYC DOHMH

MR. CHRISTOPHER TREIBER: Good morning. Welcome to the LEICC meeting. Before we get started, I just want to go through the procedures for the LEICC meeting. Attendees should pre-register on the New York City Department of Health and Mental Health Hygiene website, Bureau of Early Intervention website for the LEICC meeting. It's my understanding that yesterday for this registration there was some difficulty some people had registering. I tried to help a few people who contacted me. My understanding is everybody that went through the website was registered, except that there was a bounce-back for a training. So hopefully that will be corrected. Early Intervention was aware of it and they were trying to get it fixed; so just so you know that.

So these meetings are open to the public but the audience does not discuss or speak directly to LEICC members during the meeting. Audience members may sign up to speak during public comments and I'm sure there is a way of doing that; written and then if anybody wants to speak during the public comments section. As of

May 15, 2014, the New York City Local Law Number 103 of 2013 and the New York State Open Meetings Law require open meetings to be both webcast and archived. This meeting is being recorded today. Transcription is available for this meeting and written meeting minutes will still be made available.

So before we get started, we do have a new member of the LEICC. Kelvin Chen is replacing Anita Richichi. And Kelvin, if you could just introduce yourself?

MR. KELVIN CHEN: Sure. I'm the Director of Health and Development at the Bureau of Childcare.

MR. TREIBER: Welcome. And then we'll go around.

DR. MARIE CASALINO: Marie Casalino, Assistant Commissioner.

MS. LINDA SILVER: Linda Silver, Village Child Development Center.

MS. KATHLEEN HOSKINS: Kathleen Hoskins, Assistant Commissioner of Administration for Children's Services.

MS. ROSALBA MAISTORU: Rosalba Maistoru,

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Little Wonders.

DR. MARY DeBEY: Mary DeBey, Brooklyn College.

DR. LISA SHULMAN: Lisa Shulman, Albert Einstein College of Medicine, Montefiore.

MS. CINDY CHAU: Cindy Chau, parent.

MS. CYNTHIA WINOGRAD: Cynthia Winograd, Women's League Community Residences.

MS. TONI RODRIGUEZ: Toni Rodriguez, parent.

MS. TRACY LeBRIGHT: Tracy LeBright, Public Health Solutions.

MS. CATHERINE WARKALA: Cathy Warkala, Queens Early Childhood Direction Center.

MR. CHRISTOPHER TREIBER: I'm Chris Treiber. I'm with the InterAgency Council and I'm Chair of the LEICC. So the first item that we need to cover is review of the minutes from the March 31st meeting. Have all of you got them? Were there any changes or anything that needs to be corrected? No? Can I have a motion to accept them? Okay, thank you. So then we've got, the next thing would be the Department reports.

DR. CASALINO: Good morning. I'm going

to do this partially on the microphone I think. I wanted to start off by introducing everyone to our new Medical Director, Dr. Catherine Canary, who is in the front row.

Dr. Canary attended the University of Michigan, where she earned both her bachelors and medical degrees. She completed a pediatric residency in Milwaukee, Wisconsin and a child development fellowship at UCLA. She also earned a Masters Degree in Public Health, finishing her studies in May 2015. Dr. Canary has experience within the New York Early Intervention Program, doing core and supplemental developmental evaluations and participating in IFSP team meetings. Most recently she was at Maimonides Medical Center, where she taught pediatric residents and evaluated children with developmental concerns from newborn up through adolescence. So, Dr. Canary has been with us about a month. So join me in welcoming her to the New York City Early Intervention Program. Thank you, Cathy.

So, let’s go onto the next slide. So, we’re asking as we did at our last meeting, the

new format is to utilize PowerPoint and slide presentations to summarize more of the information that we had been providing, starting with the SEICC report. We did send to the LEICC members the PowerPoint presentations from the SEICC. So I'm really going to just touch on the highlights that are most pertinent to the New York City program at this point in time. There's a lot more detail in the documents that I sent to you.

So, the agenda items included: a discussion on the Joint Task Force On Social-Emotional Development; Medicaid Health Homes; the SSIP -- the State's Systemic Insurance Plan that we talked about previously here at our meeting; an update on NYEIS; PCG update; and an updated fiscal data report from the State Department of Health.

Social-Emotional Task Force. Please go to the next slide please. So, Mary McHugh, who is the Task Force Chair and is an SEICC representative from the New York State Office of Mental Health provided the update on this Task Force. I have talked about it in the past. The

meeting presentation in September focused on the current progress and development of the guidance document and the next steps.

There is a new editor, Bob Frawley, who is the ECAC co-chair. He is now the editor for this Task Force document, assuming that role all a few months prior to the SEICC meeting in September. What had happened up to that point in time was in August the Task Force received a draft of Section 1, which was really a generic and far reaching document discussing social-emotional development in early childhood. And the document that we received discussed social-emotional development up to age five. It was a draft. It was a first draft. It was sent on to the Committee. Section 2, which was more specifically focused on guidance for the EI field, we were told was still being developed.

Also remember that I reported at, I believe at our last meeting that New York City and the New York City program is contributing significantly to the guidance document. EI staff are writing two of the critical sections, contributing significantly. The State is very

appreciative of our efforts.

So here was this Section 1 draft that had been sent to the Committee for review, far reaching generic birth to five; significant discussion about next steps. We expressed our concern from New York City about possibly rather than continuing down the path that seemed to be before us to create two companion documents: one a generic document discussing social-emotional development generically for all children and then the specific guidance document for the early intervention field. There was discussion at the SEICC. There was a vote taken and there was a majority vote in favor of the companion documents at the SEICC.

However, the document was also then going to the ECAC -- the Early Childhood Advisory Council. This is developing into a joint document and the ECAC voted to continue along the path of creating as single document with two sections. We have some concerns about it. I have some concerns about it. Nonetheless, I think we're going to have a very important document that's going to serve us well. And if Section 2 is focused on EI

specifically and providing the guidance to the field, I think we'll have a document that's very worthwhile. This is a significant effort, as you can quite imagine for the State and for the Task Force.

Health Homes update. The State Department of Health continues to work on documents, proposals and implementation issues for early intervention. They're still awaiting the State Plan Amendment approval. EI will not be integrated into Health Homes until all issues are resolved. And I'm hearing that the dates are somewhere in 2016 now -- September 2016; so the date keeps moving forward. But the State Department of Health assured us that we would not be proceeding forward in early intervention until everything had been clarified.

State Systemic Improvement Plan -- the SSIP. The State Department of Health continues to explore Technical Assistance resources. They are developing a leadership team, which will consist of SEICC and ECAC members. They also prior to the September SEICC meeting, the SDOH leadership spoke with us about our experience conducting

Learning Collaboratives and our experience promoting embedded coaching and family-centered best practices in New York City.

So, I keep going back to the fact that we in New York City because of the work we've been doing over the last few years around embedded coaching and family-centered best practices; we are ahead of the curve compared to the rest of the State. So we need to feel good about that. We still all have a lot of work to do. But we've already started down the path that others will now need to join.

Work is ongoing with the State Department of Health to procure a contract to support implementation of the Learning Collaboratives and the other activities. And I looked forward to hear briefly last time around some of the work that we're going to be doing at an agency and a borough level.

NYEIS update. Recent updates have included provider NPI being added; the ICD-9 to 10 conversion, which was in place as of October 1st. System performance. SDOH is aware of the issues and is dedicating technical experts and

effort to monitor the system performance. They hear about it all the time. They are fully aware of it. We were told at the September meeting that after the ICD-10 conversion they will be looking at ways to improve system performance. They do continue to express their concern about the impact of the attachments in NYEIS. But remember how important having those attachments in NYEIS is the New York City program and we continue to emphasize that fact. But they are going to be looking at the system performance in the future.

SEICC fiscal reports. There were two reports: one from PCG, which is the Statewide fiscal agent; and there was a separate SDOH fiscal agent report. The PCG report shows improvement in provider payment. These are the reports that are in the package that we sent to you: improvement in provider payments, reduction in denial rates for claims for commercial insurance, progress in the call center activity. PCG efforts to promote receipt of electronic remittance data for EI billing providers; they've spent a considerable amount of time talking about that.

Prior authorization; reminding providers that they must seek prior authorization when required by the payer. PCG also has a five-payer document that outlines each payer's current requirement that's available to providers. They are also developing a guidance document for providers that is going through internal SDOH review; so it hasn't been released yet. But they said that they do have a specific document regarding prior authorization that is available to the provider community.

The SDOH fiscal agent report, again, very detailed in your package; the kinds of information that were included in that report shows that the number of children enrolled in the program is about the same year to year since the transition. Some increase, some slight increase in the number of providers in the program. But a decrease in the number of billing providers across the State, which is not the New York City issue. There's also information there about commercial insurance reimbursement and Medicaid reimbursement that you might want to review.

So that's my report from the SEICC. Do

you have any other specific questions or comments? Okay.

