Pathways from Developmental Screening to Services:
Spotlight of Effort led by Northwest Early Learning Hub -in collaboration with the Oregon Pediatric Improvement Partnership- in Columbia, Clatsop and Tillamook Counties

Columbia Stakeholder Meeting 1/8/18

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Agenda

1. **Setting the Stage- Background & Context**
2. **Findings from <u>Phase 1</u>:**
   Baseline Data Collection to Understand Where You Are Now, People's Interest in Where to Focus the Pilots of Improvement
   - Stakeholder Engagement and Interviews (Qualitative data)
   - Coordinated Care Organization (Quantitative Data)
   - Pilot Primary Care Practice (Quantitative Data)
   - Early Intervention Data (Quantitative Data)
3. **Proposal for <u>Phase 2</u>: Based on your community-level data, OPIP proposal for where to focus the improvement pilots with the three partners noted in the proposal**
   - Three pilot sites
   - Proposed pathways
   - ✓ **Group-Level Input and Guidance on the Proposal**
   - ✓ **Confirmation of Focus for Improvement Pilot**
4. **Next Steps**

From Developmental Screening To Services: Opportunity to Connect the Fantastic Individual Silos

Health Care

Coordinated Care Organization & Primary Care Sites

Early Learning

Early Intervention

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Funding to Northwest Early Learning Hub (NWELH)

- Funded by Columbia Pacific Coordinated Care Organization (CPCCO)
- Two-year project – August 2017-July 2019
- Aim: To improve the **receipt of services** for young children who are identified at-risk for developmental and behavioral delays.
- The project support:
  - **Phase 1**: **Across-sector stakeholder engagement** and **baseline data collection** about current processes and where children are lost to follow-up;
  - **Phase 2: Implement Pilots to improve** the number of children who receive follow-up and coordination of care.

    Key partners in implementing these pilots within each of those silos:
    1. Primary Care Practices (OHSU-Scappoose)
    2. Early Intervention (NWESD – Columbia)
    3. Early Learning (Proposal for entity today)
- NWELH included OPIP has a key partner in this project
  - Support the stakeholder engagement, Evaluation data collection and summary
  - Support the improvement pilots within primary care clinics

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the perfect PLACE to begin is EXACTLY WHERE YOU ARE right now.

- Dieter F. Uchtdorf -

aYEARofFHE.blogspot.com

Phase 1: Stakeholder Engagement & Data Collection to Understand Where You Are Now, People's Interest in Where to Focus the Pilots of Improvement

Components of <u>Phase 1</u>:

- Stakeholder engagement

  o Group-level meetings to gather input and guidance

  o Recruitment of parent advisors for the project

  o Individual stakeholder interviews (Qualitative data)

- Coordinated Care Organization (Quantitative Data)

- Early Intervention Data (Quantitative Data)

- Pilot Site: Primary Care Practice

Stakeholder Engagement in Columbia County

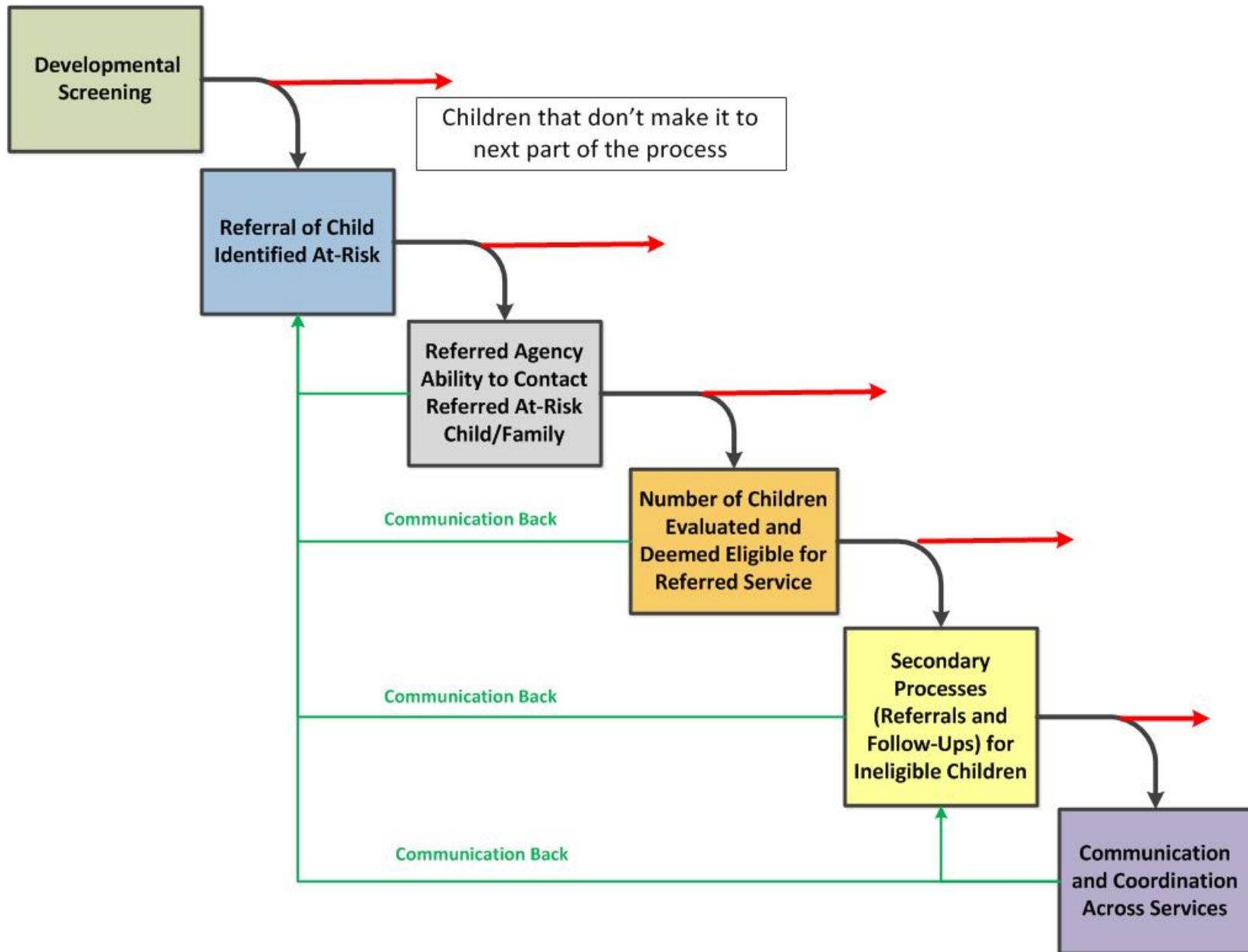| CPCCO	Primary Care	EI & Education	NW Early Learning Hub	Mental Health	Home Visiting & Head Start/ Early Head Start	Child Care and Parenting Supports
Elicia Miller* (Clinical Integration Manager) **Maranda Varsik** (Practice QI) **Joell Archibald** (Innovator Agent) **Nicole Jepeal** (Metrics/QI Analytics Supervisor) **Jeanne McCarty & Leslie Ford** (GOBHI) *To occur in January 2018	**OHSU Scappoose** • Brigit Hatch • Joe Skariah • Nicole Hoyt • Aubrey Bridges • Rachel Sircar **Legacy St. Helens*** • Naiyar Azhar *Will be engaged as part of spread efforts	**Nancy Ford** (Director of Birth to Age 5 Services, NWRESD) **Tina Meier-Nowell** (Special Education Coordinator, NWRESD) **Vicki Schroeder** (EI Data, NWRESD) **EI/ECSE Program County Coordinators** • Cindy Jaeger **EI Referral Intake Coordinators** • Mary Akin **EI Lead Evaluators** • Mary Dorry	**Dorothy Spence** (Hub Director) **Rob Saxton** (Governance Council Chair) **Elena Barreto** (Community Navigator) **Eva Manderson** (Early Learning Program Specialist/ Preschool Promise Manager)	**Mental Health CCMH** • Jill VanWormer	**Community Action Team** (Head Start & Healthy Families Home Visiting) • Joyce Ervin • Sunday Kamppi **Public Health/ CaCoon/ BabiesFirst** • Toni Harbison • Heather Bell	**Childcare Centers conducting screening** (Preschool Promise & SPARK 3 Star & above) • Martine Barnett (Cubs Corner/ St. Helens HS) **NW Parenting** • Julianne Cullen **DHS** • Nate Long • Amy Youngflesh

