



Department
of Health

Albany Connections Pilot: A Value-Driven Project to Build Strong Brains

New York State Department of Health
Office of Health Insurance Programs

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Executive Summary

The Albany Connections Developmental Screenings Pilot Initiative, originally developed as Albany Promise, was a cross-sector initiative that invited community partners along with five Medicaid Managed Care Organizations (MCOs), (CDPHP, Fidelis, MVP, United Healthcare, and WellCare), three pediatric practices (Albany Medical Center, Harmony Mills Pediatrics, and Whitney M. Young, Jr. Health Center), the City School District of Albany Committee on Pre-School Special Education, the Albany County Early Intervention program, the Capital District Child Care Council, and the New York State Department of Health (NYS DOH) to collectively promote developmental screenings in children ages zero-three. This initiative was intended to create a pilot program in Albany County that incentivized pediatricians and health plans to ensure all children are developmentally prepared for kindergarten by universalizing the developmental screening and referral process.

The pilot goals were to:

- I. Incorporate global screenings for developmental, behavioral, and social delays using a standardized screening tool (Ages & Stages Questionnaires, Third Edition (ASQ-3)) into well-child visits for all children ages zero-three;
- II. Integrate ASQ-3 as a standard procedure to identify developmental delays at a younger age, resulting in the promotion of early intervention services earlier in life;
- III. Share resources with parents, families, and fellow practitioners describing the benefits of ASQ-3 screenings; and
- IV. Promote developmental diagnostic screenings to provide support sooner to aid in increasing kindergarten readiness.

To increase the use of developmental screenings, there were several fundamental steps that needed to be in place at the practice level. These key components included: (1) implementation of a standardized screening tool, (2) a practice workflow around the administration of the screening tool, (3) capture of the results of the screening, and (4) having an individual in a referral coordinator role. Practices that had a strong process workflow were more likely to be successful in both screenings and referrals, in turn, yielding the highest levels of compliance.

Capturing the information needed to quantify the number of attributed population and children screened was an identified challenge. As a part of this project, each practice was provided an Excel workbook template to facilitate the capture of information (e.g., screening date, score within each domain, referral decision, date of referral). Completed workbooks were transmitted by each practice to the MCO and then compiled and sent to the NYS DOH for review.

Upon completion of this project, it was determined that there was potential room for improvement in the number of children screened, as well as the referral of high-risk children to the county for developmental concerns. A secondary area that should continue to be explored is the bi-directional exchange of information between Early Intervention (EI) and the provider. The sharing of information is imperative as it may bridge the gap in services and referrals and facilitate a stronger relationship between healthcare and education.

This report includes background on the development of the pilot, project goals, stakeholders and participants, an overview of the process and data flows, and a series of best practices and

barriers. The final sections of this report include the results from 2017, 2018, and 2019 recommendations for the future.

Background

In 2011, New York State created the Medicaid Redesign Team (MRT), which developed a series of recommendations to lower immediate Medicaid spending and propose future reforms for Medicaid spending. In 2014, as part of the MRT plan, NYS obtained a 1115 Waiver which was to reinvest MRT-generated federal savings back into redesigning New York's health care system through a Delivery System Reform Incentive Payment (DSRIP) Program. In 2015, as part of the DSRIP Program, NYS undertook an ambitious payment reform plan working towards an 80 percent value-based payment (VBP) threshold for Medicaid MCOs by the end of the waiver period. Other VBP pilots, like the Albany Connections pilot, were also supporting transformation at the state level and collaboration at the community level. The goal was to have 80-90 percent of all managed care expenditures in value-based arrangements by March 2020.

Children from low-income families may start school at a disadvantage and are less prepared for kindergarten than children growing up under better economic conditions.¹ Forty-eight percent of children from low-income families are ready for school at age five based on measures which examine early math and reading skills. Higher levels of school readiness in children at age five generally has translated to more success in grade school and reduces the likelihood of dropping out in high school.¹ Simply put, the work of ensuring an equitable educational foundation for all students begins in early childhood.

All babies are born with billions of neurons which connect at a rate of 700 neural connections per second in the first five years.² Eighty-five percent of brain development occurs between the ages of zero and three.¹ These connections build the brain architecture needed for every child's success. Early childhood experiences shape the developing brain. In the absence of positive experiences, the brain's architecture will not form as expected and result in potential developmental delays.² It is easier, less costly, and more impactful to intervene in the early stages of child development than to do so later in life.

The American Academy of Pediatrics (AAP) recommends developmental surveillance at every well-child visit and periodic administration of standardized, developmental screening tests to ensure timely identification of children at risk for developmental, behavioral, and social delays.² Developmental screening is a more structured process that involves the use of one or more standardized, validated screening tools to identify and refine the recognized risk. The AAP recommends that developmental screening be performed with a multi-domain screening tool at well-child visits at ages nine months, 18 months, and 24 (or 30) months.⁴ If developmental

