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ANNA COSTALAS:
Hello and welcome to Act Early Response to COVID-19 my name is Anna Costalas. We would like to thank you all for joining us today. Just a few logistical details, we will be muting your microphones throughout the webinar. You can ask questions in the chat box. You can send a chat to the whole audience or presenters. We will read the questions out loud to accommodate all attendees when we are going through the questions. We have closed captioning if you would like to access it, press the cc button. This entire webinar will be recorded and it will be found on the AUCD website. There will be a short survey to close the webinar, we would like you to provide feedback and suggestions for future topics. Please join me in welcoming Elizabeth Howe who is our AUCD and CDC Fellow for the Act Early Response to COVID-19 project. And Hannah Getachew-Smith who is our COVID 19/Act Early project evaluator for AUCD's public health team. Thank you for agreeing to present. I will now pass the mic over to Betsy.

ELIZABETH (BETSEY) HOWE:
Thank you Anna. Good afternoon everybody thank you for joining us today. I will be going to be talking and sharing some information about the Act Early Response to COVID-19 project. Which is the supporting the idea early edification of your children with developmental delays or disabilities. (Reads)

The CDC's early identification program is comprised of four steps. Parent engage developmental modern are in, developmental and autism screening, wrist furled her services and receipt of early intervention. While the figure here depicts the steps as linear and sequential, we are learning that for children and families it does not occur this way. Children can skip steps or move back and forth.

Children often get lost at the referral point because there is not enough data collection. One thing we are hearing about as well is that...

There is a small number of children who get referred for early intervention services and even smaller number of those children's pick up the phone when a program for calls. Of those families who answers, express concern about the Charles about men. This example highlights need greater focus on the first step to ensure apparent engagement do not only support the knowledge, but for early edification. The Act Early program has integration of framework.

Integration is presented as hierarchal framework. That starts with passive promotion of materials and active promotions. The five levels of the integration framework are level I, passive promotion of LTSAE materials, level II, (Reads)

Each of the 43 are asked to develop, implement, and evaluate. These goals develop estate partner team made up of a variety of different childhood programs including grants. Disability advocacy.

The second goal is to conduct a needs assessment to better understand the impact of COVID 19 in

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early identification and community resilience. The third goal is the enactment. (Reads)

I will share information about goals one, three, four while Hannah will provide a more detailed information about gold too. While all the states and territories create work plan. Each bullpen is unique. It includes demographics of the state, types of communities, additionally, the components of - the characteristics of the team leads themselves, such as the role.

For the first goal teams are asked to include representative of the child programs on their state or territory, partner leadership teams. I described those before and are listed here on the slide.

LEND training is used by notable states. For example, Nebraska, they have milestones which is a video library for providers. In Alaska, it is Gordon aiding the work for the team in the North and South. In Wisconsin, a LEND training and social worker training, they create a bridge between the Act Early and the families of young children living in those communities. In New Jersey, a social worker is working to develop a training to be used with medical students to work in partnership with families to provide training.

This cross sector team so boards of broader reach to support earlier notification. For example, Idaho reported that they have a much wider reach than expected, to a greater understanding in the state for team partners.

Moreover, many team leads are reporting a level of engagement at the sleazy answer from the partners they have not experience in the past what this may be due to the impact of COVID 19 combined with the funding of the grant. For example, North Dakota reported working with the team is different in the past when there are so many roadblocks. Because of the grant money, there is a time to devote to planning for the meeting and this feels sustainable because there is time.

Some examples of how teams are utilizing their partnership teams. In New York, they use the state team as a professional learning community. They ask their partners to create work plans describing how they will integrate LTSAE.

In South Dakota, the state team partners prioritized and ranked needs from the needs assessment to select interventions and activities. Most relevant to the state in terms of early the division resilience was in Wyoming, there has not been an Ambassador in the state for a while, so our current Ambassador is relatively new in her role and is working hard to building her knowledge in her state team. One of the ways she does this is by having those team partners participate in the Act Early ECHO trainings. The South Carolina and Utah also used partners and asking them to integrate LTSAE materials into their respective programs. Utah also asked those partners to create action plans which are describing the ways in which they will integrate it. In Arkansas, they have family advisors who will be implementing LTSAE in healthy stop sites and those are part of the leadership team. Meaning they have a voice and a role in terms of making decisions.

Goal three focuses on developing and implementing a work on. There are different ways that we see the teams approaching this was there as material dissemination, material development, training, and

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an approach called community liaisons.