MS. NORA PUFFETT: Good morning. I'm going to try without the microphone and just tell me if it's not working but I usually do poorly with it. So, we're going to go through the data report. And what you're going to see a tremendous amount that is contrasted with what you see the last quarter or two. And so I'd like to take the chance not just to look at the charts but to talk a little bit about next steps on analyses, what other information might be more interesting than just frequencies and also explain a little about some of the decisions we've made recently around data.

So, if you start out with referrals, we started to try to do everything by both borough and race ethnicity. And so you see the contrast between each. I think going forward we're going to try to put them together on one page, so it's a little easier. What you see is just as Dr. Casalino described, on pretty every measure there was an increase from 2012 to 2013 and then it's been flat. And remembering that the 2015 data is

only for the first three quarters of the year, it's all looking at this contrast to be the same again this year. Distribution, whether it's borough or race, also very consistent. We do not see -- I mean, you can see within each borough; the next page on race ethnicity. You see that it's really been at the same place for about three years now. Any questions about referrals?

So the next piece is about the percent of referred children who get an evaluation and screening. And you know we started talking about this at our last meeting; that we see that that is the first place where there is significant drop-off that really varies by group. So, about a month ago we sent to every ISC agency in the City: their performance data in getting children from referral to evaluation. But in total, within two different neighborhood poverty groups, sort of higher income/lower income; the five boroughs and the racial/ethnic categories.

We'd never looked at this before. We had no benchmarks because we're not at a point to say: How many children should be getting there? But the number one concern that we saw and that

we really wanted agencies to pay attention to was that the vast majority had significant differences between groups. Black children, Bronx children: far disadvantaged, much larger rates compared to everybody else. And so we want you to explore why overall your performance may be what it is. But the first place to focus is really: How is it that with some groups sometimes 15 percent data, than with other groups that the same agency is serving. So this data is just going to keep an eye on that.

In terms of by borough, it seems like they sort of split into two groups; where the Queens, Staten Island and Brooklyn do better and Bronx and Manhattan do not do so well. We're going to be doing a project, which we've started with the LEICC as a subcommittee, that's going to start with the Bronx for a few different reasons; including that when we look at race and ethnicity on the next page, that population is heavily in the Bronx. And if you turn to the next page, there's a little bit more division. It feels like there's three groups of: white non-Hispanic and Asian; Hispanic and other; and then black non-

Hispanic. And again there 76 percent is -- whatever we set for a benchmark eventually, I don't think anyone's comfortable with 76 percent. So this is something we're really going to be focusing on in the next couple of years. Any questions about that one?

The next moves on -- so we've talked about referrals. We've talked about whether you get an evaluation. So here you are, you're eligible: Are you getting services. And again, extraordinarily consistent over the last few years, which indicates that our referrals are coming in consistently and about the same percentage of children are evaluated, eligible, make it to services. This is by borough. The next page is by race-ethnicity. And the same trends around increase and then flat across the years and the distribution over the year.

MR. TREIBER: The percentages, they're based on -- is it based on the total number of kids?

MS. PUFFETT: Yes. So, of the children receiving general services, this one's the racial or borough breakdown.

MR. TREIBER: Okay.

MS. PUFFETT: And then the next slides you saw last time. And these are the ones where we tried to go beyond the EI population to say: Well, relative to the entire population of zero to three, what are we seeing? This data can only be run annually because the census data has to be the denominator and that's only done annually. So this is exactly what you saw last time, with almost exactly the same contrasted in the EI data. With the one exception that the Bronx has a very high referral and then low active. But the other boroughs tend to high referral, high active -- low active.

DR. LISA SHULMAN: I'm just thinking about the referrals to eval. So I'm just wondering because what I've noticed in the Bronx, there is a lot of non-Hispanic Blacks but they're Africans. And I'm wondering if when you collect the data if you can find out the language in the home, if that's possible?

MS. PUFFETT: So we pulled the data out of NYEIS.

DR. SHULMAN: Right.

MS. PUFFETT: So they don't have the option to indicate necessarily their country of origin. Language is something we try to look at it but what it captures in NYEIS is primarily: Is either parent proficient in English? And then, you know, language at home may or may not be entered and we don't really know what that means.

DR. SHULMAN: Right.

MS. PUFFETT: Is it that grandma speaks this language but parents are speaking English? You don't know. That kind of thing would be something like the subcommittee is going to have get down more granular and actually talk to parents and providers and so forth. That's where we could possibly get that information. At the same time, to start dividing up a population that isn't huge by those kind of factors, I'm not sure at what point that would have any effect.

DR. SHULMAN: I mean, this is just anecdotal. But it just seems that I'm seeing a lot of kids with a lot of different African languages. And so they're just, you know, whether the parents don't understand, whether they need the interpreter; I don't know whether it has an

impact but it probably has some level of impact.

MS. PUFFETT: I mean, I don't know if we would necessarily expect to see that any more than for other races, certainly Hispanic. Language is an issue. I want to say well over 50 percent of our kids speak a language other than English at home. It doesn't mean they don't speak English but that's what they speak in their home. And whatever it indicates about immigration or just culture or whatever it is, we can only look at that through so much of a lens before we say: You're paid to provide this child this service. If you can't provide it in a linguistically and culturally appropriate manner, maybe you shouldn't be providing it. That's the responsibility of agencies that say: We want to serve this community. You need to provide what that community needs to make it through.

MS. SILVER: Yeah, I just was noticing something on the race slides that I didn't notice last time. On 11 and 12 and it may be only showing up in the rates in looking back at the section; there seems to be nothing increasing with the other categories over the past three

years that more people are; and it doesn't matter when we look at borough, right, because that doesn't have an other. So when we look at the race and ethnicity, it seems that there are more people responding as other. And I wonder what's behind that and if we might want to jump on that, as far as people out there reporting things. So that if we are interested in looking at this over the next two or three years that data doesn't disappear in the other category.

MS. PUFFETT: So, one of the problems with other is that it's a small group to begin with.

MS. SILVER: Okay, so that's why I couldn't tell the green charts. Okay.

MS. PUFFETT: Other usually captures things like: Native American, Alaskan, Pacific Islander. But also if you enter two nations it comes out on the back end as other. We can't do the breakdown. And we were not comfortable saying: Well, if you pick these two, we're going to say this one's the real one. We can't do that. But it's a very small population.

MS. SILVER: You don't think it's

changing your overall [unintelligible] [00:27:38]?

MS. PUFFETT: No, I do not. Frankly, I would drop it, except that then they're not being represented and that's not right.

MS. SILVER: No, no, I understand. Okay.

DR. CASALINO: I want to go back to your issue, Linda and that's why your issue is why we created this subcommittee is to work with the folks that are out in the field to see if there's something we can do. Because the suspicion is always: Is there a cultural issue that a child is referred in for whatever reason: It could be by a doc. It could be by a childcare provider. It could be an agency; is there something that we need to do more in a particular community? Whether it's program outreach or working with our service coordination agencies to be sure that those children get an evaluation. So it may be a handful of children but every single one of those children --

DR. SHULMAN: There has to be a pocket.

DR. CASALINO: Yeah, I mean, it very well could be. Except the Bronx and we're not

picking on the Bronx, it's just we're going to start with the Bronx and use the information from this project throughout the Program and throughout the City. Because there could be a pocket of children in a particular area of the Bronx and it's a smaller pocket someplace else; but those children are important in the Program. And we've talked a lot here at the LEICC and we talk a lot in our program about the issue of health equity and that's what this is about; that it's reaching all of the children and making sure all of the children that are eligible get to an evaluation.

DR. SHULMAN: Okay, good.

MS. PUFFETT: I think if we get very into that, we're going to have to also reach into things like community-based organizations. Not only can faith organizations be positive and really support the families; we also hear sometimes that they're negative and they actually discourage families. So, I think if we really want to reach families that are about to disengage or have already disengaged or really never wanted to engage; we're going to have to

look beyond just the providers. So that's what this group will hopefully do.

DR. SHULMAN: I noticed that they're not exactly African Americans but they're from Africa. They've just come to America. They speak a variety of languages and it's hard to find anyone who speaks their language. And so I know it is a very small minority but they are a distinct group in that when they walk in the office there are very significant cultural issues.

MS. PUFFETT: I would not say it's a small issue. That's an issue that happens across the City with many, many ethnic and racial groups. I'm very uncomfortable saying that in this area this particular subgroup is having that issue when the reality is anyone who came from anywhere else, it's usually a complete culture shock here. They may not speak the language; do not necessarily have resources. And they may not even be recent immigrants. So I don't think that, regardless of what that particular language and culture are and you need to work with them; the overarching concept of: We need to work with the

language and culture that we're dealing with right now in this place and time; I don't think that's unique.

DR. SHULMAN: But capturing the range of bilingual exposure is not easy. It does feel that there are more active languages, partly because of the unrest throughout the world.

MS. PUFFETT: I would want to look at historical data but I'm not sure that's a concern right now, in terms of this is what we're dealing with now.

MS. SILVER: I seem to remember at one point there was a listing of reasons why persons, you know, families that did not go from -- you know, did not complete the process from referral to evaluation. I'm just wondering if that's been captured again?