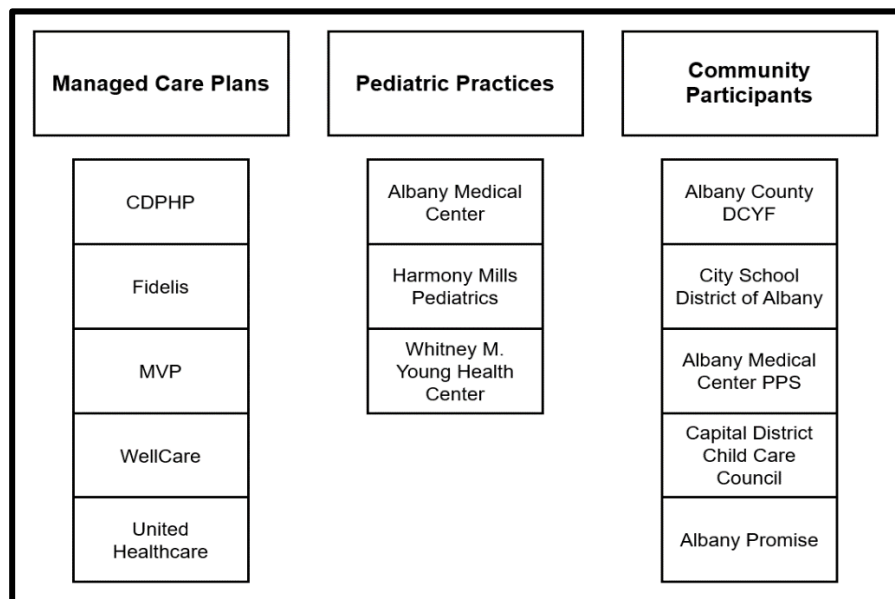
¹ Center on the Developing Child, Harvard University, A Science-Based Framework for Early Childhood

²"Screening for Professionals." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 7 Apr. 2020, www.cdc.gov/ncbddd/childdevelopment/screening-hcp.html.

surveillance or screening indicates that a child is at increased risk for a developmental disability, the child should undergo a formal diagnostic developmental evaluation consisting of a medical evaluation. However, to avoid unnecessary delays, providers should make a referral to Early Intervention (EI) services when they suspect that a child has a developmental disorder and not wait for a diagnostic developmental evaluation to be performed.³

Stakeholders / Participants

The Connections Pilot was implemented across three pediatric practices and engaged five MCOs. This project worked in conjunction with the Albany County Single Point of Entry (SPOE) and the NYS DOH. The NYS DOH provided data support as needed, analyzed submitted statistics, and shared the pilot progress and outcomes with the Implementation Working Group monthly.



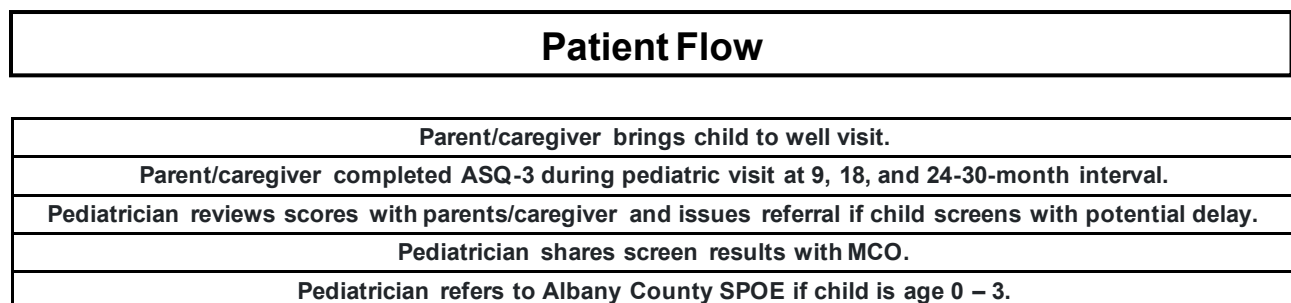
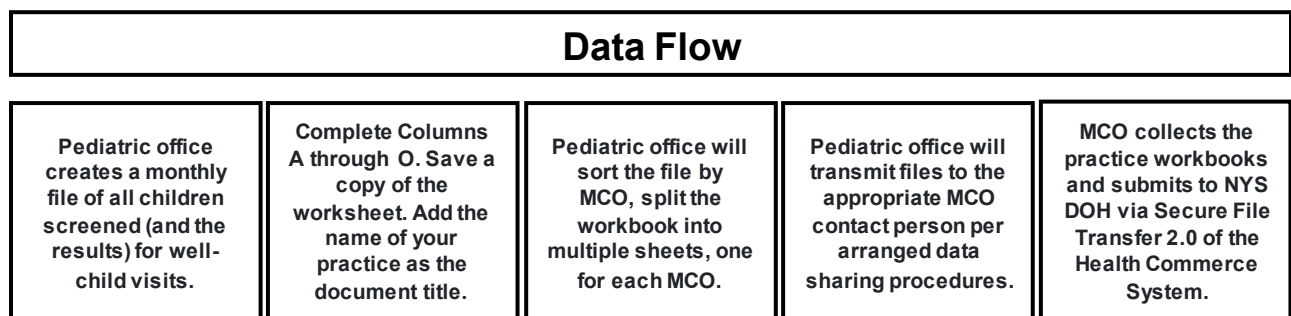
Footnote: (CDPHP) Capital District Physicians' Health Plan, (DCYF) Albany County Department of Children, Youth, and Families, Albany Medical Center (PPS) Performing Provider System

The Albany Connections Developmental Screening Pilot Initiative was led by the NYS DOH Office of Health Insurance Program's (OHIP) First 1000 Days team and the Office of Quality and Patient Safety (OQPS). Additional organizations involved in this pilot were the NYS DOH Division of Family Health and its Bureau of Early Intervention. The pilot strategy was to incentivize pediatric offices to conduct the developmental screenings. The NYS DOH developed a data process flow chart describing the roles and responsibilities of all stakeholders involved in the pilot, as well as shared a Data Dictionary as a user guide for the duration of the pilot. A letter co-authored with the MCOs was shared with the pilot participants to address additional concerns and foster collaboration among the MCOs, pediatric practices, and the community. Additionally, a data tracker and referral tracking spreadsheets were compiled and shared with NYS DOH with aggregated data. Monthly check-ins and implementation workgroup meetings were held to discuss any challenges and best practices that pilot participants were facing during the implementation of this initiative.

