

## **Consulting and Technical Assistance to Support Yamhill Coordinated Care Organization & Yamhill Early Learning Hub Efforts Focused on Ensuring that Young Children Identified At-Risk for Developmental, Behavioral, and Social Delays Receive Follow-Up Services**

### **Background and Context**

Within health system transformation and the early learning system redesign there is a specific focus on community- and population-based approaches for conducting developmental screening to identify children at-risk for developmental, behavioral and social delays. Screening is occurring in primary care offices and community-based providers like Head Start, Home-visiting, Child Care and others. While these efforts have synergy in their goals and outcomes, they are often uncoordinated and sometimes duplicative. Services that address delays have been shown to positively impact development and subsequent Kindergarten readiness. While a majority of systems are using the standardized Ages and Stages Questionnaire (ASQ), there is not standardization in the follow-up steps that are taken based on the results. These steps need to account for the risks identified, the family context/needs, and the community-based services that are available to address those risks in a family-centered way. While all children should be referred to Early Intervention, most will benefit from multiple services, and some of the children referred to EI will not be identified as eligible due to the restrictive eligibility requirements. For this reason, there is a need for alternate resources to meet these needs. In order to ideally meet the needs of these children and their families there should be a) coordination across services available for children to identify and refer to alternate resources for developmental services, and b) methods identified for tracking referred at-risk children who do not complete these referrals, and family-centered methods to address barriers to completing appointments with service providers.

Data from the Assuring Better Child Development-III project, medical home implementation efforts, and interviews with key stakeholders show that a majority of children identified at-risk for delays do not receive necessary follow-up services. Based on medical chart review data, less than half of children that were identified by primary care screening as at-risk for delays (40%) were referred for services.<sup>13</sup> Of the children referred for Early Intervention (EI) services, a majority had no documentation of receipt of the services or care coordination within the medical chart. Local EI contractors report that they are unable to connect with at least half of the referred children, or they are found to be ineligible for services due to strict eligibility requirements. In conducting interviews with primary care providers, some note that they don't refer children that fail on only one domain or on the social-emotional domain alone, as they know the child will not be eligible.

### **Focus of this Technical Assistance and Transformation Coaching**

This 12-month project **aims to improve the receipt of services for children identified at-risk** for developmental and behavioral delays through achieving four specific objectives:

- 1) **Engage and facilitate key stakeholders** on the **shared goal** of ensuring children identified **at-risk receive follow-up** services that are the best match for the child and that are **coordinated** across systems.
- 2) Develop a **triage and referral system map** that can be used to identify the best set of services for children identified at-risk (using the ASQ), and that ensure that services are accessed. This map will be tailored to the community and the resources that exist within that community through information gathered via individual and group-level facilitated conversations, and services available accounting for their capacity to take referred children.
- 3) To develop methods and processes for how **care can be coordinated**, at a child-level, across primary care and community-based providers.
- 4) **Summarize key learnings** to inform spread and innovation in the community and to inform state-level efforts.

## Project Activities

- 1) **Engage stakeholders from the CCO, Early Learning Hub, parents, community-based and primary providers conducting developmental screening around the shared goal of ensuring children identified at-risk receive appropriate follow-up services that are coordinated across systems.**
  - **Stakeholder interviews.**
  - **Group-level meetings** of stakeholders will convene to develop group-level consensus about the community-specific context, and provide review of the materials developed.
  - Parent advisor recruitment to ensure a family-centered and family –informed focus.
  
- 2) **Develop a triage and referral system map that can be used to identify the best set of services for children identified at-risk, and to ensure that services are accessed. This map will be tailored to the community. Capacity of services to take referred children will be included.**
  - Tool will be anchored to risks identified via the ASQ. Reflective of type of risks, magnitude of risks identified (i.e. number of domains the child failed), and provider assessment of the family context and need. Will include methods and tools for referrals that include ways for two-way communication with the referred providers to enhance coordination.
  - Includes potential responses for when referred services are not able to be accessed by families.
  
- 3) **Develop methods and processes for how care can be coordinated (at a child-level) between primary care and community-based providers.**
  - Operationalize, define and pilot specific methods that the Early Learning Hub can utilize to coordinate services for children at-risk for developmental delays.
  - Priority pathways within the triage and referral system map will be identified where shared communication across providers within the community would be invaluable.
    - Given the scope of funding for the project, specific providers within the HUB and in the health care system will be identified to pilot the methods developed.
    - Within this priority area, specific types of information that would be most valuable to supporting coordination across providers will be identified and a related model for communication shared. A specific community and primary care provider will be identified from the stakeholder group to implement the methods developed, and provide qualitative input about how it can be refined and improved. OPIP will then work with each to tailor and customize the community-specific elements to be integrated within their own systems and processes around care coordination and provide general facilitation on its use.
  
- 4) **Summarize key learnings to inform spread and innovation in other communities.**
  - Community-level distillation and summarization of the key activities.
    - Qualitative interviews with participants and stakeholders to summarize key learnings.
    - Align qualitative data collection with Early Learning Hub needs when possible.
  - Distillation of key activities to inform future work related to implementation and evaluation, and to spread the learnings within the community and across the state.
    - Develop strategic summaries for the following audience: OHA Project Funder, Key stakeholders within OHA and the Early Learning System.
    - As requested, present at the Joint Subcommittee of the Early Learning Council and Oregon Health Policy Board.
    - Develop a webpage on which these materials will be posted that can be publicly accessed, and share the tools developed with OHA to post on OHA supported websites such as the Transformation Center and Patient-Centered Primary Care Institute.

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