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Stakeholder Interviews

- Sharing **learnings most relevant** to inform Phase 2 –improvement pilots

- **Value of each perspective**

  – Community-level commitment to do the best for kids in the area and to support collaboration & communication

  – NWELH/OPIP intentionally conducted individual interviews to share at this group-level meeting to understand each person's experience, perspective and perception

    - There may be areas where experience and perception may not be the same across partners – that said, perception drives behavior and is integral for this project focused on IMPLEMENTATION

- Use the interviews/data to identify **current processes and assets in your community**

Key Building Blocks of the Pathways for Developmental Screening, Referral and Follow-Up

Developmental Screening

Children that don't make it to next part of the process

Referral of Child Identified At-Risk

Referred Agency Ability to Contact Referred At-Risk Child/Family

Communication Back

Number of Children Evaluated and Deemed Eligible for Referred Service

Communication Back

Secondary Processes (Referrals and Follow-Ups) for Ineligible Children

Communication Back

Communication and Coordination Across Services

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PATHWAY FOR DEVELOPMENTAL SCREENING & REFERRAL FOR CHILDREN 0-3 IDENTIFIED AT-RISK IN COLUMBIA COUNTY

KEY STEPS

Part 1: Children 0-3 Identified At-Risk via Developmental Screening

Primary Practices Conducting Screening at Recommended Periodicity:
1) OHSU Scappoose (Pilot Site)
2) Legacy St. Helens

Primary Practices Who Appear Not to be Screening to Recommendation:
1) Peacehealth Longview
2) CHC of Clatskanie

Community-Based Providers:
1) Home Visiting Programs
2) Public Health

Screening Fairs
(Children 2-6)

Part 2a: Developmental Supports to Address Delays Identified By Entity Who Screened

Developmental Promotion Activities

Internal Behavioral Health

Part 2b: Referral to Agency to Address Delays Identified

In Columbia County

EI
NW Regional ESD Columbia EI/ECSE

CaCoon/ Babies First/ Maternity Case Management

Head Start
CAT Inc.

Healthy Families Community Action Team (CAT) Inc.

Child/Parent Psychotherapy/ PCIT Columbia County Mental Health (CCMH)

Outside County

Developmental Behavioral Pediatrician
1) OHSU-CDRC
2) Providence

OT/PT/ Speech Therapy

Part 3: Additional Family Supports that Address Child Development and Promotion

NW Parenting

NW Regional Childcare Resources & Referral

Options, Inc.

Child Welfare, DHS

Amani Center (when abuse is a factor)

St. Helens High School Child Development and Teen Parent Program

NOTE: Childcare sites not included in map as ages served puts them out of scope of the project. Numerous childcare sites are screening in this community.

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Stakeholder Interviews Findings:
Developmental Screening – Punchlines

- **Screening rate for Columbia County is 57.5%. Many children are not getting screened**

- **Group 1: Screening in Primary Care Practices (Health Care Silo)**
  - Not all practices that children go to in the county are screening or screening to fidelity.
  - Children access care in places that not where they attributed for primary care.
  - Numerous stakeholders reported that there are a number of families that are against government involvement and hesitate to engage with systems, including health care.

- **Group 2: Community-Based Providers (Early Learning Silo)**: Screening occurs with number of community-based providers (e.g. *Home Visiting, Head Start***)
  - That said, the numbers of children able to be served by these programs is not near the magnitude and number of kids served by PCPs

  **Head Start is for ages 3 and up, meaning it is outside the scope of the project

- **Group 3: Childcare (Early Learning Silo)**: Screening happening in some sites, very limited for 0-3 age group

- **Sharing of screening results is not standardized or routinely in place in any group**

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Stakeholder Interviews Findings:
Referral of Children Identified At-Risk Based on Screening Tool- Punchlines

Group 1: Primary Care Sites Referral of Children Identified At-Risk on Developmental Screening

- **Need for better and standardized processes** (work flows & tracking) in practices around who to refer, where to refer, and how best to refer

- Need for **educational materials** to parents of children identified at-risk. Materials also may help providers facilitate these important conversations

- Perception that the **entities they refer to are already at a capacity** and/or have a **long wait list**, so PCPs triage and prioritize who gets referred.