Strategy	Stakeholder			
	NYS DOH	Albany Medical	Harmony Mills	Whitney Young
Developed Consistent Tools / Processes				
Developed Data Process Flow / Shared with Stakeholders	✓			
Data Dictionary (User Guide)	✓			
Co-Branded Parent Letter		✓	✓	✓
Data Tracker	✓	✓	✓	✓
Referral Tracking Document/ Spreadsheet		✓		
Monthly Check-In Calls (Plans/Practice)	✓	✓	✓	✓
Monthly Implementation Group Meetings	✓	✓	✓	✓

Methods and Data Process Flow Steps

The ASQ-3 were administered at well-child visits where the child must have been under four years of age at the time of the appointment and enrolled in one of the five participating MCOs. EI referrals occurred if the results were in the “monitoring” or “black” zone, if there were parental concerns, and/or based on the provider’s judgment. The ASQ-3 information summary page is where the provider transfers the child’s score in each of the 5 domains. The domains covered by ASQ-3 include communication, gross motor, fine motor, problem solving, and personal-social. Based on the scoring tool, scores will fall into three referral categories; the White zone (indicates the child is developing typically), the Grey zone (indicates the child should be monitored as the score is 1-2 standard deviations below the mean), and the Black zone (indicates that the child may be at risk for developmental delays (2 standard deviations below the mean) and should be referred for further assessment).



Pediatrician refers to City School District Committee on Pre-K Special Education if child is age 3 – 5.
Albany County EI Service Coordinator is assigned to a family.
Service Coordinator arranges for EI evaluation.
Albany County EI creates feedback loop with pediatricians (within 45 days) to deliver status update.
Pediatrician conducts follow-up with family of referred child if referral has not been executed by family.
Pediatrician encourages well-child visits to parents/caregivers to ensure key screens are completed.

Pilot Best Practices and Barriers

An outreach was conducted to participating pediatric practices and MCOs to determine barriers and best practices from the pilot. Barriers and best practices discussed below are based on the input from the MCOs and pediatric practices.

Pediatric Practice Best Practices

Some best practices were identified and recommended for future pilots. Effective communication and commitment were identified as two of the best practices by pediatric practices. The monthly check-in meetings with NYS DOH were identified as valuable and set the precedent for continued engagement with MCOs if data submissions were going to be delayed. There was also a great commitment to the pilot’s mission and practices sought clarity when there was any confusion.

Pediatric Practice Barriers

There were several barriers identified on behalf of pediatric practices implementing this work. The ASQ-3 screening and assessment tool demonstrated some deviations in scoring based on the individual who scored the evaluation. This could have also resulted in varied score interpretations. Referral opportunities were lost due to the multiple documents that needed to be filled out and varied referral processes. Language barriers may have played a role if parents/caregivers did not understand the questions being asked or did not have the time/interest to fill out all the required paperwork. A simpler approach to referrals could have increased participants and accuracy.

Pre-visit planning needed to occur for non-English speaking patients/families to maximize their visit and required administration of an ASQ-3 in their primary language. It is critical that parents/caregivers have appropriate documentation (identification, insurance, etc.), ability to schedule an appointment (phone or computer access for scheduling), and transportation (ability/means to travel, distance, parking, etc.). Families also face issues like time constraints, child-care needs, and role conflicts.

Lack of front office experience, staffing issues, long wait times, and miscommunication between the physician and families were identified as general office barriers. Another challenge identified by participating practices was coordinating the reporting data submission process among each of the participating MCOs and meeting their unique requirements for data reporting. Lastly, a standardized process for the pilot, from initiation to conclusion, would have allowed for a timelier flow of data and accuracy.

Managed Care Organization Best Practices

MCOs reported best practices that should be used for future pilots. First, the data template aided in data collection, was easily sharable, and unique to each location. This established a method to collect and submit data to the MCOs and NYS DOH. Second, the MCOs stated that having clear timeframes established was important as it provided providers and plans with an expectation on when data would be submitted each month, then in turn, the MCO was able to upload the data template to the Health Commerce System for DOH. In the future, MCOs identified that it would be beneficial to have input from NYS DOH and other pilot participants on the parent outreach letter. Again, frequent communication between NYS DOH, practices, and MCOs was identified as a best practice. The monthly check-in calls allowed for open communication and encouraged all to address their questions and discussion of current challenges. E-mail responses were regarded as timely and helped clarify any issues as they arose. Lastly, NYS DOH OQPS supported the MCOs in the data collection process and provided understanding on the process as it related to outcomes/impacts.

Managed Care Organization Barriers

There were a few notable barriers faced by the MCOs. First, they experienced significant delays sending out the parent outreach letter due to internal review processes. Additionally, clarification was required on the exact data for each specific template field and how to submit the data to NYS DOH. Inaccurate submissions occurred and were addressed. Clarification was also required on how to proceed if a member was no longer enrolled with the MCO, became inactive, was not able to be identified, had more than one Medicaid Client Identification Number (CIN), or was not enrolled in Medicaid. Lastly, contracting was mentioned as a barrier. Contracting required an updated list of providers for contract amendments and for accurate data collection (member attribution) by plans.