Some activities to support developmental monitory include:
-Florida, developed a postcard with a QR code to directors of their website and on my checklist was in the first month they have 3000 visits.
-In Oklahoma, they created a sticker to put on materials with a URL to the landing page for LTSAE.
_In Hawaii, they are training 75 medical students, they deemed them deputy ambassadors and on the screening the survey of young children's well-being, which addresses children's developmental milestones and risk factors. And in Connecticut, the parents use of the sparkler up includes both LTSAE and ages as they just questioners.

They can complete screenings if there is cancer. All the data is reported to United Way.

In Connecticut for referral, it provides care coordination. In you New Hampshire, they create a single system occiput for families.

Activities related to receipt of early intervention include in Indiana, part C infused LTSAE into A Child Five materials to grade one consistent message in early identification. The part Ccoordinator is part of their leadership team.

In Illinois, part C providers experiences in the echo training is used by the agency administration to address the knowledge and needs of providers. (Reads)

Each board book represents a different region of the state and includes animal characters that are native to each region.

In Florida, created a social media toolkit for 13 affiliates who are implementing work around integration on LTSAE on the local level. On Ohio, the LEND trainees are developing a physician's toolkit.

In Puerto Rico, undergraduate students from Sacred Heart University are creating three videos. These videos are how to use milestone tracker app, about child development and disability and how families access to resources and services. They will disseminate these videos through social media. This strategy is really important for Puerto Rico because the territory never opened up during the pandemic. Making it very difficult to reach children and families.

In Idaho, they created a resiliency toolkit. This is on the website and is hyperlinked on the PowerPoint. (Reads)

Examples of trainings that are being conducted are, Connecticut, they created a playbook of how to use LTSAE to support training for early childhood providers and for families. Illinois is developing home visiting training module that will be part of their training package for providers. They had to benefit - they initially wanted to do a more extensive training but the home visiting training is not comfortable for that. Instead, they are including this in their overall training package.

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Indiana is creating a narrated PowerPoint and implementation guide to provide statewide training to (Reads)

This training will be delivered to all Headstart involved in this year. They are able to do this to reach all of the state Headstart sites because they have their Headstart liaison on the state team. In North Dakota, they created monthly mini lessons using narrated PowerPoint and Loom. Again, they had to pivot from their original plan to do a more extensive training. The Headstart coordinator was hesitant about asking providers to engage in one more training which is why they are calling these mini lessons. And the many lessons entailed that each month is that they focus on a different resource.

The mini lesson provides information to the providers about how they can use these material. Finally, Ohio, Virginia and Wyoming are collaborating together to implement an Act Early ECHO.

Examples of community relations. Community liaison is somebody at the local level who is working to integrate LTSAE. It is represent a grassroots approach for the use of LTSAE across the early childhood system. In Arkansas, the family advisors help family voices to be part of advocating for change in those sites. They are going to be working directly with families in those sites. Florida has 13 Help Me Grow Affiliates. It engages them. Louisiana is working with five ready set networks through the Louisiana Department of education in the state to become community leaders in five different high needs parishes in the state. New Jersey is recruiting parent champions or disseminate LTSAE to families and other community agencies and work with pediatric residents. In Texas, (Reads). By using these deputy ambassadors from these different regions, they have achieved a statewide reach of integration through variety of different early childhood programs at the local and state level.

Goal four focuses on implementing activities related to the resiliency of children and families. In Hawaii, in addition to the survey, they also do parent cafés which are program for strengthening families which focuses on protective factors. Nebraska is using Lemonade for Life which is an intervention. Louisiana is using an intervention called safe, secure, and loved to teach parents resiliency using mindfulness.

Cultural brokers in Virginia is "uniquely defined expires. It is applying family strength and resources in a way consistent with their beliefs so that they think about life changes and... More positively."

Vermont is using a statewide framework. Trainings that are occurring in North Carolina, they have a statewide conference on infant in early childhood providers on infant and early childhood mental health. Florida conducted a two hour training for Help Me Grow Affiliates on trauma. Kentucky developed a virtual training resiliency for all early childhood system partners. NDC will conduct virtual parent cafés, including one for children development and one for children with autism.

Some examples of how state and territory teams are supporting this. Alaska works in collaboration... (Reads).

The Alaska Act Early Ambassador describes the work as building resiliency because the conversations about child development stems from the strength-based perspective. It is important for

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this community which has experienced historical and generational trauma. In Oregon, the Act Early Ambassador our training parents live this (Reads).

So this map highlights the work of the 43 state and territorial response teams. By clicking on each pin, you can learn more about each team's project activity. As well as contact information. I encourage anyone on this call, if you are not involved in your state or territory, reach out to your team leads.

