



Bundling for Babies: Bridgeport Prosper's Baby Bundle Meets MAPOC

March 8, 2021



Part I

What is the Bridgeport
Prosper's Baby Bundle and
how did we get there?

Bridgeport Prosper's Baby Bundle Framework is...

1. A ***community-designed*** framework created to address the alarming fact that about three in four of Bridgeport, CT's children living in low-income families do not consistently reach expected developmental milestones at the age of three years.
2. Anchored in a continually evolving, relationship building, lifespan-oriented, ***collective impact process***.
3. Designed to advance the health and well being of all children and families with a special focus on families living with economic, racial, education and health inequities.
4. Informed by science, focused on resilience, driven by social justice and customizable, scalable and sustainable.
5. A ***"proof point" opportunity*** for building a "more just" post-COVID world.

Bridgeport Prospers collective impact community work focused on data for 2016-2017...

- ☐ 14% of 5th graders proficient in math
- ☐ 24% of 3rd graders reading at level
- ☐ 3 in 10 entering K school ready
- ☒ 75% of three-year-olds enter Head Start BEHIND (2014; 2017)
- ☐ 21% no or inadequate prenatal care
- ☒ 70% of the city's 1800-2000 yearly resident births are Medicaid funded



We asked “What if.....

...All babies and their moms
experienced a healthy and supported
pregnancy and birth...

...All children are healthy and on-
target developmentally at three...

...All families, caregivers and
neighborhoods are safe,
supported, thriving and resilient...

...We co-designed with
community and focused on
health equity, universal access,
and whole family supports




We rejected the idea that any single program that can “fix” systemic problems faced by Bridgeport families. Instead, we crafted three core principles...



Part II

The Baby Bundle's
very powerful vision



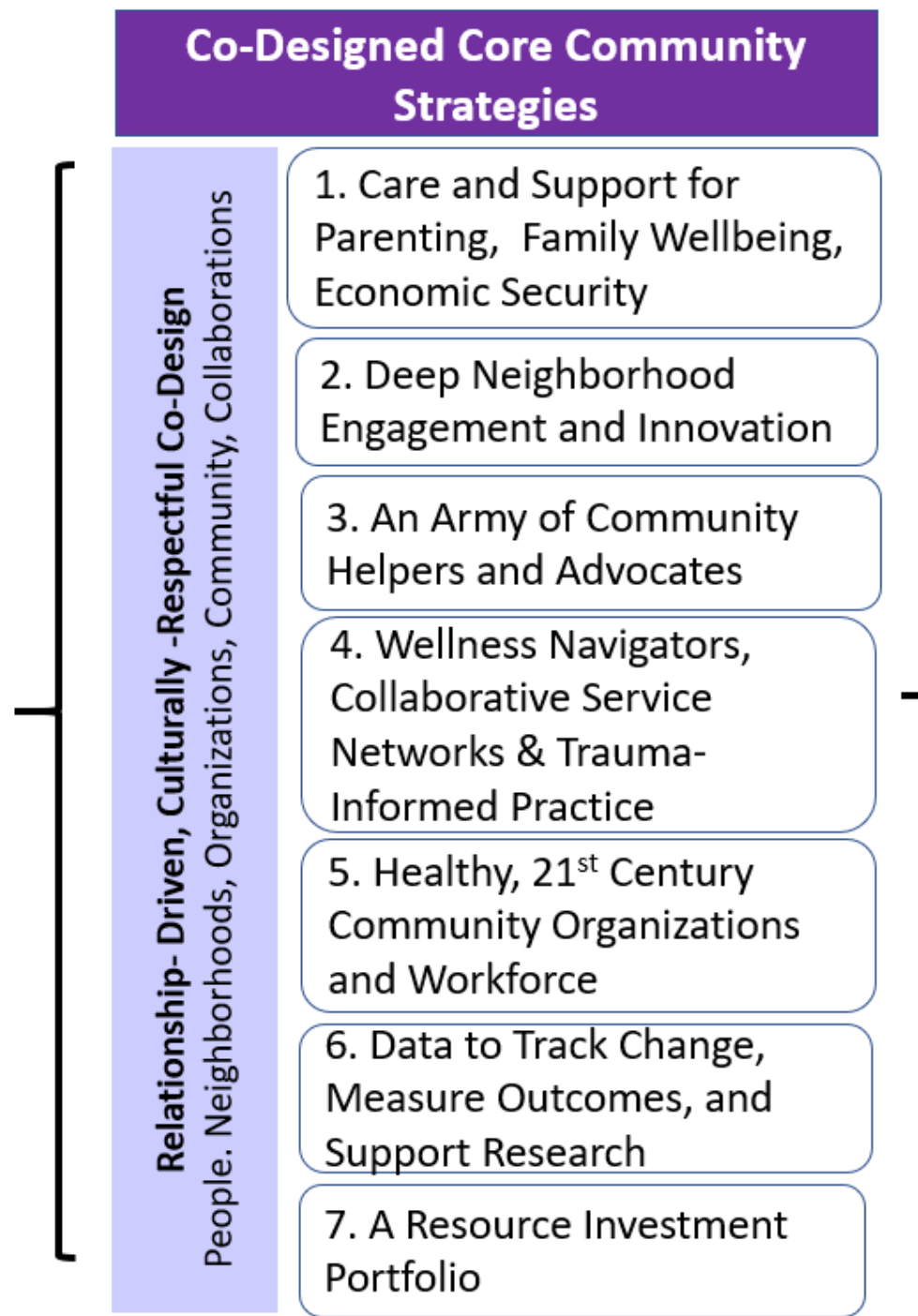
A brave vision emerged
for young children and
families in the city