- **Perceptions about EI eligibility** and evaluation processes impact **whether and who they refer**

- **Limited and inconsistent use of community based mental health (Columbia County Mental Health)**

- Lack of **AVAILABLE resources** to address some of the risks identified

- **Barriers to referral to developmental pediatricians** located in Portland
  - Transportation and time commitment (multiple visits)
  - Wait lists for those referred to developmental pediatrician

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Stakeholder Interviews Findings:
Referral of Children Identified At-Risk Based on Screening Tool- Punchlines

Group 2: Home-visiting programs, Head Start, Public Health

- **Knowledge of early learning providers enhances their referral, more contact with families to help them navigate the referral**

- Lack of **AVAILABLE resources** to address risk identified

- **Barriers to referral to developmental pediatricians** located in Portland
  - Transportation and time commitment (multiple visits)
  - Wait lists for those referred to developmental pediatrician

Group 3: Early Learning/Childcare

- **The 5 star program we interviewed does do some referring to EI when appropriate. Work with family to determine best process.**

- **Important to consider now:** Increases in referral rates will result in an increased need for the resources to which children are referred – *think about capacity as we plan and implement pilots*
  - Past literature has shown that 19-22% of children will be identified at-risk

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Stakeholder Interviews Findings:
Ability of Referred Agency to Contact Families- Punchlines

- **Difficulty connecting** when the entity to which the child/family is referred tries to connect over the phone
- **General difficulty engaging some families in referrals meant to support delays, promotion tied to kindergarten readiness**
  - Numerous stakeholders reported difficulty engaging families in these referrals- and noted hesitance to engage with government offices and systems.

- **Mental Health**
  - Especially difficult when stigma is at play, or if the family has had a previous experience that may influence their decision to go to the referral

- **Not currently any cross-sector communication/coordination around inability to contact referred families**

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Stakeholder Interviews Findings:
Getting to Referrals and - Punchlines

This is a key area where the data will show children drop off

- **Transportation is a consistent barrier**

- **Early Intervention**
  - While home evaluations can be offered, they present other challenges

- **Mental Health**
  - Referral is actually to an assessment to determine eligibility (as per Medicaid standards). This sometimes impacts a family's likelihood to return.
  - A better process for hand off from primary care would be helpful

Stakeholder Interview Punchlines:
Secondary Referral and Follow-Up & Coordination/Communication

- **Early Intervention**
  - Secondary Referral for EI0Ineligible Children
    - Connect families to CCMH when concern is known, provide a packet with resources and developmental promotion materials, but not currently a standardized process for *referral*.
    - Value of PCP engagement and support in helping the family
  - Coordination/Communication
    - Currently send information back to referring provider when requested and have correct contact information, but not sure they are sending what providers actually want (***there is wide confusion among PCPs about what the feedback options are on the universal referral form***)
    - Opportunity for improved coordination/communication with primary care, both eager to pilot

- **Community-Based Providers:**
  - Value of more specific **information about resources** available, based on risk identified

Perspective from Parent on Their Experience

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Punchline for Improvement Pilots:

- **Need to address better follow-up for children identified at-risk that includes secondary steps for when a child is referred to one resource and then not found eligibility**
  - Value in promotion activities that the parent can do and lead, general education to parents
  - Value in asset map to identify services and WHICH ones would be the best match set of resource for the family based on ASQ scores AND child and family factors
    - Acknowledge that some resources may not currently exist, but quantifying how much children need them is valuable
    - Some children and families needs multiple resources, not just one
  - Need to standardized and specific ways to then connect family to those resources
    - Referral forms
    - Two communication
    - Family support to get to services
  - Resources in community that may be underutlized
    - EI
    - Behavioral health and mental health
    - Parenting supports through home visiting, although limited capacity
- **Pilot needs to address spread to primary care practices given the large variation seen and relatively strengths acknowledged in OHSU**
  - Value of more specific **information about resources** available, based on risk identified

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Using Data to Inform Our Discussions and Proposed Priority Areas to Focus Our Community-Based QI Project:

Examining Quantitative Data to Understand
The Pathway of Screening to Services for Young

Population of Focus for the Project: <u>Children 0-3</u> identified on developmental screening tools as at-risk for developmental, behavioral or social delays
Data

- **Data Available That will be Examined**

    1. **<u>Census Data</u> – How many children 0-3**

    2. **Columbia Pacific Coordinated Care Organization (<u>CPCCO</u>) for Publicly Insured (Funder)**
        - Children covered, Continuously enrolled
        - Children who have a visit
        - Children who receive a developmental screening, according to claims submitted

    3. **Primary Care Practice Data: OHSU Scappoose (Primary Care Pilot Site)**
        - Children practice saw for well-child care
        - Children who received a developmental screening
        - Children identified at-risk on developmental screen
        - Children identified at-risk who received follow-up

    4. **Early Intervention: According to Bright Futures Data, A Referral for All Children Identified At-Risk (A Pilot Site)**
        - Referrals
        - Referred children able to be evaluated
        - Of those evaluated, eligibility

    5. **Pilot Early Learning Provider(Tracking data will be collected for pilot sites to evaluate pilot)**

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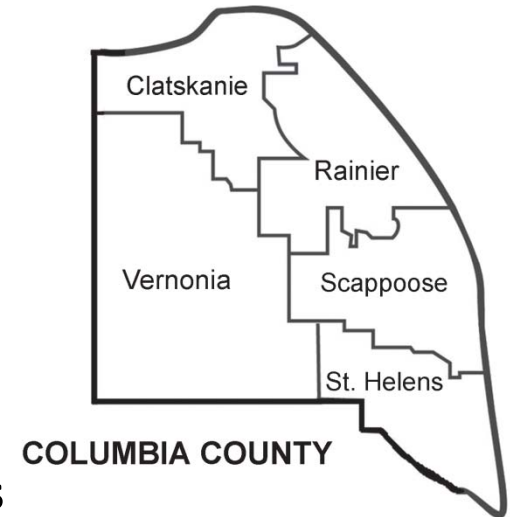   - Of those evaluated, eligibility
  5. Early learning providers – Home Visiting Data
  6. Pilot Early Learning Provider(Tracking data will be collected for pilot sites to evaluate pilot)