MS. PUFFETT: Absolutely. The problems around those things are the list is usually very brief. It does not go into any detail. You know, family unavailable; what does that mean? And you don't know whoever's entering that data actually either knows what happened or wants to record what happened, which might be --

MS. SILVER: Confidential.

MS. PUFFETT: Or, I lost track of the family because I didn't have time.

MS. SILVER: You could have a dropdown, you know, let it dropdown and you could say like unavailable and a dropdown of what that means. It might just shed some light, as far as where the problem is, because that's a huge, significant drop off.

MS. PUFFETT: Absolutely.

MS. SILVER: I know the staff in other boroughs at different times of the year drop off as well. And that seems to be it. And I don't think that this is unlike any other period, even like in preschool special ed: Have referrals, many families just don't go through to the next step. The same thing with CPSE. So I don't think it's an uncommon denominator. But I just think it would be something to look at, as far as then helping to move things forward and maybe education is a piece.

MS. PUFFETT: And that's what this project is going to do.

MS. SILVER: Right.

MS. PUFFETT: Dropdowns may or may not ever happen. But if we can do something that's, you try to see what are the categories of challenges or problems on all sides that cause this; that's really what we're trying to get at. It's not like we'll ever be able to do that ongoing in every case; but this is where the study is sort of --

MS. SILVER: Right, thank you.

MS. LeBRIGHT: I was just going to say that to me the data is not surprising at all if you look at behavioral health and you look at health in general, you see the inequities. And it's not just poverty. It was also people who were living in disadvantaged neighborhoods. And when we look at the Bronx, I mean, it's the most impoverished, disadvantaged county in the State. So, if it would interesting if we were able to break out some of the ethnic and racial data; not just by the borough but by neighborhoods.

MS. PUFFETT: We are actually very interested in looking at neighborhood poverty. For those of you who got this, for those of you in ISC agencies who got this data, referral to

evaluation, we did an either/or on the poverty. And what we really found was it was not meaningful. And we need to find a way to divide enough that there are meaningful distinctions between the groups but not so much that it's too much information. But I think that the low income group, frankly was just not uniquely low income enough and that some families really overrode. Because frankly, it's just very hard to believe that there was so little difference between the two.

DR. DeBEY: I'm backing what Tracy said. I think we need neighborhood information; that it would be really helpful. How do they break the neighborhoods up in the Bronx?

MS. PUFFETT: So the way we break it up for analytic purposes is we have it by zip code. And the easiest way for us to aggregate is by United Hospital Fund data. Because zip codes do not roll up perfectly into community districts or - they're a little tricky. But that's what we have it by because that's what the family is entering in NYEIS. I think there's a total of eight UHFs in the Bronx, four of which are among

the poorest in the City. So, we can definitely break out neighborhoods. And they usually pretty well coincide with what people, residents think of as their neighborhood. But in order to get other data from other sources to integrate it, we have to use some kind of standardized format. The Department of Health has used that traditionally; so we can get other health data on that level.

DR. DeBEY: Do you think it's the same breakdown as like Early Head Start reviews or that --

MS. PUFFETT: I'd have to ask.

DR. DeBEY: Because it'd be interesting to see if we're all looking at the same things, we could start to crack it a little.

MS. PUFFETT: Yeah.

DR. DeBEY: So we're talking about the same things.

MS. PUFFETT: Absolutely. I mean, the challenges are around zip code is too fine a distinction and just as you [unintelligible]. And also to what extent again is it meaningful if you cut things up, to what point are you like: Okay, I can't do something different for each of these

because I've got 20 of them now. So, you're right. We have to look at it -- we have to do something that's common because, yes, we can't use data from other sources unless we are in alignment with their time periods and their geographics.

So, that was good though. That is where I'd like this discussion, the discussion of this part of the meeting, to go. You can read the number of referrals yourselves. It would be much more meaningful to get this kind of feedback I think and talk about priorities and so forth. So I'm actually really happy that we're moving there.

MR. TREIBER: I just want to follow up on what Mary said. Is it possible maybe at the next LEICC meeting to present this UHF data and give us an idea of what it would like geographically maybe for the Bronx. I mean, we'll do it on --

MS. PUFFETT: We can do that, yes.

MR. TREIBER: Because then I think we could all sort of discuss it and analyze it, whether or not it really does reflect what makes

sense and maybe give some more feedback regarding that. So that might be helpful.

MS. PUFFETT: I feel like last time I know that some people asked for something that didn't get into this report. And there are definitely things like that that we really want to look at. What we're trying to do is just with every report is to be able to add some more and figure out what maybe can come out or doesn't need to be in every single report. But definitely that's one that we have really started to look at. And it's fairly manageable to do it by UHF. There's 50-odd in the City. So, compared to like zip codes, which I think there are over 180, you can sort of absorb it.

DR. DeBEY: I was just going to say, Chris, that when we look at it from Brooklyn: Brooklyn is very much divided by -- you know, Flatbush and Gravesend; we had towns before it all united. The Bronx historically did not. And so just the way, when you think about things in the Bronx, it's different than how we think about things in Brooklyn. It's a historical thing. I teach social studies in early childhood. But

other things that I want to say is that in Brooklyn, when we say we're going to Manhattan, we say: We're going to the City. In the Bronx, we say: We're going downtown. Because they don't see themselves as separate. So you live on a street, not so much in Flatbush. You know what I mean, it's just historically? So that's why I ask. It's a deeply ingrained historical difference. Not better or worse, just I think it's how we developed as a City.

MS. PUFFETT: I think ultimately probably the number one question is: Wherever you live, what are the resources available and how accessible are they? Whatever your culture or language, if they're not there, if you have to travel too far, if you have to go into a neighborhood you don't feel safe in; you're not going to use them. So that's a really key element. And as I said, talking with people like community-based organizations who can tell us about: What are the local concerns? What is it that people feel comfortable with or that helps them, versus makes them feel like they're not being included or considered? We need to look at

all those things. And we don't know that right now. Providers don't always know that.

Alright, this one I think will be fairly quick because it's raising more questions than it's answering. And I need to come with answers next time. This is about percent of children getting each type of service. It doesn't address the combination of services they're getting. And the vast majority of children get more than one type of service. So we need to understand why it seems like we are having significant increases in each area. My guess is that increases in children with autism spectrum disorder and auto-eligible conditions, for which you may get many more types of services at one time, are driving this. But I really need to dig into it. And so I will come back to you next time with more information on this.

DR. SHULMAN: Can I ask one question? The increase in special education is pretty dramatic, right?

MS. PUFFETT: Mm-hmm.

DR. SHULMAN: So that would make me say: Are there more children in the program who have a

diagnosis --

MS. PUFFETT: Exactly.

DR. SHULMAN: Do we know that?

MS. PUFFETT: We know that -- I'm really happy to say that next time we're going to have ASD and diagnosed condition data. Historically, from what we were able to see the last few years, yes, there is a massive increase in the percent of children in our program who have a diagnosis of autism spectrum disorder. Whether they come in with it or they get it while they're here; that has absolutely mirrored all the national trends.

DR. SHULMAN: That's interesting. Because for the longest time, it was kind of -- the numbers were similar. There weren't gigantic increases in terms of the children with the diagnosis for whatever the reasons were. Maybe they just didn't get the right evaluation. But now we use the word massive; so then it has an impact even if it's not associated with a set number. Okay.

MS. PUFFETT: Well, with children with autism spectrum disorder, even an increase in a few percent of children you get vastly

exponentially more services with certain types; will have a huge increases on that angle.

DR. SHULMAN: Right, yes.

MS. PUFFETT: So I will come back to you with something that's a little more helpful.

DR. SHULMAN: Okay.

MS. PUFFETT: This is the one we added last time. Just to remind everybody that just because we're not giving you general services doesn't mean we don't interact with you. These are families that we touched in any way. So we have about 30,000 active children a year. But we touch 45 to 50,000; whether they only get SC, whether they do make it to evaluation. So you can argue about: What does it mean to say we only gave them SC? But I think that at a minimum, a family was exposed in some way, if only to the idea of early intervention, and had a first opportunity.

I want to point out and I don't know if we've ever reported on this: About 20 percent of children are re-referred. Leaving EI the first time doesn't mean you don't necessarily come back. It's not the end all. So we think that just

having touched you that first time, maybe has opened the door that you might be ready to come through later.

DR. CASALINO: And I want to add to this one too. We've been asked a number of times about the number of children in the program and should we use the number 30,000 children a year versus this 45 to 50,000 children a year. We tend to focus on the 30,000 because those are the children that are getting the packages of services. They've been found eligible. They've had their IFSP. They're active in the program. But the reality is if you're looking at the scope of the program, these are the numbers because even if it's service coordination to evaluation, those are services that were provided to New York City children. So you'll hear us sometimes using the two numbers.

DR. SHULMAN: I just have one more question. On the re-referral, does that ever get to be more specifically examined? Like what is the timeframe of the re-referral? Is it a six-month timeframe from the time of -- well, you'll time it from, I guess it's from the time the case

is closed I guess? So, is it a six-month timeframe? Is it a year? I know the age of the kid is going to play a role in that as well. But I also think that it might or might not have an impact on the evaluations coming down the path, right? I don't know, but if that's 20 percent of re-referral and then I'm assuming those re-referrals become eligible or you don't know that yet?