All Bridgeport babies born
beginning in January 2018
will reach expected health
and developmental
benchmarks by the
age of three.

Part III
Our theory of change:
Four years in evolution

Through the collective impact process, a set of seven Core Community Strategies has evolved to advance healthy births, responsive services and supports for parents, and on-target development for children (measured at three).

These core strategies are adaptable by other communities and aligned with Medicaid's *First 1000 Days* framework.



From the very beginning, this community work was informed by developmental neuroscience. But we quickly added knowledge from other “sciences” that would support accountability, scale and sustainability.

We then applied filters and identified levers that would result in equity and justice, build for resilience, promote engagement across sectors and agencies, and support research partnerships

Finally, we continue to identify, build and borrow “tools” that can guide us in partnership development, mapping, assessment and implementation.

Informed by Science, Tools, Filters and Levers

Knowledge and Science

- Developmental Neuroscience
- Population Health
- Implementation and Outcomes Research
- Human-centered Design
- Communication science

Filters and Levers

- Equity and Justice
- Family Protective Factors
- Community Resilience Model
- Policy, Data, Financing
- Cross-Agency TF Work
- Research Partnerships
- Scale/Sustainability Feasibility

Tools (A sample)

- Bundle Rule of P
- Racial Equity Assessment
- Self-Sufficiency Matrix
- Fiscal Mapping
- NIRN Hexagon Tool

Bridgeport Prosperers' Bundle Theory of Change

Goals

Healthy Births,
Development on
Target at Three,
K Readiness,
Reading at 3rd

Strong Parent-Child
Relational Health
and Adult Social
Networks

COVID-Informed
Youth & Adult
Education,
Workforce and
Economic Success

A Resilient
Community with
Strong Social
Capital

Co-Designed Core Community Strategies

Relationship- Driven, Culturally -Respectful Co-Design
People. Neighborhoods, Organizations, Community, Collaborations

1. Care and Support for
Parenting, Family Wellbeing,
Economic Security

2. Deep Neighborhood
Engagement and Innovation

3. An Army of Community
Helpers and Advocates

4. Wellness Navigators,
Collaborative Service
Networks & Trauma-
Informed Practice

5. Healthy, 21st Century
Community Organizations
and Workforce

6. Data to Track Change,
Measure Outcomes, and
Support Research

7. A Resource Investment
Portfolio

Informed by Science, Tools, Filters and Levers

Knowledge and Science

- Developmental Neuroscience
- Population Health
- Implementation and Outcomes Research
- Human-centered Design
- Communication science

Filters and Levers

- Equity and Justice
- Family Protective Factors
- Community Resilience Model
- Policy, Data, Financing
- Cross-Agency TF Work
- Research Partnerships
- Scale/Sustainability Feasibility

Tools (A sample)

- Bundle Rule of P
- Racial Equity Assessment
- Self-Sufficiency Matrix
- Fiscal Mapping
- NIRN Hexagon Tool

Part IV

What services and supports are
in Core Community Strategy #1?