Department of Health Best Practices

Regular communication with the practices and MCOs was identified as a necessary element of pilot success. There were separate, monthly check-in meetings held for each of the plans and practices, as well as larger work groups including all the pilot participants. This allowed for individual technical assistance support to the practices and their staff, as well as to address any specific MCO-related issues. There was open communication between practices and plans in sharing of materials (e.g., best practices, practice flow).

Department of Health Barriers

The NYS DOH noted that practices and plans had varying resources and were in different stages of readiness. Staff turnover, especially at some of the practice sites, hindered their ability to fully engage in pilot activities. Practices with limited staffing capacity could not provide additional referral follow-up based on staffing responsibilities and limitations. Sites that designated an RN to meet with the families, discuss developmental milestones, complete the ASQ with the families, and conduct appropriate referrals demonstrated a significant reduction in screening and referrals completed due to the additional clinical responsibilities of the practice. An option to explore for future pilots would be to suggest a non-licensed provider assist in the screening/referral process as to not contribute any undue burden to the clinical staff.

Ages & Stages Questionnaire

Ages & Stages Questionnaires, Third Edition (ASQ-3) is a developmental screening tool designed for use by early educators and health care professionals. It relies on parents as experts, is easy to use, is family friendly, and creates the snapshot needed to catch delays and celebrate milestones.³ The ASQ-3 are available in multiple languages including but not limited to English, Chinese, French and Spanish. Pre-visit planning in pediatric offices is frequently found to be helpful when patients with different language proficiencies are scheduled, ensuring the correct materials are available. The ASQ-3 became a standardized screening tool in the pediatric practices that provided a streamlined process for tracking development in young children. “The AAP [recommends](#) conducting developmental surveillance at every health supervision visit and conducting general developmental screening using evidence-based tools at 9, 18, and 30 months, or whenever a concern is expressed. In addition, autism-specific screening is recommended at ages 18 and 24 months, and social-emotional screening is recommended at regular intervals.”⁴

A well-child visit would begin by establishing that the child was enrolled with one of the participating Medicaid MCOs and hence eligible for the pilot and that the correct ASQ-3 based on age would be performed. If the ASQ-3 results were in a zone that would require additional attention or that a clinical concern was identified, the practice would complete a referral to the Albany county’s SPOE department to screen for appropriate county-based services. Screening to identify developmental delays earlier provides a greater opportunity to focus on strengthening these identified areas prior to the child entering Kindergarten. SPOE is unique in that it serves as a point of entry for county-based family resources, and ensures parents and families receive the most appropriate referral based on their identified need.

Project Specific Metrics

The Connections Pilot Project was committed to providing information regarding metrics related to the screening and referral process of the children engaged with EI across the three practices. The specifics are listed below:

1. # of children 0-3 completing their 9, 18, 24-30-month visit
2. # of children 0-3 completing the ASQ-3 at their 9, 18, 24-30-month visit
3. # of children who are screened by the ASQ-3 as above the cutoff, close to the cutoff, or below the cutoff in the 5 developmental domains
4. # of children who are referred to SPOE
5. # of children who are referred, evaluation for EI, meet the eligibility requirement.

³ “ASQ-3.” *Ages and Stages*, [agesandstages.com/products-pricing/asq3/](https://www.agesandstages.com/products-pricing/asq3/).

⁴ “Early Childhood Development: Developmental Screening” American Academy of Pediatrics. <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Early-Childhood-Development.aspx>

Results

The results of the performance measures are displayed in each respective section that follows. Performance Measure #1 is the proportion of children who turned age one, two, and three years during the respective measurement year (2017, 2018, or 2019) and had evidence of a well-child visit (Table 1). Member-level data were submitted by each managed care plan to the NYS DOH for children attributed to each site. Children without a valid Medicaid Client Identification Number and those who were greater than three years of age were excluded from the attribution data for each site. For children turning age one year in the measurement year, the nine-month well-child visit was noted as compliant if evidence was found of any well-child visit between eight and 11 months of age. For children turning age two years in the measurement year, the 18-month well-child visit was noted as compliant if evidence was found of any well-child visit between 18 and 23 months of age. For children turning age three years in the measurement year, the 24 and/or 30-month well-child visit was noted as compliant if evidence was found of any well-child visit between 24 and 33 months of age. Column 1 in Table 1, *Number of Unique Children Turning 1 in The Measurement Year (MY)* over 3 years represents the cumulative sum of the unique number of children who had a well-child visit and who turned 1 in 2017 (minus Whitney M. Young Health Center), 2018, or 2019, and for column 2, those Turning 2 in the MY is all those having had a well-child visit who turned 2 over the 3-year period.