MS. PUFFETT: So, we have looked at this a little bit. It was a file review, SC notes.

DR. SHULMAN: Oh, okay.

MS. PUFFETT: So, I don't know. However, age definitely played in. The reason for dropout was huge. So, re-referred is not necessarily dropout. A child is found ineligible. They were back three months and a day later, to confirm that. Some children got as far as right before the initial IFSP and the family decided at the last minute: not right now. But they came back. We already knew the child was eligible.

DR. SHULMAN: So it's a whole bunch of stuff.

MS. PUFFETT: And then life factors. If

you're not doing this right now because a family member's been sick, later that might be a different story.

DR. SHULMAN: Okay.

MS. PUFFETT: Okay, so that was those two. This last one I just wanted to bring because we haven't seen it in a while and I'm going to beat a horse with it. So this is data about the insurance profile of children getting general services. And it's not that different from historical except children get to 17 percent with no insurance. Historically that was around eight percent. So we did a review and we found two factors: One, uploaded the form but never entered the fields -- huge. But the other was a very, very high to us rate of parents declining to give their insurance information. Of those with nothing entered and there was no uploaded form, 50 percent had declined.

We don't have stats from previously because that wasn't something we could track in NYEIS or KIDS. But that seems very high to us. And we would really like to talk to people about why that's happening. And is that families have

misunderstandings about what it means to give us their information or what that situation is? Because that is very, very high. And 17 percent of our children not getting any insurance billing at all is not good for the program at all. So we're really to encourage SC providers to really please look at this. Are your folks entering it after they upload? What's happening in their conversations with families about insurance?

MS. LeBRIGHT: Nora, can I ask a question? And no insurance, no insurance recorded; does that include the families that have nonregulated insurance and do not want to --

MS. PUFFETT: That I would have to look up because it's not there.

MS. LeBRIGHT: Because that's a huge number, bigger than I think most people realize.

MS. PUFFETT: So maybe we need to do a little hand count about some of this because I can't tell that from this. But that's a good point. But again, I'm not sure if that was true previously as well. And it just seems when we were originally showing eight percent, no insurance and that again would have shown the

nonregulated because we couldn't break it up and now we've gone to 17 percent; it may be a contributing factor.

MS. LeBRIGHT: I don't know over the years what the number of increases, but I think more and more companies are going for being self-insured. I mean, we are. So that if it's a factor --

MS. PUFFETT: Okay, so that's something to look at. You're right, that's a good point.

DR. SHULMAN: So families with a type of insurance who are thinking they might be able to access other services through my insurance, have a reluctance to give information that will get in the way if they're getting perhaps some remedial at home through their insurance.

MS. PUFFETT: So, I'm going to ask other folks because I'm not an expert around the insurance stuff but that seems like maybe we could be; if that's what they're thinking, then we could maybe help them with that a little bit. But that's a good point. I had not heard that before.

DR. SHULMAN: I would estimate that the

majority of those have private insurance.

MS. PUFFETT: Oh, yeah, I think so too.

DR. SHULMAN: Then I wonder: Does this map capture -- a question that I've asked before, which is that of the children completing the evaluation process, are there disparities by borough or ethnicity in terms of getting approval for services or getting services?

MS. PUFFETT: Right. Okay, so if you're eligible, you are thereby approved for services. So the question is, I think the most common period of dropout is not ever getting to an initial IFSP. We can look at that. I know it's not a very large percent, which is part of the reason when we talked about addressing retention, we started with that referral to evaluation piece. But we can definitely look at that.

DR. SHULMAN: If that 17 was adding to the 20, you have a large percent [unintelligible] [00:50:25] receiving EI services. I don't know if that was right for the demographics in New York City or not.

MS. PUFFETT: Okay. I think there was one thing I wanted to tell you about. Okay. So, I

think that's about it for data. Again, we're going to be trying to add more as we go forward, pull out -- for instance that insurance thing might be an annual thing. And we're pulling up conversations that are a little bit more about what you think. I'm really just throwing out numbers at you and I'm not giving you a lot in the way of analyses, on the assumption that you only have so much time to read. But I hope this is the kind of the conversation you think is useful. And if not, you should tell someone or me and I'll stop. So that's data.

So just to come back to the usual provider oversight message. It's looking pretty consistent from the last time you saw it. Which is that after three years of improvement, we're seeing some not improvement. And I'm not sure what's driving that. And in particular, the statistics on evaluation, where people always did so well; we were almost worried about it but that has now gone up. So for those of you who did poorly in evaluation, I would really strongly encourage you to look at your findings and say: What's different here than last year? Because

it's significant and we really don't know what's driving it.

MS. SILVER: After you have an evaluation, you have the indicators and the indicators didn't meet the good area. You know what indicators but the indicators are not being as they were before. So, is that information available in terms of a general; I understand what you're saying, each individual evaluator or service provider has to look uniquely to their own review. But is there a more general, I don't know, like an indicator, like were evaluations reviewed with the parent? Is that one of the indicators that has shown -- that has been a real problem; that kind of information?

MS. PUFFETT: So we would really like to get to that level of standard and indicator. And it would be helpful to you and it would be helpful to us.

MS. SILVER: Right.

MS. PUFFETT: We are building a system that will do that analysis for us because it is a very, very complex and time-consuming analysis. But I do think that it should also inform, you

know, because we'd like this tool to evolve. In places where people do really well, we don't need to measure you every year. And so we would really like to get down to that level of detail. But honestly, this is our fourth year and I feel like this is really the year that we've really hit our stride and everything is rolling smoothly and now we have the luxury to do things like that.

MS. SILVER: Right. But I just found it kind of like surprising --

MS. PUFFETT: It is.

MS. SILVER: -- that everything is great, everything is great, everything is great. And then all of a sudden, things aren't so great. And I don't understand it.

MS. PUFFETT: We don't either. [ALL LAUGH]

MS. SILVER: I understand what you're saying. But if people, just over the years I know there are certain things that people were not necessarily always paying as much attention to as they should have. So when it's called to your attention, you go: Oh. And then you can kind of clean up your act. So that's all I'm saying. For

things to be that significant, there's got to be I would think it's not going to be a scatter and it's going to be some generalization in terms of certain indicators, that people are just not consistently meeting I would guess.

MS. PUFFETT: I think that would be very helpful for us to know portfolio-wide. But for the individual providers and quality improvement --

MS. SILVER: I understand that.

MS. PUFFETT: I mean, they can definitely look at their own. Yes, for us to understand if there is something bigger going on, yes. But for the moment, people are still good to figure out based on their own findings: What were the differences here from last year?

MS. SILVER: Okay.

DR. CASALINO: No, Linda, you're making a very good point. And that's why we do need these kinds of reviews from 40,000 feet analysis. And now we know we have to look more specifically at what's going on in evaluations. Because we've all been very comfortable with the fact that everybody knows exactly what to do in evaluation.

But something happened here.

MS. SILVER: Something happened.

DR. CASALINO: This is too obvious.

MS. SILVER: Right.

DR. CASALINO: So here we are at Year Four, as Nora said; so it's our opportunity to go back and look at more detail. And you know, we've always been very encouraged by the provider response to their findings. I keep using the example from one of the meetings that Nora and Patricia – Patricia Pate, who oversees Provider Oversight; we went and we met with groups of providers. And someone in the provider audience said when we were saying: well, there's just a little bit, if it's a one percent difference; but someone in the audience said: But we are the kind of people that always want an A on our exam.

MS. SILVER: It's true.

DR. CASALINO: It's true, everybody wants to perform.

MS. SILVER: Everybody, they want to be perfect. And there could be a couple of things that just shared people can get it right, you know, if they know what they're falling off on.

DR. CASALINO: Absolutely.

MS. SILVER: And my guess is it's probably some regulatory component that's just not being done. Oh, there's somebody in the back. Did you have your hand up? No?

MS. PATRICIA PATE: To [unintelligible] there's only one for the individual agency to improve their performance: all they need to do is look back at the prior year's results. Because it's not as though the standards and indicators themselves have changed. We don't change them dramatically without letting you know.

DR. CASALINO: Okay.

MS. PATE: Just look at the percentage of compliance and noncompliance. And therefore for each individual agency, you'll be able to see and exactly pinpoint where your part may be -- if that happens -- falling off happened? You'll be able to get down to the indicator level, just like comparing your percentages. So if in one year, you only miss talking to parents two percent of the time and the next year it was 40 percent of the time, that's your clue.

MS. SILVER: Okay, alright. That's good

advice. Thank you.

DR. CASALINO: So this is actually something, as we're having this discussion here, we have periodic meetings with provider leadership and I think this is something that we could bring to that group, to really start to drill down on it to see what we can effect. And Patricia's joining the provider oversight group, joining us with this group, I think would be helpful. And remember that we're always available to meet with provider groups. We enjoy that interaction and it is very informative and helpful for us. We hope it was helpful for the providers in the room. But this is something that I think we can engage more actively.