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Children 0-3 in Columbia County

2016 Census Data under 3 years:

- **Children 0-3: Columbia: 1635**
- **N=797 Children Covered by CPCCO in Columbia**
  - **Proportion of children 0-3 Publicly Insured: 49%**
- **N= 419 Children Continuously Enrolled for 12 months**

Clatskanie

Rainier

Vernonia

Scappoose
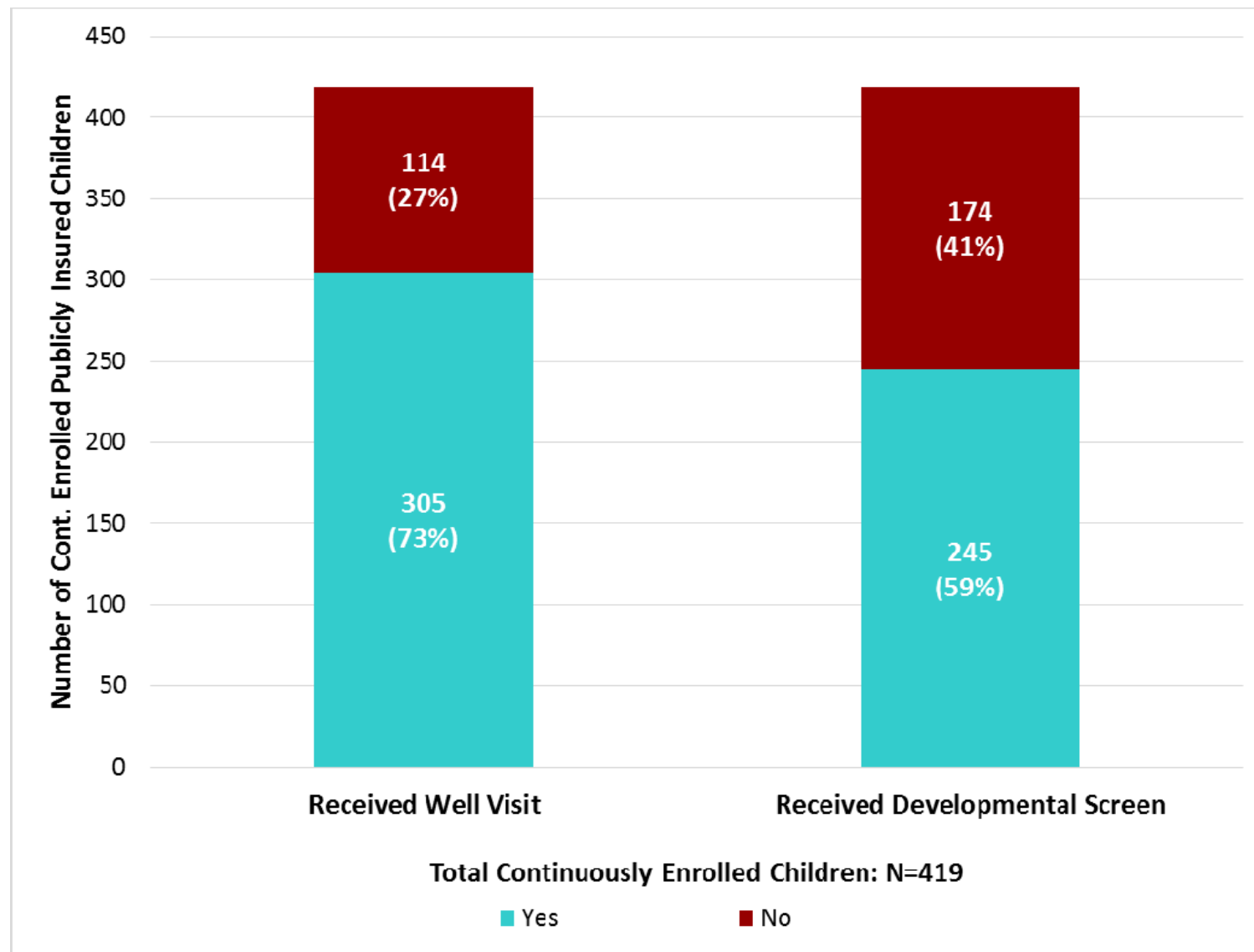
St. Helens

COLUMBIA COUNTY

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Publicly Insured Children Under Three Years Old: Number Continuously Enrolled; Proportion Who Received a Well Visit & Developmental Screen