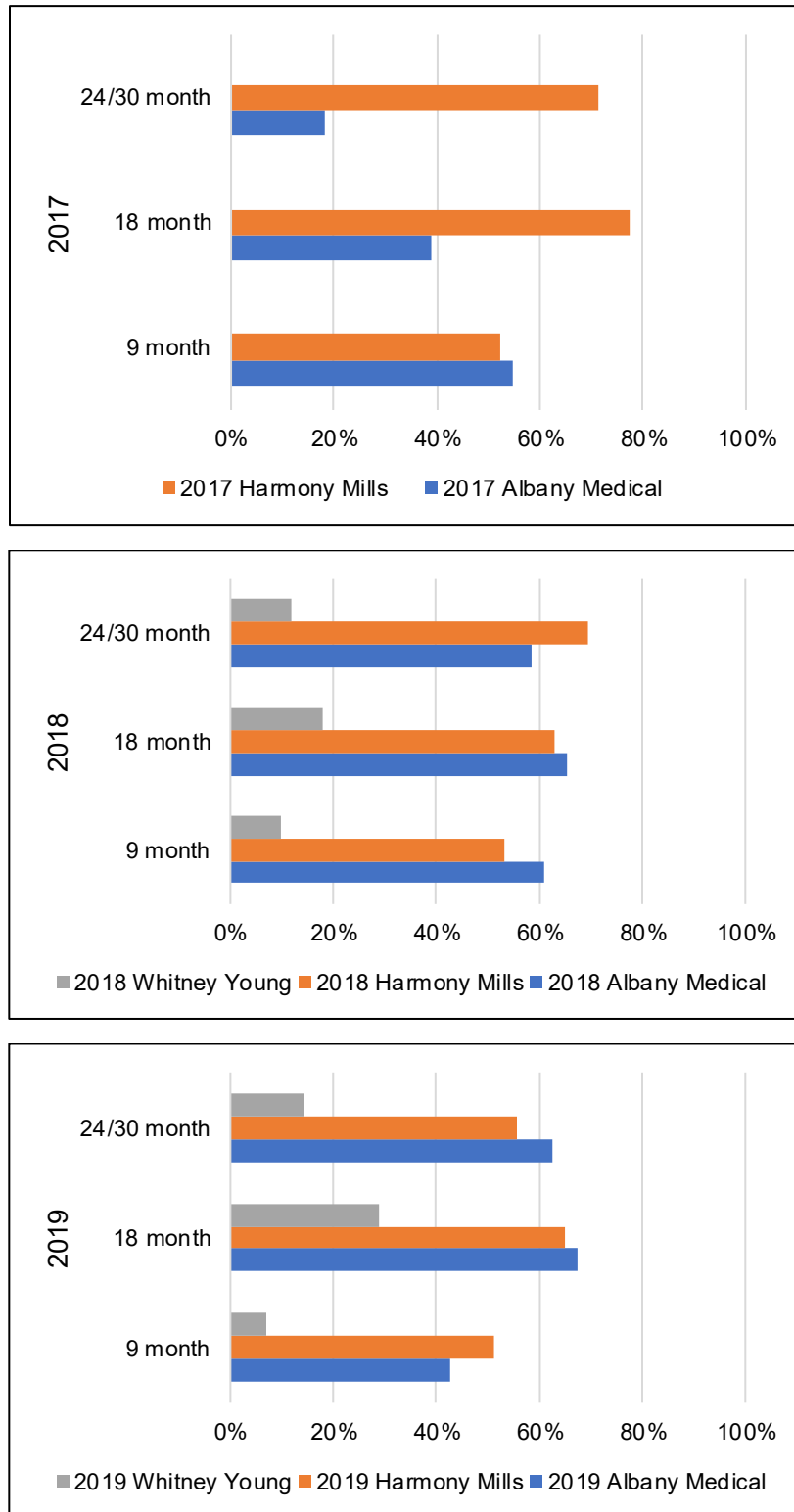
Evidence of a well-child visit included a Medicaid claim or encounter, or a documented screening. These metrics do not take into consideration catch-up schedules or visits that happened outside of the regularly scheduled visit timeframe. The table below summarizes results across all three years and all sites. Following this, Figure 1 displays compliance for each age group by site and by measurement year (MY).

Table 1. Performance Measure 1- Proportion of Children Completing Well-Child Visits Over Pilot Demonstration Period (3 years)

Site	Number of Unique Children Turning 1 Year in MY			Number of Unique Children Turning 2 Years in MY			Number of Unique Children Turning 3 Years in MY		
	9 Month Visit	Total Attributed	%	18 Month Visit	Total Attributed	%	24/30 Month Visit	Total Attributed	%
Total	526	1189	44%	70	103	68%	48	76	63%
Albany Medical Center	383	738	52%	312	512	61%	160	302	53%
Harmony Mills	76	145	52%	296	440	67%	160	261	61%
Whitney Young*	67	306	22%	205	302	68%	110	171	64%

* Whitney M. Young Health Center was not participating in data collection in 2017.

Figure 1. Performance Measure #1: Proportion of Children Completing Well-Child Visits by Year and Practice Site.



Note: Whitney M. Young Health Center was not participating in data collection in 2017.

Performance Measure #2 is the proportion of children who turned age one, two, and three years during each respective measurement year (2017, 2018, or 2019) and who had evidence of a well-child visit and a documented ASQ screening (Table 2). Only those children attributed to each MCO and who had evidence of a well-child visit were included in this measure. Children without a valid Medicaid Client Identification Number and those who were greater than three years of age were excluded from the attribution data for each site. For children turning age one year in the measurement year, the nine-month well-child visit was noted as compliant if evidence was found of any well-child visit between eight and 11 months of age. For children turning age two years in the measurement year, the 18-month well-child visit was noted as compliant if evidence was found of any well-child visit between 18 and 23 months of age. For children turning age three years in the measurement year, the 24 or 30-month well-child visit was noted as compliant if evidence was found of any well-child visit between 24 and 33 months of age.