Thank you for listening. I appreciate you being here today and I will turn this over to Hannah so you can hear more about needs assessment.

HANNAH GETACHEW-SMITH:
Just give me one moment.

Oops. Wrong screen. Sorry give me one second.

Can you see my slides? Yes. Perfect.

Before we get started I just want to say that I have a sick child at home who can be a little loud. So I apologize in advance if you hear him in the backyard. My name is Hannah Getachew-Smith and I am the project evaluator for Act Early Response to COVID-19. I will go into a little bit more detail about goal 2.

Again, just a quick reminder as part of the overall Act Early Response to COVID-19, we conducted a rapid needs assessment to understand current and emerging needs, strengths, barriers, and opportunities related to the four steps of early identification of developmental delays among children from birth to five years old. During the COVID 19 pandemic. We assess this across early childhood systems and programs.

I will briefly touch on the methods that were used to conduct the needs assessment. Our methods consisted of primary data collection via two web-based while trick surveys.

First survey was the team lead survey.

The second survey was the Parker survey, which was completed by representatives from key partner programs and system serving children from birth to five years old. (part c, WIC, etc).

The aim of this survey was to gather specific early childhood program and system information related to the 4 steps of early identification.

Here are some snapshot of them serving mashers. I will be sharing key findings related into the engagement in four steps of early identification. If you're interested in hearing more, please reach out and I will be happy to share. To analyse the data, we integrate the data in three different ways.

First, following the end of data collection, the data was returned to all of the response teams to

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summarize using a template that was provided by CDC. This is a way for the teams to reflect and look at their own data within their state and territory because it was not just team lead information, but also from their partners.

Second, we analysed the quantitative data using – looking at descriptive surveys. Finally, the open ended survey responses were analysed by three coders in a qualitative data using the software called Dedoose.

Which is using a coding scheme based on the Social Ecological Model.Used a content analysis approach using a coding scheme based on the social ecological model, a theoretical framework to understand multiple levels of influence within a society and how individuals and the environment interact within a social system.

To share some of our key findings, overall, there were 392 needs assessment surveys completed, of those partners, 349, and all 43 response team leads
complete the survey. A majority of respondents identified as female and have a Masters degree. And on average, the response were from 39 years old. The number of partners invited ranged from five to 48 different partners a representative. And the number of surveys completed ranged from two to 17 responded by state for territory. This map shows some of the distribution of survey completed by region. And more than 1/3 of the responses were from the south. Respondent on the survey sales identified as one of the 12 programs system. Nearly 1/3 of the respondent other for their category.Examples of others include UCEDD/LEND, Medical systems, Higher Education, and Department of Education. The next highest percent of respondents represented Part C and Title V.

Next, I will share preliminary findings about engagement in and activities related to early identification overall. Almost all respondents (93%) reported engaging in at least 1 of the 4 steps of early identification. Additionally, most respondents reported engaging in at least 3 of the 4 steps of early identification, with an average of 2.9 steps engaged in. There is a lot of great work being done across the country. Respondents were asked which of the four steps of early identification they engage in. Over 85% of respondents report engaging in referral for services which is step 3 of early identification followed by developmental monitoring (step1) and developmental and autism screening (step 2).

In this figure, the programs and systems are grouped by each of the 4 steps of early identification denoted by colored bars on the x axis and total percent of reported engagement on the y axis. Most programs and systems report the highest engagement in step three, referral of services which are the yellow bars in the figure.

Notably Part C reports highest levels of engagement for providing services (blue/green bar) and general Early education reports highest engagement in developmental monitoring (purple bar).

On the survey, we asked about the extent to which COVID-19 has had an impact early identification. We asked this on a 5-point Likert scale from not at all to extremely impacted by COVID-19. Over 90% of respondents reported that COVID-19 has highly impacted early identification. Notably, only about

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3% reported that COVID-19 has had no impact on early identification. We also asked about number of children served by the respondents program or system and 48% of respondents reported a decrease in the number of children served since the beginning of the pandemic. I should note here that this question was only asked of partners, on the partner survey. A lot of people also noted that they were unsure about what that number is. That also

Tells us that more work needs to be done in terms of how we collect data and how that information is shared.Lastly, we asked several open-ended questions about the impact COVID has had on early identification engagement, activities, and processes. The right side of this slide shows some examples of these responses. Respondents reported collective trauma (including fear, isolation) and described a decrease in screening, referrals, and evaluations. They also noted completing priorities to meet basic needs like food, shelter, utility assistance, and emergency funding really having an impact on how early identification is being laid out in their state or territory.Poor program/system coordination was mentioned. Noting challenges tracking/following up with families. Respondents mentioned changes in service delivery from in person to virtual or hybrid methods. Finally, they describe resources,specifically staffing, funding, and time—have been severely impacted by COVID-19. For example, respondents report difficultly scheduling appointments due to closures,
, limited working hours, and wait lists. Additionally, appointments need to be spaced out more for remote sessions since it is taking longer to document/chart after an appointment.