MS. SILVER: And I think the providers enjoy that level of intimacy in terms of those meetings; that they're just not normally available. So I think that's a good idea.

MS. PUFFETT: Okay?

MS. SILVER: Yes.

MS. PUFFETT: So thank you for giving me so much of your time. I know it was more than you expected.

DR. CASALINO: Thank you, Nora.

MR. TREIBER: Thank you. So, we have a presentation from ACS Early Learn, Brigitte Sotel [phonetic] is here. Good morning.

MS. KAIYA DUDAL: Good morning. Hi, my name is Kaiya Dudal [phonetic] [unintelligible] [00:58:43]. Thank you so much for giving me the opportunity to introduce Early Learn to you all this morning. I'm here representing Vidia Cordero, our Associate Commissioner, who very much wanted to be here. But we happened to have our borough-based directors meeting for our providers and she has to be at those meetings. So, I'm here and thank you for this time.

So, Early Learn is ACS contracted care system for families and children who qualify for subsidized care, solely for low-income, poor families or no-income families. Early Learn, these are children who are from six weeks to four years of age. I don't have to tell you how important those years are for children with overall with development [unintelligible] [00:59:33] that come up.

Through Early Learn we're able to really

look at different funding streams to strengthen the services that we provide. For example, we get from federal program about $10,000 for each [unintelligible] [00:59:50]. And because we have that graded funding system, we're able to put close to 50 percent more in some cases to really strengthen the services that children are receiving.

Early Learn is really focused on supporting working parents through providing services for eight to ten hours a day; and also focusing on the comprehensive services, you know, around mental health, nutrition, other health services. And the purpose really is for our providers to create community linkages. They don't necessarily have to be experts in everything themselves. But if they link up with a good community-based organization, they can help support that family and really strengthen that child's experience while they're in our care.

So we have center-based and then we extend our programming to family childcare. And family childcare is where the majority of our zero to three-year-old children are served; about

6,500 - 7,000 citywide. We have about 3,000 center-based feed for most of the toddlers who are two and close to three-years-old. But the babies are really in family-based home. And our efforts really through this system of zero to five care is to provide children a safe, healthy environment, where they can develop and learn and then move on to kindergarten and elementary school.

A little bit about our numbers. We currently have 154 community-based organizations that we contract with. We have 303 sites, which means centers; early childhood centers where we provide services for children. And these center-based programs -- contractors, some of them have what we call is a family childcare network. There are 31 of them in the City. And they are really charged with providing the services for the young children -- the youngest ones from six weeks to three years. The purpose is really that they go to a family-based program and then after they've turned three or four, they move to the center-based and become more involved in that type of programming.

Currently, our enrollment -- it's at 76 percent. I think many of you probably know that pre-K for all has really changed the landscape of early childhood programming in the City. And it's a good challenge to have for all of us. And we're looking at different ways to respond: Do we take a portion of our three and four-year-olds [unintelligible] [01:02:50] to really, really strengthen our investment to those youngest children? Which obviously provides a very interesting and amazing opportunity for us to continue our conversation with you staff.

We are currently in our fourth year of contract. Our contracts expire next year. So we're going to be renewing. And then leading up to 2018, we're going to be reorganizing the entire system. And we are just in the process of finalizing the community to meet with us and then to really look at the areas in the City where the services that we provide for low-income and poor families are most needed and hopefully having a lot of data to inform that. It was so interesting to look at the slides that you were just sharing and seeing the interesting intersections that

families who have Medicaid coverage and what that might mean in terms of their need for other program services that we might be able to provide.

So a little bit about the quality in our program. So, we're very much focused on not just compliance when it comes to Head Start standards or Article 40A; but really making that compliance into high quality and development, a really appropriate approach to learning that our children get in our centers. They all follow a valid, a research-based curriculum. They have some leeway to choose what they want but it has to be published; it has to be researched. It has to be a real thing. It's not just a playgroup or a babysitting service.

And our staff, when we got to our programs to monitor and provide technical assistance, it's really focused on looking at: How is the child's experience? Are they developing appropriately? How are the teacher-child interactions? Is there anything we can do to build the capacity of staff at that site? And really looking at the overall learning

environment for our children.

A really, really important part of our work and our providers' work is working with families to ensure that they have access and information about services that are available for their families. We see this opportunity to present to you about Early Learn and building our system's capacity in terms of identifying early intervention needs. We see this as such a wonderful opportunity to further collaboration. This is one of the highlights of our week actually.

So I don't know if we have a little bit more time, I wanted to share a little bit about the childcare program. And this is really based on the funding stream. So, childcare program means that the families qualify for childcare funding under Childcare Development Block Grant. And there are obviously specific guidelines that families have to qualify for; so it's either care for mandated service, for example, cash assistance. And then families have to be 200 percent of federal poverty level. And there's actually a pretty high work requirement of 20

hours of documented work. And what we find is that in many communities families have trouble proving their work requirement because it's undocumented work or they work a lot but their employer is unwilling to give that signed piece of paper. So, we're actively advocating to revisit some of these requirements, to hopefully open doors to more families and more children to receive these services.

Obviously you all know Head Start. So, Head Start serves three and four-year-olds. And there are specific requirements. I mentioned the different landscapes that we're all facing with the fantastic expansion of pre-K. We're really taking a close look at our system to see: Is there a space there that we may want to build an early Head Start for zero to three? And what that might mean for our communities? What it might mean for our providers in terms of capacity building? How do we need to train our staff? And so these are all important conversations that we're going to be having in the very near future. And obviously our colleagues at the Department of Health, we look forward to including you in

those.

Some of the sites are dual eligible, which means that the families actually have to qualify for both childcare funding and Head Start funding. So that's very complicated. There aren't that many people who qualify for that but enough that we had reserved this specific number of slots for them.

This is such a fantastic opportunity, I want to thank you again. We began this collaboration really just maybe three, four months ago and came together. Dr. Casalino and my boss, Associate Commissioner Vidia Cordero brought key staff and really started talking about how we could better collaborate, share information and provide capacity building. And what's really exciting, actually I was just telling Vidia, my boss, about the training that's coming up for our Family Childcare Networks in early December, that your staff has graciously agreed to train our Networks who serve the 10,000 zero to three-year-olds in our system, in terms of: What early intervention means? What to look for? What the process looks like? And I think

this will be a start of something that I expect we'll want to really build on. So I want to thank you all. I don't know that we have time for any questions. But your staff could probably connect you with me?

DR. CASALINO: We have time for a few questions.

MS. SILVER: How do families usually get connected or referred to your program?

MS. DUDAL: So all our providers are community-based organizations. So they also have ongoing presence in the communities that we serve.

MS. SILVER: Can you state some locations?

MS. DUDAL: So for example -- let me think; we have West Harlem Head Start has been in the community for probably 40 years, almost since the start of the Head Start program. So they have really ongoing relationships in the community. They do a lot of recruitment activities in the community. They have community-based individuals on their board serving. They serve families in the community and then help lift families out of

poverty. In some cases, parents contacted teachers or board members or advisors.

So the purpose of Early Learn is to strengthen the community-based work. And that's why we contract and provide these services to community-based organizations because that's who families know and trust. But if there's a family who wants services and is unsure who in that community would be an appropriate provider, they can call 311 and they can get a list of Early Learn programs in their neighborhoods by zip code. Or if they want to go to a program that's close to their workplace, that's also allowable. We don't have, especially under this healthcare for the youngest children, we don't have geographic attachment area.

MS. SILVER: Do you have a website that we could see?

MS. DUDAL: ACS's website has it. And I can send the direct link and if you want to share that link with everyone?

DR. CASALINO: Yeah. You can send it to us and we'll send the information out to the committee.

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MS. SILVER: [unintelligible] [01:11:55]

MS. DUDAL: Good question. ACS Division of Early Care and Education is divided into two sides. So there's the program development side, which is the contracted care, Early Learn; where we contract with programs to provide services. Some of them also qualify for vouchers. Then there's the whole voucher side, which falls under the operations side of ACS. So our portion is about 40,000 children. That portion is 60,000. So families receive vouchers based on eligibility requirements. And they can bring that voucher to any service provider or family member or another community organization that they want to choose. So it's the same division at ACS; it's just a different side of the -- I won't say building, but that's --

MS. HOSKINS: If I could add something? The eligibility criteria for those vouchers is different than what you would find at any system that provides vouchers, like HR. Most of our vouchers can be used for families who are actually involved in our system. So, that's really child [unintelligible] [01:13:21] cases,

children in foster care or families receiving for that system.

MS. DUDAL: And I should add to Kathleen that all children who are known to ACS in terms of a child protection case or preventive are also in Early Learn.

DR. SHULMAN: Do you have data, like we were just looking at with Nora, about the Bronx and about different community schools giving the vouchers of who's giving the services in Early Learn centers.

MS. DUDAL: For Early Learn centers, I'd probably have a little bit more data. For the voucher side, I would have to just follow up with a call to operations side to get to you. But I can follow up on that.

DR. SHULMAN: That would probably be very helpful for us --

MS. DUDAL: Sure.