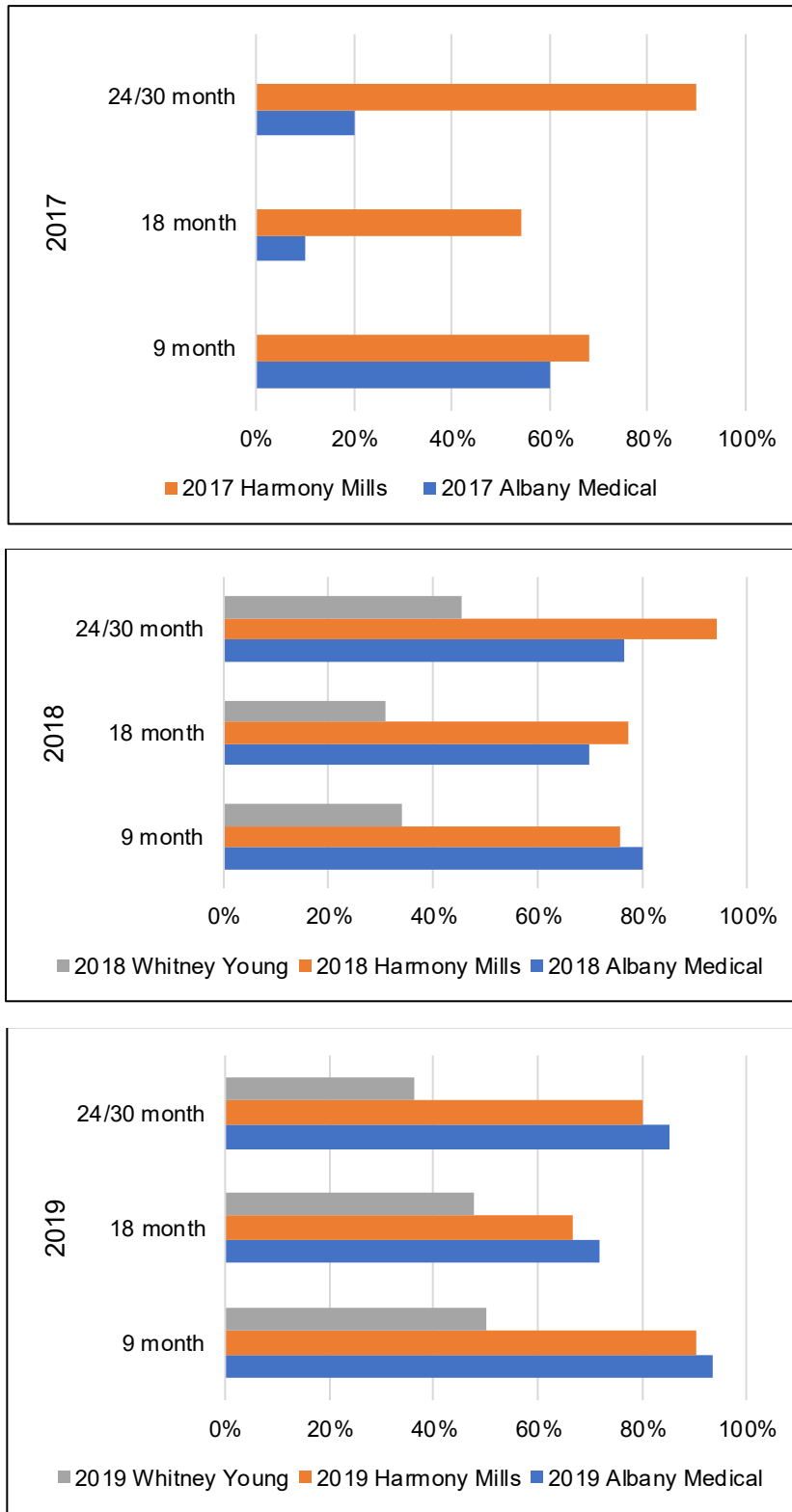
Evidence of a well-child visit included a Medicaid claim or encounter, or a documented screening. Documentation of an ASQ screening was submitted by each site through monthly tracking sheets to their managed care plan partners and limited to only children attributed by the managed care plan to the practice site. If the practice site did not record the ASQ screening on the tracking sheet and if data were not submitted to the managed care plan, the screening was noted as not completed. These metrics do not take into consideration catch-up schedules or visits that happened outside of the regularly scheduled visit timeframe. The table below summarizes results across all three years and all sites. Following Table 2, Figure 2 displays compliance for each age group by site and by measurement year (MY).

Table 2. Performance Measure 2 - Proportion of Children Screened at Well-Child Visit Over Pilot Demonstration Period (3 years)

Site	Number of Unique Children Turn 1 Year in MY			Number of Unique Children Turn 2 Years in MY			Number of Unique Children Turn 3 Years in MY		
	ASQ	9 Month Visit	%	ASQ	18 Month Visit	%	ASQ	24/30 Month Visit	%
Total									
Albany Medical Center	312	383	81%	197	312	63%	124	160	78%
Harmony Mills	59	76	78%	206	296	70%	131	160	82%
Whitney Young*	26	67	39%	144	205	70%	96	110	87%

* Note: Whitney M. Young Health Center was not participating in data collection in 2017.

Figure 2. Performance Measure 2: Proportion of Children Screened at Well-Child Visit by Year and Practice Site.



Note: Whitney M. Young Health Center was not participating in data collection in 2017.

Performance Measure #3 is the proportion of children who turned age one, two, and three years during each respective measurement year (2017, 2018, or 2019) and who had evidence of a well-child visit with reported results of the documented ASQ screening, Table 3). Only those children attributed to each health plan who had evidence of a well-child visit and a documented ASQ screening were included in this measure. Children without a valid Medicaid Client Identification Number and those who were greater than three years of age were excluded from the data for each site.