After asked about early identification overall, we asked respondents series of questions about each of the four steps. I will highlight some of the findings that we found related to the barriers, needs, strengths, and opportunities for each of the four steps. The first step, again, is develop mental monitory. Some of the barriers on this are provider and staff awareness or knowledge of DM. And taking a wait-and-see attitude approach instead of acting early. They also noted that family awareness of DM and level of interest in engaging in DM was a challenge. Again, those resources that I mentioned in competing priorities which are honestly barriers long before the pandemic started.

Some of the supports our needs that they identified include culturally and linguistically appropriate materials. As well as generating family buy-in which could be achieved through increased opportunities for family engagement. Some of the strengths is is finding innovative boys to support families. For several, helping farmers to find new ways to engage with children since libraries, museums, gyms, using venues are close. Another strength is that some of the changes that have been made to billing and reimbursement during COVID allowed for well and sick visit to happen in the same appointment.Finally, there are some opportunities to increase reach using virtual & on-demand trainings to educate families/increase awareness about developmental milestones.

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Moving on to step two, barriers include lack of awareness about the importance of screening. And again, reimbursement and resources which we have seen. Some of the identified needed supports for screening include provider training to understand the importance of parent concerns and not to take that wait-and-see approach. Some of the strengths include increased collaboration between programs and systems to work to overcome challenges. One respondent explained that creating new partnerships to leverage resources and connect children and families to resources that really did not exist in the past. But because of COVID, it happened. And then up potential opportunity to ability to screen more children in virtual environment while reducing other barriers to screening like transportation.

For step three, respondents identified several barriers, needs, strengths, and opportunities. Some of the barriers for referral include referral hesitancy from families and providers and just generally missed appointments or visits. Some of the needs include a more coordinated referral system. As one respondent pointed out, need an “easy, consistent way to share information on children receiving care in multiple settings. Strengths include programs/systems assembling work groups with a history of collaboration to get children into early intervention services . Opportunities include bringing programs/systems together to minimize duplication of services and provide coordinated services.

Then finally, the fourth stop of early identification is receipt of services. What we found is that respondents identified barriers such as

Timeliness of referrals for receipt of services where staff may be waiting too long to refer patients. And there are also a lot of service deserts and inadequate access to services.Needs and supports related to receipt of services include increased access and better quality data on the early identification process .

Strengths that are particularly important right now in the context of COVID-19 include innovative and creative ways of providing services. Opportunities include more comprehensive services provided to families such as mental health supports which is a great opportunity given COVID.

To summarize, we found high overall engagement in each of the 4 steps of early identification across programs/systems. The highest engagement was in step three. Other programs or systems and part C reported highest engagement in each of the four steps.

It is very clear that COVID 19 has highly impacted each of the four steps. Mainly, the number of children served over all has decreased since the pandemic started and the majority of transition to provide virtual or remote or hybrid service delivery.

Common barriers, needs, strengths, and opportunities identified across steps of early identification.For example, resources (i.e., staffing, funding, time) are major barriers to all 4 steps. Respondents also identified Better coordination among programs/systems an important need and innovative ways to support families and identify strength and need. And an opportunity to capitalize on ability to screen

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more children in this virtual environment
was an identified opportunity.

Grantees have used findings to guide project implementation to address identified early identification barriers and needs during the pandemic. Our hope is that this needs assessment will inform future efforts to support early identification of developmental delays and disabilities.

Here is a quick snapshot of our key program contacts. Please reach out to us if you have any questions about the needs assessment or the program overall. Thank you very much. Both our emails are on the screen and we welcome any questions.

ANNA COSTALAS:
I will give a couple of seconds to see if there any questions. I am also going to put the survey on the chat box - the evaluation survey. I am also going to put the link on our event page and recording will be available and slides on this page as well.

Looks like we have quiet crowd. That is OK. Thank you again this wonderful presentation. Thank you everyone for joining us, again, this webinar has been recorded and will be archived, probably will be available by end of day tomorrow. I put the survey in the chat box and invite you to fill out the survey to provide feedback and also new topics for the early childhood, or any special topics you want to hear. Thank you again to our presenters and happy Monday everyone! Have a great day! Thank you.

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