Universal and Targeted Services within the Baby Bundle for PN-3



Support parents and primary caregivers with universal access to **The Bridgeport Basics**, a neuroscience-informed parent education and skill-building tool. Targeted services include expansion of Circle of Security and Music Together.



Increase the number of families receiving universal **pre- and post-natal home visits** through **coordinated**, evidence-based home visiting programs including Healthy Families America, Parents as Teachers, Child First. Expand access to **Doula** care partnered with OB providers. Explore expansion of Centering Pregnancy.



Increase access to a one-week postpartum **Wellness Check** for mother and baby at Bridgeport Hospital and link with home visiting supports. Explore partners for a universal **Wellness Check In** portfolio including ACES and trauma, protective factors and the presence of Positive Childhood Experiences.

Universal and Targeted Services within the Baby Bundle for PN-3



Increase access to **maternal mental health** services including through the MOMs Partnership, advance access for fathers, and support CT's proposed Medicaid post partum service expansion from 60 days to one year.



Increase **developmental screening** and its linkage to services using CT's **Sparkler** app with parents and their service providers, in partnership with 211 Child Development Infoline and the Office of Early Childhood.



Achieve universal family access to evidence-informed **early literacy programs** in health care settings. Explore early literacy linkages with Bridgeport's evolving Home Visiting Partnership. (BTW: NC just added ROR to its Medicaid transformation plan).



ALL OUR KIN

Increase access to **licensed family child care** settings for infants and toddlers through All Our Kin and potential COVID II stimulus OEC funding.

Sandra is an expectant mom in Bridgeport.



She receives prenatal care from OBs who partner with doulas, and she is introduced *The Bridgeport Basics*. She is also connected *Healthy Families America* home visiting and meets her personal *Wellness Navigator*

At Bridgeport Hospital for the birth of her baby, she meets *Read to Grow* and is offered a one-week *Wellness Check*.

She can also get help to find infant/toddler childcare through *211 CDI*.

Sandra's Baby Bundle

At well-child check-ups, pediatricians use *Reach Out and Read*, trauma-informed case practice, *The Basics*, and *ASQ* to keep an eye on Xavier's growth.

If Sandra needs support for postpartum depression, she is connected to the *MOMS Partnership*. She can also join the *Music Together* program with her baby.

Home visiting may continue through *HFA*, *PAT* or *Child First*, and she is connected with help for basic needs (like diapers and *WIC*). She gets access to *Circle of Security* and *Sparkler* for relational health coaching and tracking her child's progress.

Part V

Opportunities for systems, data
and resource integration, and
efficacy

Connecticut's Potential Players and Stakeholders in Innovation and Change



2017

The first 1,000 days of a child's life are a critical window for development. Exposure to adverse childhood experiences (ACEs) dramatically increases the potential for life-long negative health and social outcomes.



North Star Framework

New York 2018

13

1. For general child population, value will be driven by emphasizing quality and long-term outcomes, not cost-cutting in areas where investment may already be insufficient
2. Need clear child-focused goals and outcomes to drive systems change



Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

	Preterm to 1 Month	1 Month to 1 Year	1 Year to 5 Years
	Overarching "North Star" Goals		
	Optimal birth outcomes for mother and child	Optimal physical health and a secure attachment with a primary caregiver	Optimal physical health and developmentally on track at school entry
	Key Indicators		
	<ul style="list-style-type: none">• Birthweight <2500 grams• Preterm births• Severe maternal morbidity	<ul style="list-style-type: none">• On-target developmental and social-emotional screens• Reported cases of abuse and neglect	<ul style="list-style-type: none">• On-target developmental and social-emotional screens• ED visits for unintentional injury• Expulsions/suspensions• Kindergarten readiness using standardized tool (aspirational)• Reported cases of abuse and neglect
	High-Value, Often Underutilized Primary Care Strategies		
	Early and regular prenatal care visits including: <ul style="list-style-type: none">• Birth spacing/contraceptive use counseling• Breastfeeding encouragement• Care transition plan for use by obstetrician, newborn nursery and primary care doctor• Screening/treatment for preterm birth risks and tobacco/substance use Co-located/integrated behavioral health services Screening/referrals for: <ul style="list-style-type: none">• Adverse Childhood Experiences (ACEs)• Social determinants of health• Domestic violence/personal safety• Maternal depression Enhancing parental skills through evidence-based education/home visitation programs Seamless information exchange between women's health and child health providers	Regular well-child visits including: <ul style="list-style-type: none">• Developmental screenings in four domains: motor, language, cognitive, and social emotional• Weight/nutrition/physical activity counseling• Early intervention referral Co-located/integrated behavioral health services Screening/referrals for: <ul style="list-style-type: none">• ACEs• Social determinants of health• Domestic violence/personal safety• Maternal depression Enhancing parental skills through evidence-based education/home visitation programs Seamless information exchange between women's health and child health providers (when mother is primary caregiver of child)	Regular well-child visits including: <ul style="list-style-type: none">• Developmental screenings in four domains: motor, language, cognitive, and social emotional• Weight/nutrition/physical activity counseling• Early intervention referral• Dental screening/treatment• Eye and hearing examination/referral• Vaccinations Co-located/integrated behavioral health services Screening/referrals for: <ul style="list-style-type: none">• ACEs• Social determinants of health Enhancing parental skills through evidence-based educational programs Management/treatment of chronic conditions

page 1 of 2

North Star Framework (cont.)

14

3. Child health best measured by outcomes across child-serving sectors

4. Primary care can drive change, especially in earliest years of life

5. Brain science tells us social determinants and family systems must be included



Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

6 Years to 10 Years	11 Years to 14 Years	15 Years to 21 Years
Overarching "North Star" Goals		
Staying healthy and strengthening social, emotional and intellectual skills	Staying healthy and coping effectively with challenges of early adolescence	Staying healthy and able to succeed in the world of work, school, and other adult responsibilities
Key Indicators		
<ul style="list-style-type: none"> Average daily school attendance Hospitalization for asthma Obesity Positive screens for depression/anxiety Grade progression Standard 3rd-grade reading scores 	<ul style="list-style-type: none"> Average daily school attendance Hospitalization for asthma Obesity Positive screens for depression/anxiety Tobacco/substance use 	<ul style="list-style-type: none"> Algebra 1 Regent passing Hospitalization for asthma Obesity Positive screens for depression/anxiety Tobacco/substance use Cohort graduation Post-secondary enrollment Pregnancy, ages 15-17
High-Value, Often Underutilized Primary Care Strategies		
<p>Regular well-child visits including:</p> <ul style="list-style-type: none"> Weight/nutrition/physical activity counseling Dental screening/treatment <p>Co-located/integrated behavioral health services</p> <p>Screening/referrals for:</p> <ul style="list-style-type: none"> ACEs Social determinants of health Behavioral health risks <p>Enhancing parental skills through evidence-based educational programs</p> <p>Management/treatment of chronic conditions</p>	<p>Regular adolescent visits including:</p> <ul style="list-style-type: none"> Weight/nutrition/physical activity counseling Health care self-management/health literacy education Vaccinations <p>Co-located/integrated behavioral health services</p> <p>Screening/counseling/referrals for:</p> <ul style="list-style-type: none"> ACEs Social determinants of health Behavioral health risks <p>Enhancing parental skills through evidence-based educational programs</p> <p>Management/treatment of chronic conditions</p>	<p>Regular adolescent visits including:</p> <ul style="list-style-type: none"> Weight/nutrition/physical activity counseling Health care self-management/health literacy education Vaccinations <p>Co-located/integrated behavioral health services</p> <p>Screening/counseling/referrals for:</p> <ul style="list-style-type: none"> ACEs Social determinants of health Behavioral health risks <p>Management/treatment of chronic conditions</p>



NC INTEGRATED
CARE FOR KIDS



North Carolina
2020

HOME

OUR STORY

OUR WORK

OUR TEAM

NEWS

GET INVOLVED

OUR WORK

Vision

Healthy, thriving children and families living in a model collaborative community

Mission

Partnering with communities to support and bridge services where children live, learn, and play

Integrating Care

We are working towards a model where care is integrated for children across core child service areas to improve their well-being. These core child service areas include clinical care (physical and behavioral health), schools, early care and education, food, housing, child welfare, Title V, mobile crisis response, juvenile justice, and legal services.