DR. SHULMAN: -- to look at what's available for the children in the areas that we really want to [unintelligible] [01:14:13].

MS. DUDAL: Yeah, definitely. For Early Learn, I can share that very easily. For the

voucher side, I'll follow up.

DR. SHULMAN: That's the side I think that is the hardest to get.

MS. DUDAL: Yeah. And I think it makes it hard because the vouchers can be used in informal care placements too. So it's a little harder to provide.

DR. SHULMAN: Right. And our concern is that it also has much less oversight.

MS. DUDAL: Sure.

DR. SHULMAN: And so if we're looking at the Bronx, again we're looking at the places in the Bronx that we're concerned with have mostly -- have a lot of vouchers and multiple [unintelligible] [01:14:54].

MS. DUDAL: Right.

DR. SHULMAN: So that would be helpful to us.

MS. DUDAL: Yeah, I think that will be a good conversation to have.

DR. SHULMAN: I hear that you have 24 spots open, which is such an amazing opportunity. And I just want to understand how we could do something more to the parent focusing on one. I

see a lot of kids and they require [unintelligible] [01:15:27] and I'm sure everybody else does too. But if there's some brochures that are directed towards parents or other opportunities to discuss how to get referrals with the greatest ease for family members?

MS. DUDAL: Yeah, we have brochures that our staff is shipping to your local offices. But any information that I can share, I can come share in person or I can send you via E-mail. You can look at the information and I'll be happy to; it would be a really wonderful opportunity.

DR. CASALINO: The reason for the presentation today is that we saw opportunities here. So definitely we will be sending out to the LEICC more information, so that our families can take advantage of these incredible opportunities. So thank you so much.

MS. DUDAL: Thank you. It's wonderful being here.

DR. JEANETTE GONG: Good morning everybody.

ALL: Good morning.

MS. GONG: Today, I'm just going to just give you a brief update on some of the projects we've been doing in the Early Intervention Quality Initiatives Unit. Next slide please.

So, right now we are doing the supporting and retaining Early Intervention families through reflective practice. It's a three-day training that we offer to Early Intervention provider agencies. And it's on October 30th, which has just happened two weeks ago. November 13th is the second day, which is Friday, and December 11th. It's co-sponsored with Brooklyn College and the City College of New York, CUNY. And the presenters for this training are Phyllis Ackman, Elaine Geller, Haroula Ntalla and Rebecca Shahmoon Shanok. The focus of this training was twofold: One was to support Early Intervention providers in learning about different ways that you could retain Early Intervention families in the program. And the second was to provide them ways to work with the parent-child dyad in using families and the best practices.

So the purpose of the training was

twofold. And the good thing about this three-day training is that also participants will be receiving a certificate from the Early Intervention Program for about 15 hours of training. And the focus was primarily clinical supervisors, SC supervisors and quality assurance managers.

I have to say that this training is quite popular. Actually, we sent the E-mail about this training and within 48 hours, 120 people registered for this training. So it was closed out within two days. And we also have a waiting list because we want to engage more people in taking this training. And there were some people on the first day of training who asked us if they could bring their whole staff to the next day. And we said: No, we can't because we have limitations of the venue and not enough seats. But we'll keep that in mind for the future.

The second training that we're currently working on is the bilingual evaluation training with Catherine Crowley and a lot of people know her. She's head of the Bilingual Institute at Teachers College. And this one is scheduled in

the spring or summer of 2016. The training will look at the kinds of factors that influence bilingual evaluations for children who speak two languages and who speak a language other than English. So they're going to look at the kind of elements or components that people should consider when they're doing a bilingual evaluation. And I have to say in retrospect: If you look at the items that are important for a bilingual evaluation, they're also important components for any evaluation in Early Intervention as well.

So the training sessions will be provided to speech language pathologists. There will be a session for other interventionists, occupational therapists, physical therapists, psychologists and early childhood special educators and social workers. And then there's going to be a training session for evaluation coordinators, quality assurance managers and administrators. And then lastly, there's a training session for the New York City Early Intervention staff. So, we're right now in the process of trying to find a venue for the six

trainings. And keep an eye out for this announcement because I think this is going to fill up pretty quickly as well. So, next slide please.

So the next thing I want to talk about is, as you know, we've done three or four Learning Collaborative trainings in the past; and what we've learned from that is that lots of people want to know about the content that we use in the Learning Collaborative training about family-centered practices. So one way we thought to get this content information out to more people is to create online training modules, that people can access at any time to learn more about family-centered best practices or evidence-based best practices in early intervention.

So we decided to create a series called the Incremental Family-Centered Practices Modules. And there are five modules altogether. This screen tells you about the different titles and it ranges anywhere from The Mission of Early Intervention to Planning and Better Strategies for Parents and Caregivers and Coaching Parents and Caregivers. The training modules will be

posted online we hope within the next month. Right now the Training Unit, and I have to thank the Training Unit because they're picking out content and transforming it into something that's interactive for the online viewer; so I have to give them a lot of kudos because if you waited for me to do that, it would be impossible. But everyone who completes a module can print a certificate at home after completion. The five modules in total will give you nine hours of training, which will help fulfill your SDOH training requirement.

So the other thing I want to tell you is that for physical therapists who take these modules, they can apply for CEUs from NYPTA. And New York City Early Intervention is approved by the New York State Department of Ed Office of Professions and Response of Continuing Competency for Occupational Therapists and Occupational Therapy as well. So, we'll be sending an E-mail out to everyone to let them know when all five modules are available online. Next slide please.

As part of that, we're offering to all Early Intervention provider agencies a voluntary

structured technical assistance once the modules are posted online. And who is this training for? It's really for clinical supervisors and quality assurance managers, academic partners, referral placement partners and interventionists. The purpose is to support the efforts of our agencies in their professional development and quality management work with their interventionists to support the evidence-based best practices and service deliveries and also to meet the system and requirement for service provision according to the SDOH provider agreement, regulations of New York State Early Intervention Policies and Procedures.

And what they'll get is also a Professional Development Guide that was created by my Unit. You get operations and guidance for your agency's areas of practice. You get online technical assistance by the New York City Bureau staff. And you also receive certificates for the training as well. So this is something that will be coming also as well, once the modules come online. Next slide please. Well, we want to do as much as we can to support our Early Intervention

providers.

DR. SHULMAN: I would say very nice.

DR. GONG: Okay, so the next slide, I'm going to briefly talk about our academic partners. All our academic partners: Brooklyn College, which has an Advanced Certificate in Early Intervention and Parenting; SUNY Downstate OT program, which is an EI core curriculum within its graduate program. Hunter College has a multidisciplinary continuing educational courses that they're going to be offering; so that's cross discipline. So those continuing ed courses at Hunter College will be open to any discipline. It's not discipline specific. And Queens College is developing a Masters of Science in Education, in Early Childhood Special Ed and Bilingual Education.

So these are our four academic partners. And right now Brooklyn College and SUNY Downstate occupational therapy programs are currently formalizing their fieldwork placement with different EI agencies. So if agencies are interested in participating and being a fieldwork partner with these academic partners, I highly

recommend it. It's a great opportunity for EI provider agencies to discover potential speech or Early Intervention providers for their agencies that know best practices. So, I wholeheartedly recommend that EI agencies consider doing this. And if you want the content information, it's listed on the chart. But you could also E-mail my Unit and we'll make the connection for you and that's it. Next slide please.

If anyone has any questions about any of the things that I talked about today, about any of our projects, particularly about the structured technical assistance program? Oh, by the way, we've already started to do the structured technical assistance with our academic partners. We did Hunter College and SUNY Downstate OTP, October 15th. And we're actually going to do Brooklyn College and Queens College on Monday, November 16th. And if you have any questions about any of the future trainings we're planning as well, please E-mail us at embeddedcoaching@health.nyc.com. Are there any questions? Thank you.

MR. TREIBER: So, Dr. Brown wasn't able

to join us today. So I'm going to I guess reschedule that. So, I just have a few things that I want to share with you regarding some things that I had spoken about at the last meeting and then some other new things.

I attended an Assembly roundtable discussion meeting in Suffern, New York on October 1st. And the Assembly roundtable was convened by two Committees of the State Assembly: the Committee on Health and the Committee on Oversight Analysis and Investigation. So, Assembly Member Jaffee and Assembly Member Gottfried, who basically chaired the Assembly meeting. Dr. Casalino was there and I'll go through who attended.

But the main reason for the Assembly meeting was to discuss the State Fiscal Agent, since New York State is spending a lot of money on this Fiscal Agent, to find out: Is it of value in terms of the fact that are they providing good quality service? Are they helping to improve the collection of insurance from private insurance companies? And are they also meeting the needs of the EI providers in terms of billing and

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claiming, specifically around private insurance [unintelligible] [01:28:19] law.