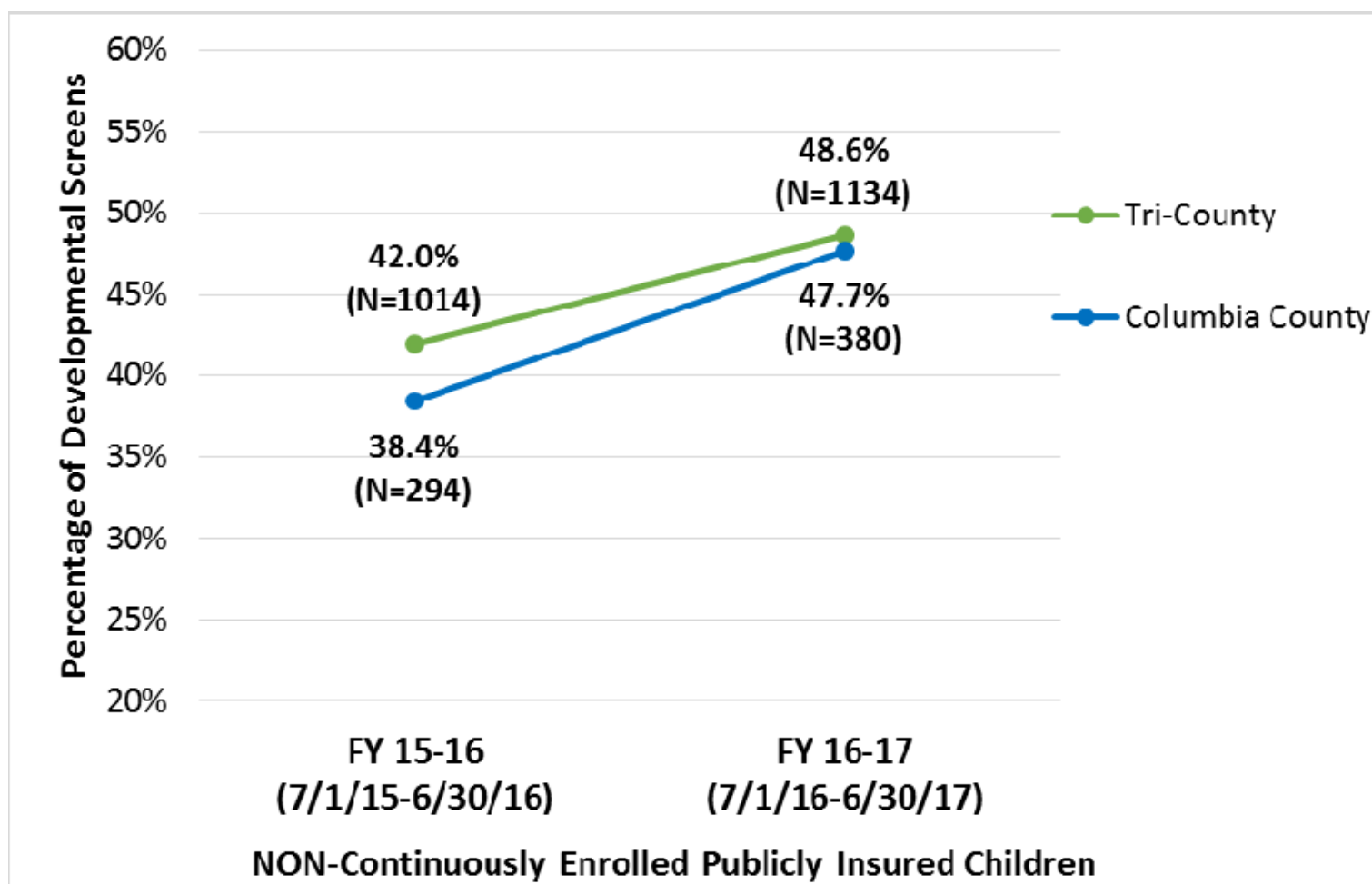Data Source: Provided by CPCCO, October 2017
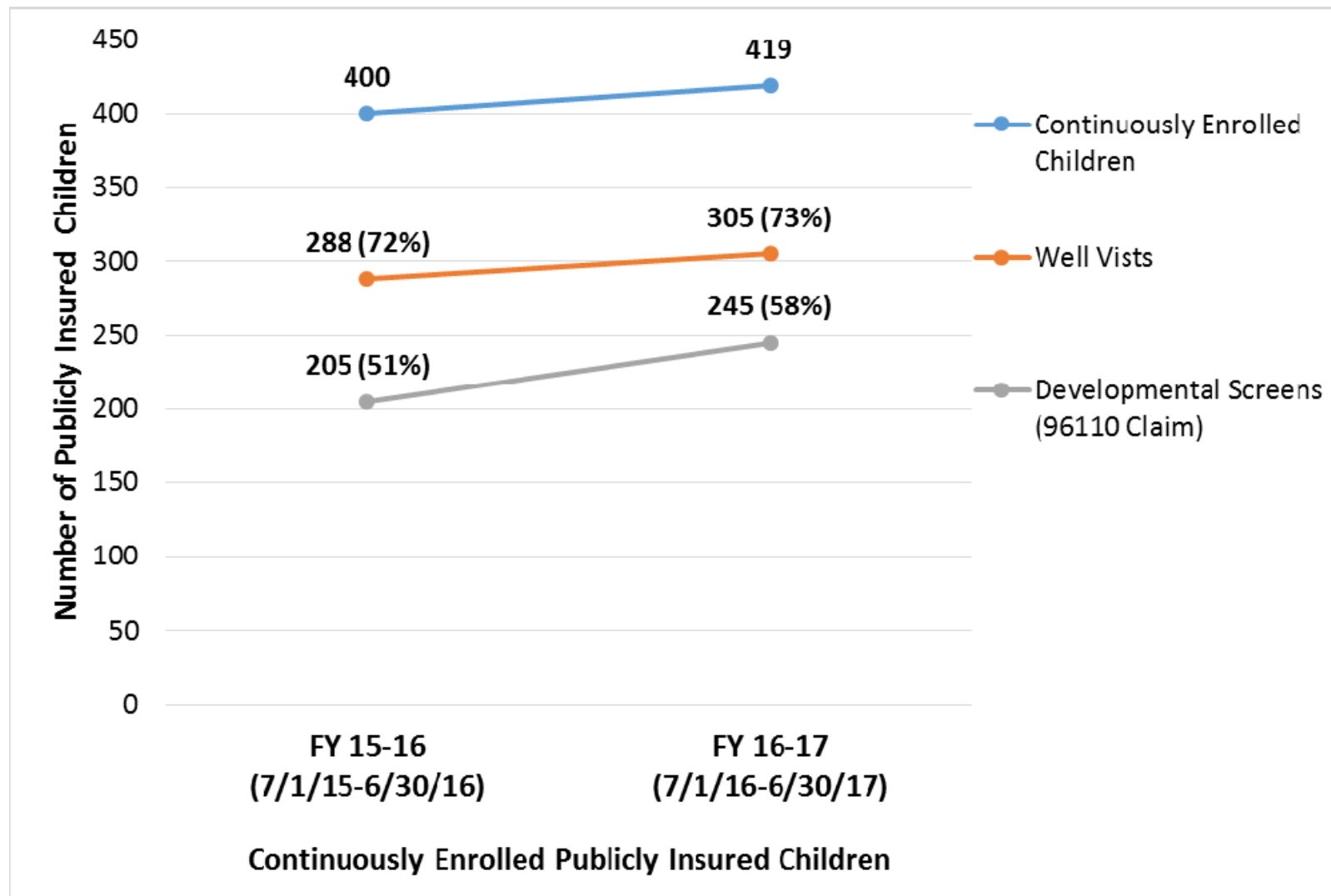
Proportion of Continuously Enrolled, Publicly Insured Children Who had a Well-Visit, Developmental Screen in the Last Year