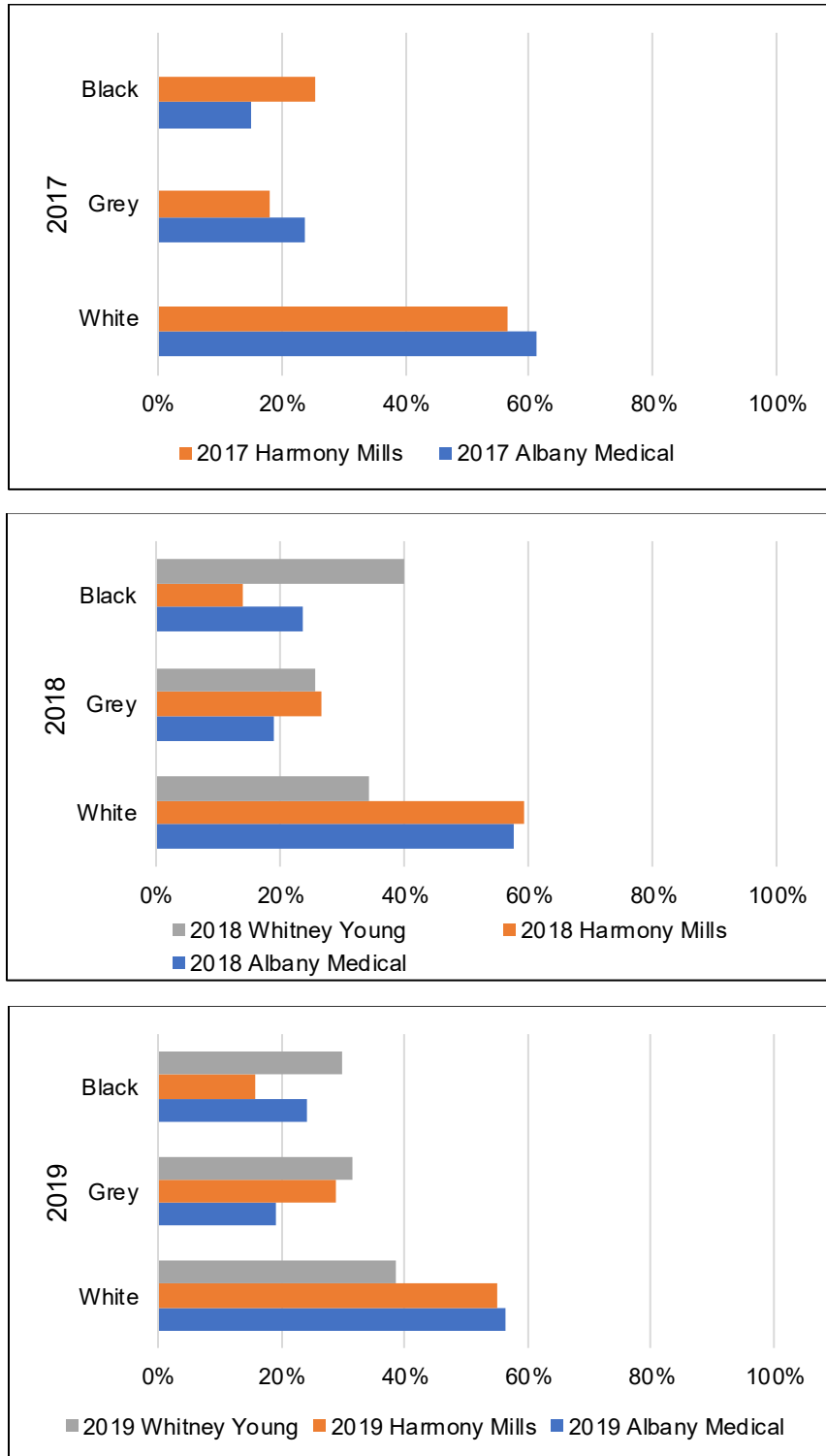
Documentation of an ASQ screening was submitted by each site through monthly tracking sheets to their managed care plan partners and limited to only children attributed by the managed care plan to the practice site. If the practice site did not record the ASQ screening on the tracking sheet and if data were not submitted to the managed care plan, the screening was noted as not completed and it was not counted in the analysis. Screenings noted as episodic were removed as they could not be classified into age-specific ranges. Numbers of ASQs reported are counts of screens and not unique counts of children. Some children were screened more than once. Age-specific cutoffs are provided for each age range and are identified by the Ages and Stages measurement tool. Scores from each screening were compared to mean cutoffs and standard deviations. The screenings classified in the white area are considered in the normal range and no further follow-up is needed. Screenings classified in the gray area, close to the cutoff, should be monitored, and screenings classified in the black range, below the cutoff, are considered high risk and should be referred. Figure 3 shows the proportion of children identified by measurement year and practice site.

Table 3. Performance Measure 3 - Proportion of Children Who Are Screened by the ASQ-3 as above the cutoff (White Area), close to the cutoff (Gray Area), or below the cutoff (Black Area) in the 5 developmental domains.

Site	Total ASQ Reported	White Area		Gray Area		Black Area	
		N	%	N	%	N	%
Albany Medical Center	1,074	619	58%	211	20%	244	23%
Harmony Mills	223	127	57%	54	24%	42	19%
Whitney Young*	92	34	37%	27	29%	31	34%
Total	1,389	780	56%	292	21%	317	23%

* Whitney M. Young Health Center was not participating in data collection in 2017.