So there was a good representation of seven members of the Assembly, which is pretty significant for kind of a non-Albany event. Assembly Member Jaffee was there and Gottfried as well, and Buchwald, Galef, Shelly Mayer, Abinanti and Lawrence. Most of them were from the Rockland, Westchester area. And then there were representatives from the New York State Health Plans. PCG had representatives there. They're the State Fiscal Agent. County Department of Health, representatives from Saratoga and Rockland. New York City, Early Intervention was represented. And then most Early Intervention provider associations from around the State: ACTS, New York State Alliance, UCP, New York State IEC, United New York Early Intervention Parents and Providers, Speech Therapy Association, and OT and PT associations. So there was a really good representation of providers there who are impacted or can have some interaction with the State Fiscal Agent.

So there was a question raised regarding

the Department of Health -- State Department of Health was invited according to Assembly Member Gottfried but they did not send any representatives.

So most of the provider groups in terms of discussion all pretty much agreed that PCG has been working hard, that they're doing a good job. And that they're doing as good a job as they can within the parameters of their State contract. PCB themselves had said that there are some limitations in terms of what they can do because the State contract limits them. But most people weren't as critical of PCG. The main focus of the criticism I think came consistently regarding the NYEIS response and the interaction with NYEIS and billing and how that is basically messing up most of the ability of providers to bill consistently and also from PCG's perspective, to be able to track what's kind of going on. Because all they can do is take the information that's fed to them through NYEIS.

So that was one of the criticisms. And there was a number of discussions about that. PCG did report that they've improved their collection

rates on claims from 9.3 percent before they took over to 15.5 percent. But Assembly Member Gottfried asked a more specific question regarding the 15.5 percent: Was it based on all the claims or just claims specifically to commercial insurance? And that was one of the things that was clarified that was specific to commercial insurance.

And the whole issue around self-regulated plans came up. And that became a very important discussion because I don't believe that the Members of the Assembly who were there understood the issue of what really was being presented regarding self-regulation. And what it comes down to is that, like Tracy had said before, a lot more plans are becoming self-regulated. More and more companies are self-regulating. If they're self-regulated, that means that the State law that protects families that if insurance is used it won't impact lifetime benefits or other benefits is not in place for a self-regulated plan.

The other thing that came up that was very clear and even the State Health Plans

representative confirmed that it's very difficult to determine if a plan is self-regulated or not anymore. Service coordinators, it's nearly impossible for them to figure it out.

And so there were examples of providers of the group. I think there was a physical therapist from someplace in a small county Upstate, who said that they had inadvertently thought that the plan was regulated by the state and it wasn't. And so the child's lifetime benefit was impacted because the child had to have an operation, came out and needed additional PT and the insurance company said: No, no, no. Your maximum has already been used. So that's really a very critical issue and we were trying to stress that point with the Assembly Members that something's got to be done around that.

The other big point that was raised from the providers there is that the changeover to having providers bill directly for the provision of services is a huge financial burden and a tremendous personnel requirement on providers. And we were trying to again explain to the Assembly Members that providers, unlike a medical

or a doctor's office; a doctor sees a patient and they bill for that specific thing. Every single time you see a child for every single service has to be billed individually. So you're talking about thousands and thousands of claims. And again I don't think the Assembly Members sort of understood the complexity of what we were talking about until some of the providers started to explain the level of responsibility. So that was another issue.

And then the third big issue was that there is a significant shortage of providers around the State; not in New York City, but around the State and especially in some of the small rural counties in way Upstate New York. Western New York, for example, they might have one speech therapist that also knows how to do special feeding with kids. That therapist is gone and now there is nobody left to provide service. So, I think that was something that Assembly Members were very concerned about in terms of that very specific shortage.

And then the last big piece I think that was really discussed was also the significant

change to service coordination in terms of being responsible for all of the commercial insurance billing. Most service coordinators are expected to be EI billing experts almost in terms of knowing insurance and entering the data.

And that can also be part of the issue that when Nora brought up about parents who have reported there isn't insurance or insurance isn't documented; it's possible the service provider is not even being able to get all the information correctly and then putting it into the system. So there was a lot of questions raised about that. The Rockland County representative in fact said that their State Department of Health Unit was going to stop providing ongoing service coordination simply because it was just too much of a burden on them, regarding that. So that was mainly the discussion.

Assembly Member Gottfried at the end basically said that a lot of the Members of the Assembly don't believe that what they got in terms of the vote for the Fiscal Agent was what they actually wanted to happen. And so that's something that they're thinking about in terms of

looking at how to maybe evaluate this. Because ultimately they believe, they're all committed to early intervention and making sure the system works. But at this point, there are a lot of serious concerns, especially around the State regarding shortages of providers and providers who are still having to cope with billing.

DR. SHULMAN: Did it come up what's new about prior authorization? Because that prior authorization thing is relatively new. But that's a hefty amount of work: prior authorization. So, I think that prior authorization, I guess it's going to have the greatest impact on the escrow fund, I would think, in terms of whether people do it or not. But the mechanism in order to get prior authorization is close to crazy. And I was wondering why PCG isn't taking a bigger role in the prior authorization? Was that brought up at all?

MR. TREIBER: It didn't come up. And I think it didn't come up because it wasn't presented to the field yet. And also there was no one there from the Department of Health; so they would have been the likely group to bring it up.

I think it definitely would have been an issue. I think it is something that may be important to alert Assembly Member Gottfried to, in regard to another increasing burden being placed. And ultimately, you know, the provider message was: You've increased all of these burdens. You've given us no financial reimbursement for any of it. And it really has pushed some providers to the point of basically saying, I can't do it anymore; especially in Upstate.

DR. SHULMAN: Yeah. So, again, this prior authorization is even bigger and my guess is it's not going to be implemented particularly well. Which eventually over time is going to have an impact, right, in terms of having less contribution on the part of the insurance companies.

MR. TREIBER: Yes. State Department of Health issued a notice to the field saying basically through -- I guess it was through PCG, but basically providers need to get prior authorization; that that's one of the reasons why many of the claims are being denied. And so PCG put on their website basically a breakdown in

each of the insurance plans and what the requirements are regarding prior authorization. But it's a significant burden in addition to all the others for providers, to show that they have attempted to get prior authorization or not before they can bill.

DR. SHULMAN: And they can't even see it because it's billed through NYEIS.

MR. TREIBER: Yeah, exactly.

DR. SHULMAN: So it's blind. It has no frame of reference.

MR. TREIBER: Mm-hmm, yeah.

DR. SHULMAN: Okay.

DR. CASALINO: Can we go over one thing?

MR. TREIBER: Sure, absolutely. You were out there.

DR. CASALINO: Yes, I was at the roundtable. Just to step back to add to what Chris said, the way this was rolled out, the way this happened is that Members of the Assembly wanted to have a roundtable to open a dialogue; rather than have a hearing where folks come to a table, do their presentation and then the next person comes and there are questions of

individuals. And the goal, our understanding of the roundtable was the goal was to open a dialogue and to identify multiple factors.

And Chris pointed out and has just mentioned a number of them. New York City was invited. I went, along with Sandy Rozza, our Chief Financial Officer. We approached this as an opportunity to bring to the table, to bring to the legislators where we are in the process and what could be done moving forward. Because the bottom line is we are now two years into this reform, these administrative changes. New York City supported this initially and we continue to support it. But we are also aware of the implementation shortfalls. And there are things that need to be done to fix the system.

At this juncture, there is no going back. There is only going forward. But going forward means identifying those implementation shortfalls and presenting recommendations and activities and actions and devoting resources to what can and should be fixed. And it goes to NYEIS. There are issues regarding the billing and claiming. There are issues regarding the

contracting. The capacity issue as you said; we have many more providers in New York City than we did before. We've taken on additional administrative tasks in our orientation process of new providers. There are providers coming into the New York City system that had not worked in Early Intervention before and we have an orientation process. That being said, there are still areas in the City where we are still feeling capacity issues.

So, there are things that could be adjusted or fixed or modified in this entire implementation process that will have a positive impact. And even beyond New York City, clearly we're coming with a New York City agenda but everything we're presenting or is something that we brought to the table at the roundtable will serve the entire system of early intervention. There are things that need to be fixed. Resources need to be dedicated to these fixes. And that means the State Department of Health, many recommendations can be made, will be made.

But it's about going forward in the most positive sense with the appropriate resources and

identification of everything that needs to be fixed going forward. The providers are feeling it. The municipalities are feeling it. We're concerned about the money the way everybody is. We have to be. We have to support this program. So, it was a good opportunity. And it was a good opportunity to be sitting with the provider community presenting to the legislators who can work with us to do what needs to be done.

MR. TREIBER: And the last thing actually I did want to point out. Sandy Rozza said something I thought I was significant. On behalf of New York City, she was talking about there's an increased financial cost to the City of this. Most people didn't think; the idea was you remove the burden of billing from the municipality and the municipality will benefit somehow financially. However, Sandy said that prior to the April 1st transition to a State Fiscal Agent, the City paid 49 percent of the early intervention budget with tax levy dollars. After the State Fiscal Agent, the total cost of EI spending to New York City tax levy dollars for Early Intervention increased to 56 percent. It's

a seven percent increase.

So clearly the intent of what was intended to happen didn't happen. And so they've got to fix it, like Dr. Casalino said. And I think there were some specific suggestions and recommendations. I think that we have followed up as a provider group with the Assembly Members to basically sort of see what are the next steps. I think they're going to have a follow up meeting internally with the Members of the Assembly that were there and then determine what they're going to do going forward.