Number of Cont. Enrolled Publicly Insured Children

Received Well Visit
- 114 (27%)
- 305 (73%)

Received Developmental Screen
- 174 (41%)
- 245 (59%)

Total Continuously Enrolled Children: N=419

■ Yes   ■ No

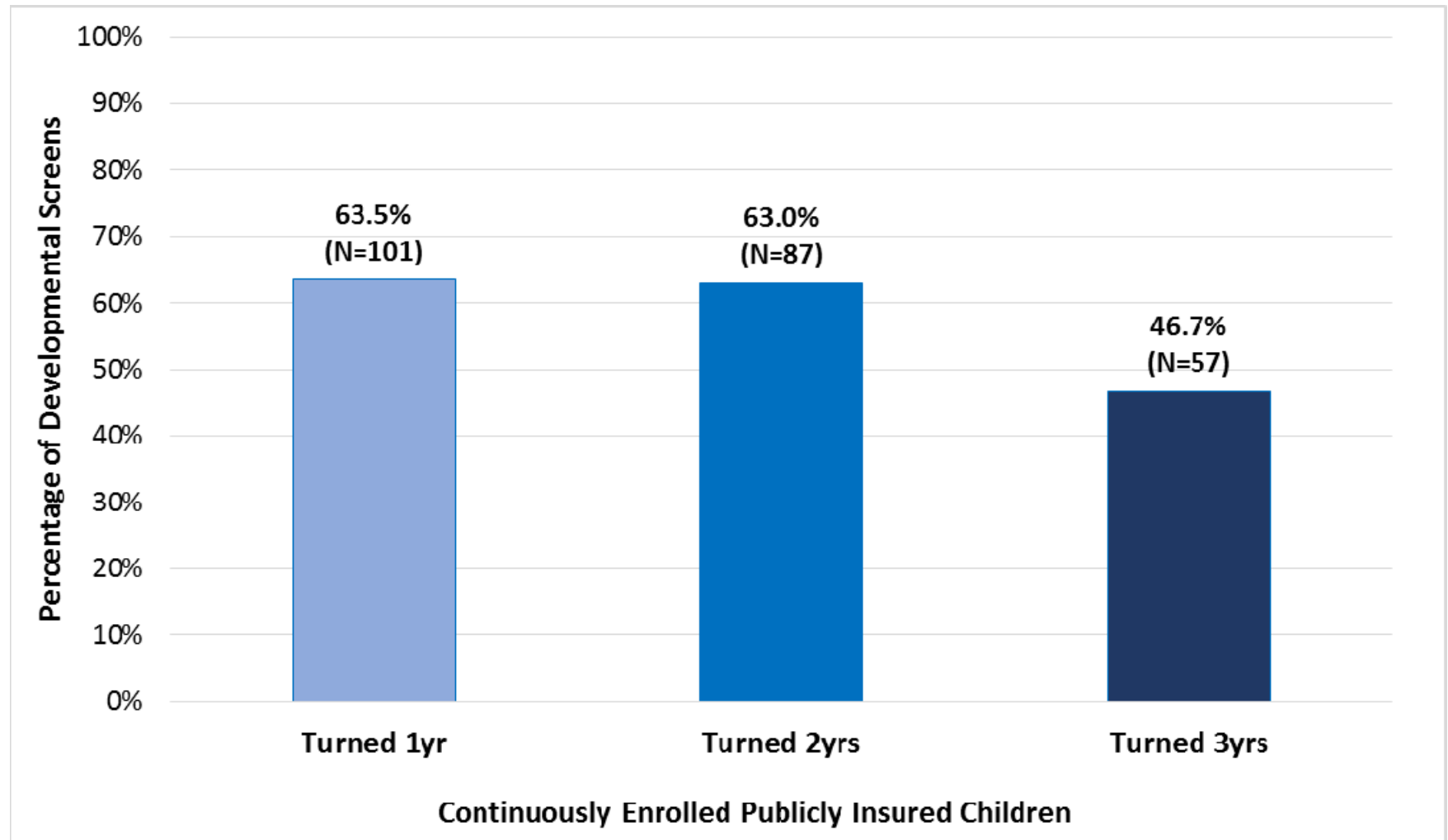Data Source: Provided by CPCCO, October 2017 – FY16-17 ONLY