Figure 3. Performance Measure 3: Proportion of Children Who Are Screened by the ASQ-3 as above the cutoff (White Area), close to the cutoff (Gray Area), or below the cutoff (Black Area) in the 5 developmental domains by Year and Practice Site.



Note: Whitney M. Young Health Center did not participate in data collection in 2017.

Performance Measure #4 is the proportion of children who turned age one, two, and three years during each respective measurement year (2017, 2018, or 2019) and who were identified at risk and also referred for follow-up (Table 4). Documentation of an ASQ screening was submitted by each site through monthly tracking sheets to their managed care plan partners and limited to children attributed by the managed care plan to the practice site.

Evidence of a referral was counted if the pediatrician indicated a referral on the tracking sheet or data from EI indicated a referral was accepted for the child within the timeframe of the measurement year. For those children with more than one documented screening during the measurement year (screened at multiple well-child visits), any evidence of referral within the measurement period was accepted. Numbers were too small to look across years and practice sites. Only aggregate numbers across all three years are shown in Table 4.

Table 4. Performance Measure 4: Proportion of Children Identified at Risk and Were Referred for Follow-up Over Pilot Demonstration Period (3 years)

Site	Number of Unique Children Turning 1 Year in MY			Number of Unique Children Turning 2 Years in MY			Number of Unique Children Turning 3 Years in MY		
	Referred	At-Risk (Black Area)	%	Referred	At-Risk (Black Area)	%	Referred	At-Risk (Black Area)	%
Total	43	146	29%	31	85	36%	6	35	17%
Albany Medical Center	36	104	35%	25	70	36%	3	25	12%
Harmony Mills	4	16	25%	5	11	45%	3	5	60%
Whitney Young*	3	26	12%	1	4	25%	0	5	0%

Performance Measure #5 is the # of children who are referred and evaluated for EI and met the eligibility requirements (Table 5). This measure was tracked by the Albany County SPOE team.

For those children with more than one documented referral during the measurement year (screened at multiple well-child visits), any evidence of referral within the measurement year was accepted. Children who were referred and not evaluated were taken out of the percent eligible for EI but are captured and displayed along with the total number of referrals. Numbers were not collected at the practice site level. Only aggregate numbers across by years are shown in Table 5. The number of referrals reported to Albany County was greater than the number of

referrals reported by health plan and by site in Table 4. There are a few reasons for this discrepancy. First, the children referred to Albany County by the practice may be outside of the scope of the pilot (e.g., enrolled in Medicaid FFS and/or a different Managed Care Organization) and second, these referral numbers may be the same children represented multiple times. We did not track patient-level details for the pilot. Challenges with the sharing of FERPA and HIPAA data should continue to be explored to allow the further tracking of children through the entire process. We did not go on to examine how many children who were EI eligible ended up receiving EI services. This is an area of further interest but was outside of the scope of this pilot.

Table 5. Performance Measure 5: Proportion of Children Referred, Evaluated, and Found to be EI Eligible

	Number of Referrals Made to Albany County Single Point of Entry (SPOE)				
	EI Eligible	Evaluated	%	Not evaluated*	Total Referrals
Total	64	115	56%	29	144
July 2017-Dec 2017**	7	15	47%	4	19
2018	35	60	58%	12	72
2019	22	40	55%	13	53

*Children were not evaluated for EI for various reasons: lack of response to outreach, parental declination, or the child was not a resident of Albany County.

**This data was only tracked for part of 2017

Conclusion

The Albany Connections Pilot, synonymously known as Albany Promise, provided insight on developmental screenings during well-child visits, referral processes to Early Intervention programs, and bi-directional correspondence between providers and Early Intervention. This data collection allowed NYS DOH to determine successes, as well as aided in identifying areas to improve related to childhood developmental screenings in NYS. Results documented that developmental screenings are not at or above a 90th percentile completion rate and in one case, substantially below the 90th percentile. The data suggest that providers that implemented a strong process workflow into their practice were more likely to be successful in both screenings and referrals, in turn yielding the highest levels of compliance. In this pilot, Albany Medical Center consistently performed well in this area. However, Whitney M. Young Health Center reported experiencing setbacks due to challenges dedicating a single individual to oversee screening and referrals due to training, availability, and process flow limitations.

A secondary area that should continue to be explored is the bi-directional exchange of communication between Early Intervention and the referring provider. The sharing of information was identified as an opportunity for improvement to promote closed-loop referrals between the primary care provider and community-based service providers. In a broader sense, improved information exchange could help bridge the gap in services and referrals, encourage a stronger relationship between health and education sectors, and better support the overall growth and development of young children.

The Centers for Medicare and Medicaid Services has planned to make developmental screenings during well-child visits a part of the core child set in 2024. Additionally, the NYS DOH has included developmental screening in its Kids Quality Agenda that aims to improve MCO performance on children and perinatal health care quality measures. And early childhood screening is reflected in the NYS DOH's work with the State Education Department to standardize a Kindergarten Developmental Inventory upon school entry.

In summary, the legacy of the Albany Connections Pilot should guide conversations to help bridge the gap in services, minimize barriers to and promote awareness of the importance of strong developmental growth, emphasize the need for improved provider and community-based organization communication, and strengthen the linkage between health and education sectors. Finally, the number of children who are EI eligible and receive EI services should ultimately be tracked. These are necessary elements to better support the overall growth and development of children in New York.