Three key NC InCK initiatives to support integrated care:

- (1) a universal screening and risk stratification approach that incorporates caregiver (e.g., maternal depression) and cross-sector risk factors (e.g., housing instability)
- (2) a shared action plan across the core child services for children with higher needs.
- (3) a team of NC InCK Service Integration Consultants to facilitate more cross-sector integration.

Improving Quality

Within NC InCK, we are developing a model where quality of care is measured and improved using both standard healthcare measures (e.g., proportion of children receiving well-child checks) and novel cross-sector, well-being measures (e.g., kindergarten readiness, chronic absenteeism from school, food insecurity, housing stability).

Reducing Costs

Finally, our model is being developed with a goal of reduced cost of care for children engaged in NC InCK. We are developing child-specific alternative payment models that will be implemented to cover the costs of care.

InCK Core Child Services



[Physical and Behavioral Health](#)



[Early care & education](#)



[Housing](#)



[Food](#)



[Schools](#)



[Title V](#)



[Child welfare](#)



[Mobile Crisis Response Services](#)



[Juvenile Justice](#)



[Legal Services](#)

Ohio 2020

Ohio Medicaid's Mom & Baby Bundle

January 9, 2020

Cross Agency Leadership Team

Ohio

Department of
Developmental Disabilities

Ohio

Department of
Medicaid

Ohio

Department of
Education

Ohio

Department of
Mental Health &
Addiction Services

Ohio

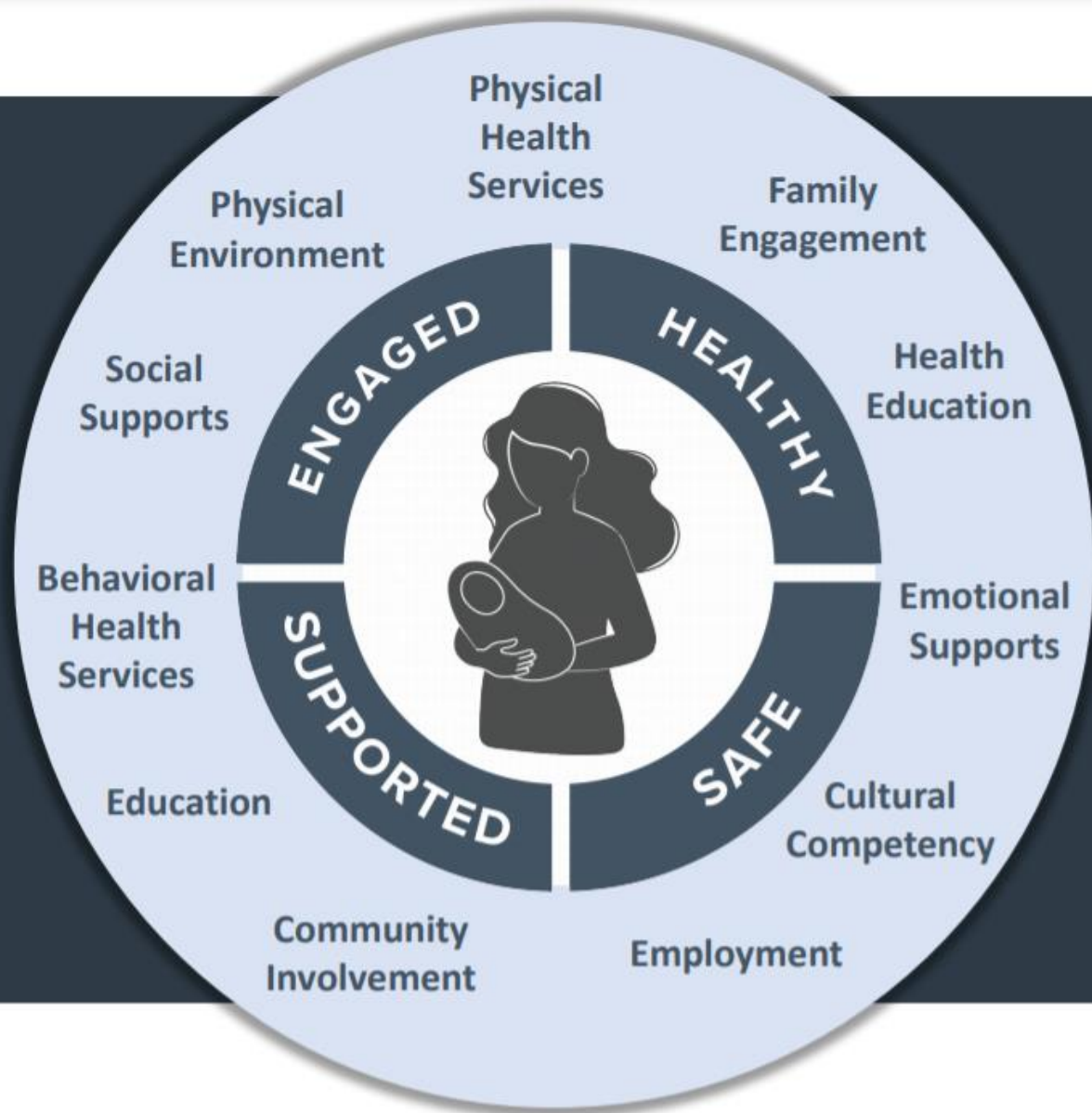
Department of
Health

Ohio

Department of
Job & Family Services



MIKE DEWINE
GOVERNOR OF OHIO



Women's Wellness Wheel™



Coordinating Policy, Process and Practice

Integration of community-based services into the traditional healthcare system

Components of Mom & Baby Bundle

```
graph LR; A[Patient Identification] --> B[Mom & Baby Bundle Entities]; B --> C[Activities]; C --> D[Payment Structure]; D --> E[Outcome Reporting and Monitoring]
```

Patient
Identification

Mom & Baby
Bundle
Entities

Activities

Payment
Structure

Outcome
Reporting
and
Monitoring

Connecticut 2020

Slifka Center

Building forward

CELEBRATING 25 YEARS OF JEWISH LIFE AT YALE



Slifka Center:

Under Construction!

Learn about the current building renovations and how you can help.

**Mailboxing
Printing**

[LEARN MORE](#)