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Developmental Screening Rate for Columbia County and the Tri-County CPCCO Regions (Clatsop, Columbia, Tillamook)
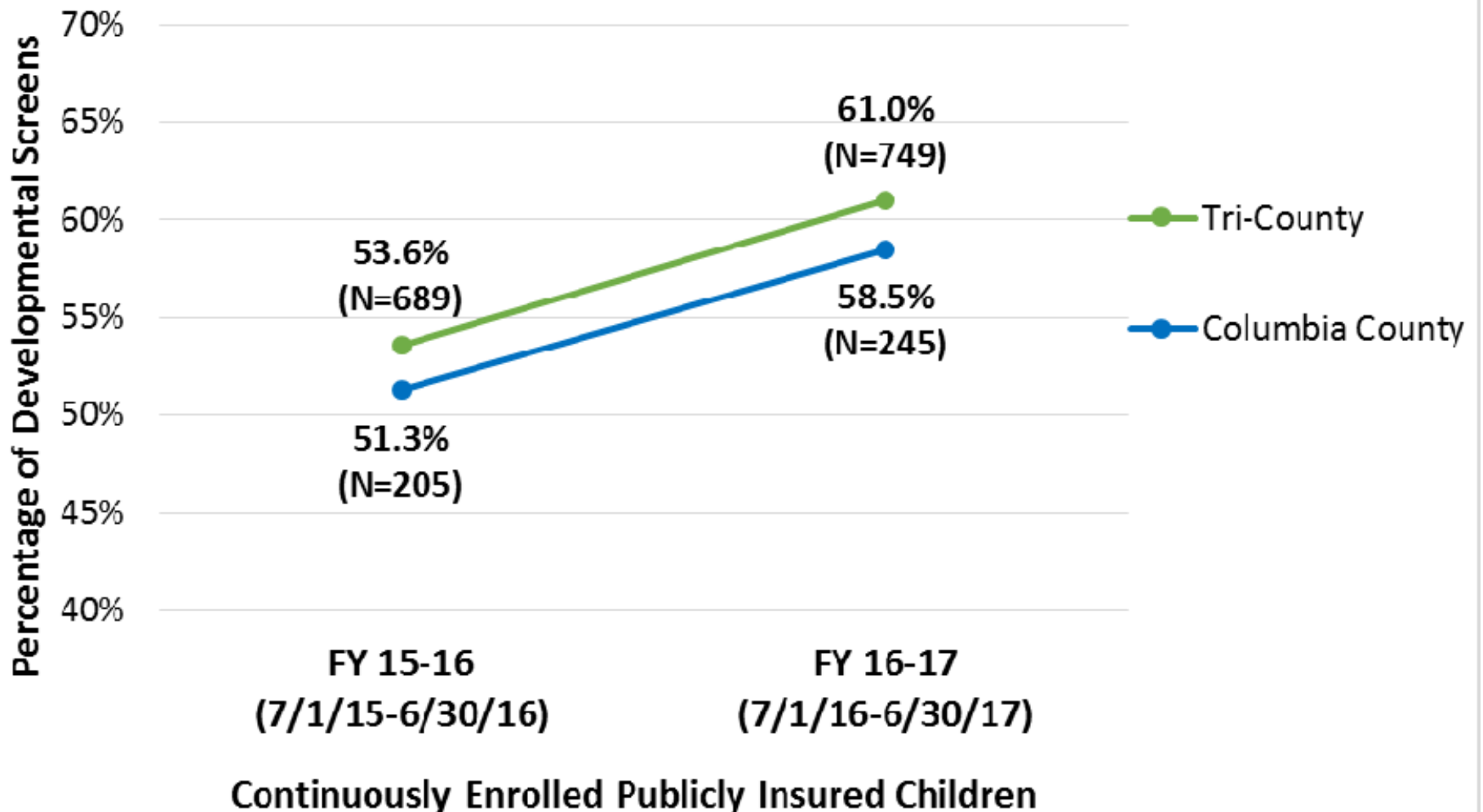
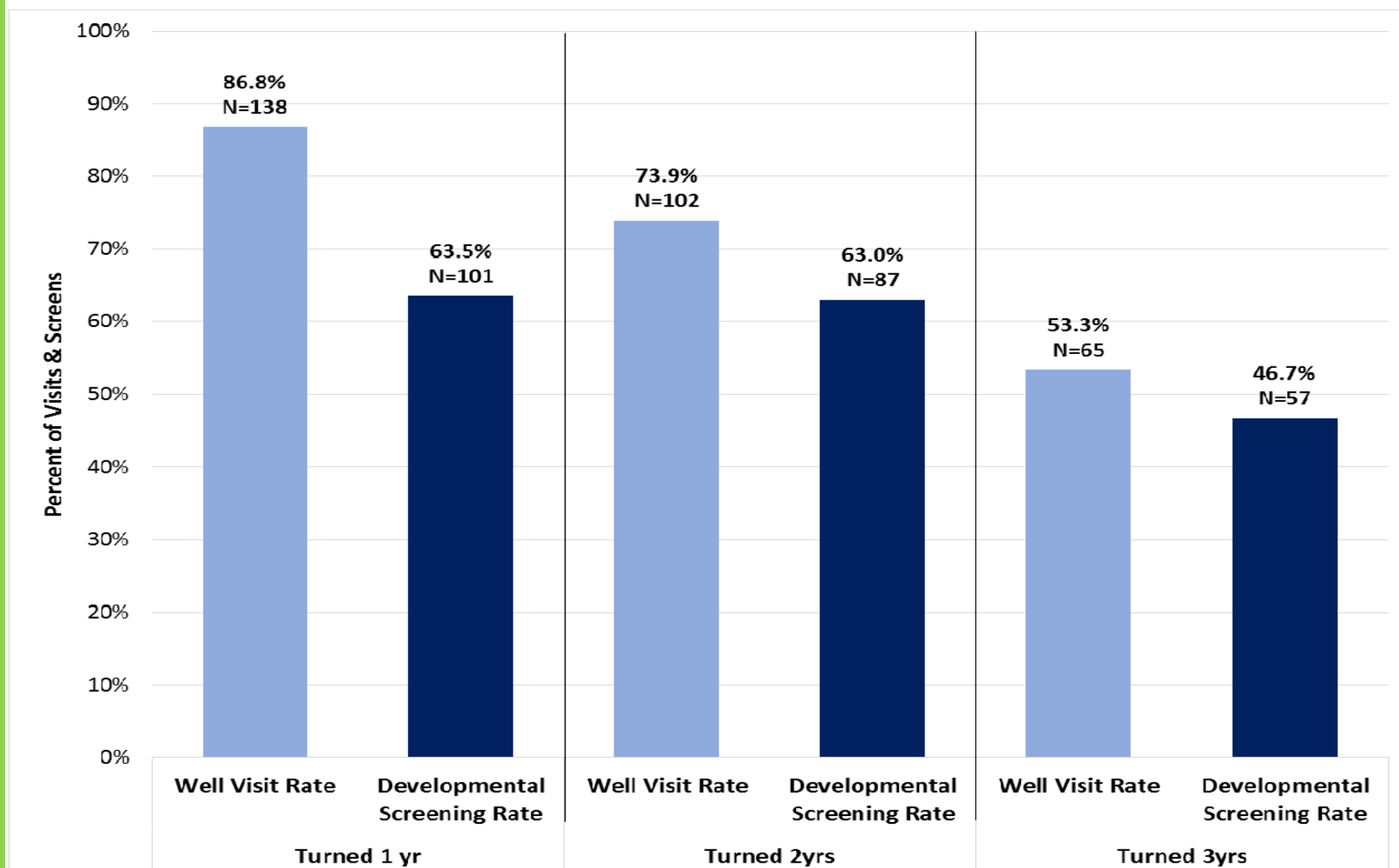# Developmental Screening Rate for Columbia County and the Overall CPCCO Region for NON-Continuously Enrolled Children

Data Source: Provided by CPCCO, October 2017. Developmental Screens according to 96110 Claims.