So just to continue on sort of the Albany thing. The State Education Department issued a special ed field advisory. And I don't know if all of you saw this, regarding initial evaluations of children transitioning from early intervention to pre-school special ed services. It was issued just a few days ago actually, at the very end of October. And it basically is a reminder to the pre-school community that initial evaluations for pre-school kids leaving Early Intervention must be completed within 60 calendar days. It basically says that some specifics: the

Early Intervention service coordinators are responsible to submit reports only with written consent of the parent. So that's another sort of thing to say to the pre-school administrators: You can't get the reports unless parent consents to those.

And that they also stressed in the memo that it is not the responsibility of Early Intervention to complete new testing to determine if a referral should be made or to assist in making that eligibility determination. So school districts should not be requesting Early Intervention to conduct new tests and assessments for children. Which based on the information here, it sounds like this must have been an issue around the State. I haven't heard it necessarily in New York City but I think around the State it must been an issue. So, just so know how that came out.

And then the two other bills. The school psychology bill was in fact signed by the Governor. The bill however sunsets June 30, 2016. So basically what it says right now is that a New York State Early Intervention Agency may request

approval to employ a school psychologist. And there's actually a form and a process. I have actually personally raised a question about this regarding what the intent of the law was and whether or not there needs to be a request for authorization for approval because the law never specifically required that. So that's something that we're in the process of trying to get some clarification on.

But basically what it says is that you can employ a school psychologist right now, until June 30, 2016. After that it may be that we're going to have to pursue getting the law extended. A lot of the times when they do these provisions, they sunset it. This one was sunsetted specifically because it has to go back to 2014 when the State issued guidance that school psychologists couldn't provide this service. And so to protect providers, they extended the law backwards to cover everybody from the official notice went out to the community. So that's one thing.

And then the other thing, there was a bill that was in both the Assembly and the Senate

regarding collection of data that the State Department of Health had to collect on Early Intervention. I just found out today that the bill did pass both Houses. However, it has not been delivered to the Governor yet. So, we don't know why it hasn't been because it passed in June. And so we don't really know the status of that in terms of going forward.

The last thing that I just wanted to discuss with the committee is that the IAC, my membership organization, we did a survey of our schools regarding staff losses. We've done this the last two years because our schools have reported significant losses of staff, specifically teachers, from sort of sometime at the end of August when the school year ends to the beginning of September. And what we found this year from about 30 of our pre-schools is that they lost 109 teachers in that period of time. Some schools lost half of their teachers; others lost a significant number.

And it's not just specific to New York City but it's worse in New York City, specifically because of universal pre-K. And most

of the teachers, when we did the survey we asked where they went. Almost a hundred percent of the teachers went to school districts because they could pay more. And the reason I'm bringing it up here, I'm just kind of wondering: Is that something that Early Intervention providers are starting to see in terms of is it impacting teachers yet or not? And if it isn't, you should be aware that it may very well soon. Because the Department of Education through your UPK offered a $2,500 signing bonus for all new teachers who went over to work for them. That's something that most of the pre-schools couldn't match at all because they haven't had any increases in six years. Early Intervention is in that same situation, very few increases.

So I'm just kind of raising it just to bring it up, to let you know that's something that we are looking at. And we have raised it with both the State, as well as New York City, in a letter to the Chancellor. We're not saying that this isn't a great thing that you're doing universal pre-K. But we're also trying to recognize that most of the children that you're

taking teachers away from are your own children, New York City children who are being served. And once you take a child [sic] away from providing special education or in fact Early Intervention, you're losing them to a system that we'll never get them back. So, I'm just raising it as something to be concerned about. Is that any issue that anybody has seen regarding early intervention?

MS. LeBRIGHT: I don't think so. But I also think it's really more of a fiscal thing as well.

MR. TREIBER: Oh, no question.

MS. LeBRIGHT: Sure. So in Early Intervention, the pay system is so different and the Board of Ed pays so much more than any 4410 can afford. So, it is what it is.

MR. TREIBER: Yeah.

DR. DeBEY: I don't know about Early Intervention by itself. But every week from past students, from people who know and at the College, I think I get probably two, three requests from different agencies saying: Do you have any new graduates who are teachers? They're

desperate for teachers. One of our graduates from our graduate program, he just went to an agency that didn't have a teacher since August. And so she just went on just say the 1st of November and now there's another. So these children are not getting the services [unintelligible] [01:50:23].

MR. TREIBER: Yeah. The biggest challenge, last year when we did the survey we found that about -- I think our schools were able to replace about 70 to 75 percent of the teachers by the time we had completed the survey, which was sort of sometime in October. This year they're at less than 50. And one of the things we're hearing from the directors is: There's no one left to hire. There's just a very large vacuum. Normally, teachers graduate in June and then you're able to sort of fill your classroom. We have a lot of schools right now that don't have certified teachers -- a lot.

DR. DeBEY: Would it be out of order for me to do my little; I was going to talk a little bit about this very thing? So, instead of me being third, maybe now?

MR. TREIBER: Yeah, absolutely. Sure, we

could do the Committee report, absolutely.

DR. DeBEY: Because we're feeling it a great deal, just there's such a need for qualified teacher; that we're really trying to put together like a coalition with the agencies, just to see what we can do. Can we do an internship program, so they get out to you more quickly and then stay and work for you? Is there anything like that we can consider?

The other thing we're working on as part of my role here is really developing a developmental; we're calling it Developmental ABA Program. Because as you see in all the data that most services are given in EI and once they get older [unintelligible] [01:52:03]. But we've always been reluctant to do it because it's so much developmentally appropriate and it doesn't really look at that parent-child dyad. And we've been really struggling with it. But I do think we have a plan now. And Queens does have a plan that they do do ABA and it's within the early childhood program. We're working with them and we're working with some of the others; hopefully developing again a program that's ABA, that keeps

the focus on the child and the family.

Right, from all the research we know that that's the problem with ABA with young children because you have this child-centered focus until you get to ABA and then it's not. And it doesn't have to be that way. Many people around the table know that it doesn't. So, we're developing a training program but we don't know how to get our graduates out [unintelligible] [01:52:54]. We really would like to get them out before, while there's such a need. Because we look at that early learn at 75 percent. You see the same thing in Early Learn. Our students are all working because they're on study [unintelligible] [01:53:09]. Because there's just not enough people left out in these community-based organizations.

And the only thing is in my presentation is that I did attend the training on Friday on the supervision and it was fabulous. And the thing I would just add to my presentation of it is that there's really to me a sea change. There's a real change in that it's not only the zero to five community and the EI would be

together. And the interdisciplinary work, that there's speech and language pathologists there. There were OTs and PTs there. But I think the universities, the city colleges are really looking at it differently.

And that's thanks to all this work is that EI used to be sort of: If we had it at all, we'd relegate to the special ed and sort of in a corner you did it. Now faculty who teach anything about young children, it has to include the infant. You can't teach about early language and literacy without also thinking about young children with disabilities. I mean, it's not a separate thing. And so that is what has happened I think in this whole committee that looks at [unintelligible] [01:54:32]. Anyway, that's it. Thank you.

MR. TREIBER: Thank you. Any transition things?

MS. WARKALA: Well, apparently there are things still about the Policy and Procedure Manual that is out there on transition. EI is still currently reviewing it. They want to make sure that it's aligned with the federal

guidelines because that's really, really important in moving forward. So, at this point I don't think there's a timeline of when it's coming out. They're hoping that it will come out soon. And I don't have a date at this point. But as soon as I have a date, I will provide that to you. So, we're still moving forward. They're still moving. You know, they're not dropping the ball on it. It's really very, very important. We've all really recognized the importance of transition. So, we're really hoping it will come out very soon.

MR. TREIBER: Tracy?

MS. LeBRIGHT: Policy review. We not met because we're waiting for the Department to have a policy ready for us to look at. In terms of the health equity committee, I spoke we spoke a lot about the data. We had one meeting. I think it was a really good meeting, trying to brainstorm. And I think the challenge is really trying to narrow the focus. Because we're not going to solve the ills of New York City's communities, particularly the Bronx. We think we need to take a multi-pronged approach. We talked about working

with service coordinators and provider agencies, as well as engaging community organizations and also importantly, getting feedback from families who did not make it through the evaluation process.

We can speculate but we really don't know. So I think what our first step is: We've started developing sort of a questionnaire to hopefully engage parents who did drop out of the system, to get more information about why that is. We're also going to be developing focus groups and questions for service coordinators. And hopefully we can use the information from that to really inform us on what is our project exactly going to be.

MR. TREIBER: Thank you. Any other comments? Okay, well, I think that's it then. Thanks for coming.

[END OF MEETING]

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CERTIFICATE OF ACCURACY

I, Andrew Slawsky, certify that the foregoing transcript of the LEICC meeting on November 10, 2015 was prepared using the required transcription equipment and is a true and accurate record of the proceedings.

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Date: December 28, 2015

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