33 Dixwell Avenue
Near Payne
Whitney Gym

The UPS Store



Health center awarded federal grant

MACKENZIE HAWKINS | 11:47 PM, FEB 25, 2020

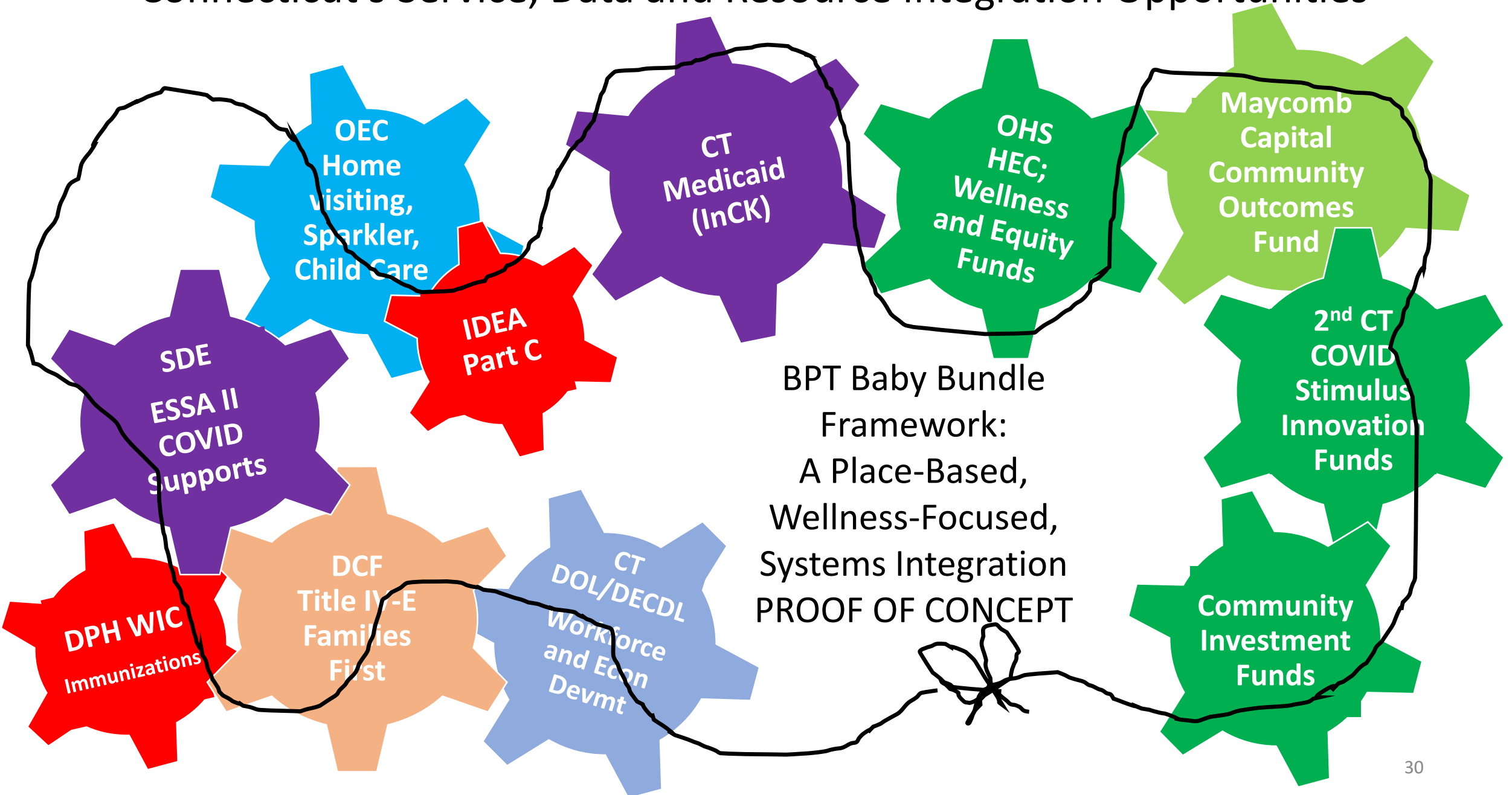
STAFF REPORTER

As an InCK recipient, Clifford Beers has been designated the “lead organization” for Connecticut’s Department of Social Services — or DSS — which administers Medicaid and related programs. This means that Clifford Beers is responsible for delivering outcomes in its geographic area that will provide data for an in-state comparison. Ultimately, stakeholders hope that lessons learned from the seven grant recipients can inform healthcare provision in other settings.

DSS Commissioner Dr. Deidre S. Gifford said in a press release that the department is interested in improvements across many areas that connect to health provision, such as improved educational outcomes, fewer referrals to juvenile justice and reduction in substance use.

Clifford Beers is the only grant recipient focused specifically on behavioral and mental health — other recipients are large medical centers with public or university affiliation.

Connecticut's Service, Data and Resource Integration Opportunities

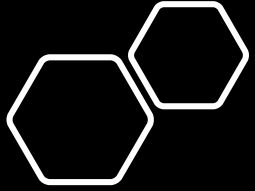


Part VI
We can do better...

Working together we can address the most basic question facing us here in Connecticut...

In these times of COVID, racial and economic turbulence that have laid bare the intergenerational fault lines of our society...

What can we do to support the health and well-being of our youngest children and their families that is *better than the best* we have done so far?



Thank you...

For more information about the
Bridgeport Baby Bundle, contact

Allison Logan, Executive Director
Bridgeport Prospers
alogan@unitedwaycfc.org

Janice Gruendel, Senior Advisor
jmgruendel@yahoo.com