Do not reproduce without proper OPIP citation

Developmental Screening Rates by Age of Child

Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

Well Visit Rates vs. Developmental Screening Rates by Age in Columbia County

Bar chart showing Percent of Visits & Screens:

Turned 1 yr
- Well Visit Rate: 86.8% N=138
- Developmental Screening Rate: 63.5% N=101

Turned 2yrs
- Well Visit Rate: 73.9% N=102
- Developmental Screening Rate: 63.0% N=87

Turned 3yrs
- Well Visit Rate: 53.3% N=65
- Developmental Screening Rate: 46.7% N=57

Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

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Well Care Provided by SBHCs in Columbia County

| County	SBHC School	Medical Sponsor
Columbia	Clatskanie Middle/High School	Coastal Family Health Center (Prior to April 2017), Now Yakima Valley Farmworkers Clinic
	Lewis & Clark Elementary School (Sacagawea Health Center)	The Public Health Foundation of Columbia County
	Rainier Jr/Sr High School [†]	The Public Health Foundation of Columbia County
	Vernonia K-12 School (Spencer Health and Wellness)	The Public Health Foundation of Columbia County

- SBHCs can provide preventive services and bill CPCCO
  - Ages 0-3: All 4 sites are open to pre-school-aged kids.
  - 55 visits for children 0-3. N= 24 were well visits.
  - In 2016-17, the SBHCs # of visits for ages 0-3 was:
  - o Clatskanie: 15 visits (out of 197)
  - o Sacagawea: 12 visits (out of 290)
  - o Rainier: 20 visits (out of 663)
  - o Vernonia: 8 visits (out of 204)
- PCPCH: Both Rainier and Sacagawea are PCPCH-certified Tier 3 (under the new 2017 criteria).
- That said, CPCCO does not attribute or assign children to a SBHC to be entity responsible for the child's primary care

Data Source: Provided by Oregon Health Authority- Adolescent Health

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Developmental Screening Rates by Race/Ethnicity – CONTINUOUSLY ENROLLED CHILDREN

Percentage of Developmental Screens

- 57.1% (N=187)
- 50.8% (N=155)
- 56.5% (N=13)
- 50.0% (N=13)

White
Hispanic/Latino

FY 15-16 (7/1/15-6/30/16)   FY 16-17 (7/1/16-6/30/17)

Continuously Enrolled Publicly Insured Children

Data Source: Provided by CPCCO, October 2017

OPIP
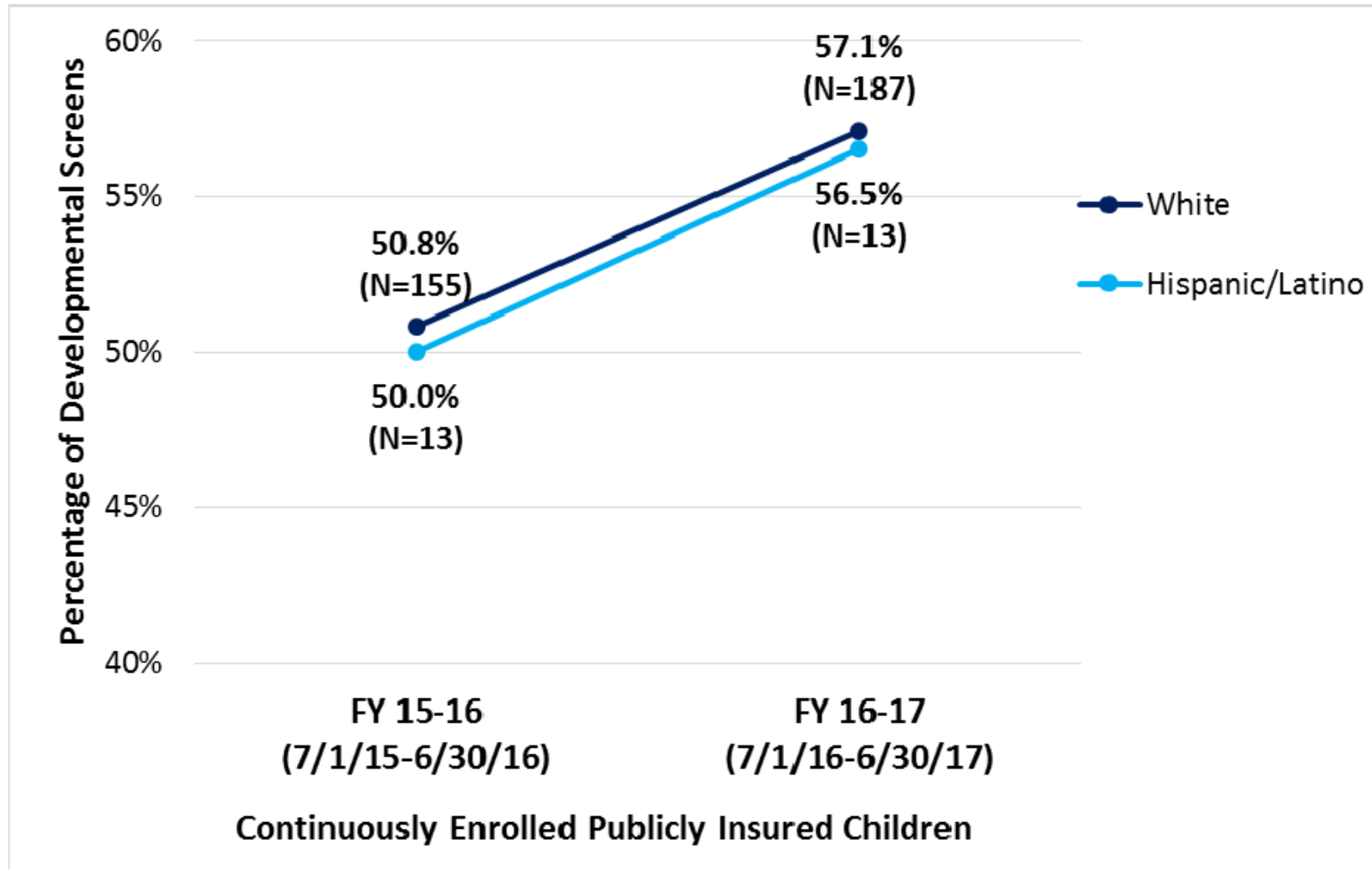
Number of Continuously Insured Children Assigned to Clinic vs. Clinic's Developmental Screening Rate
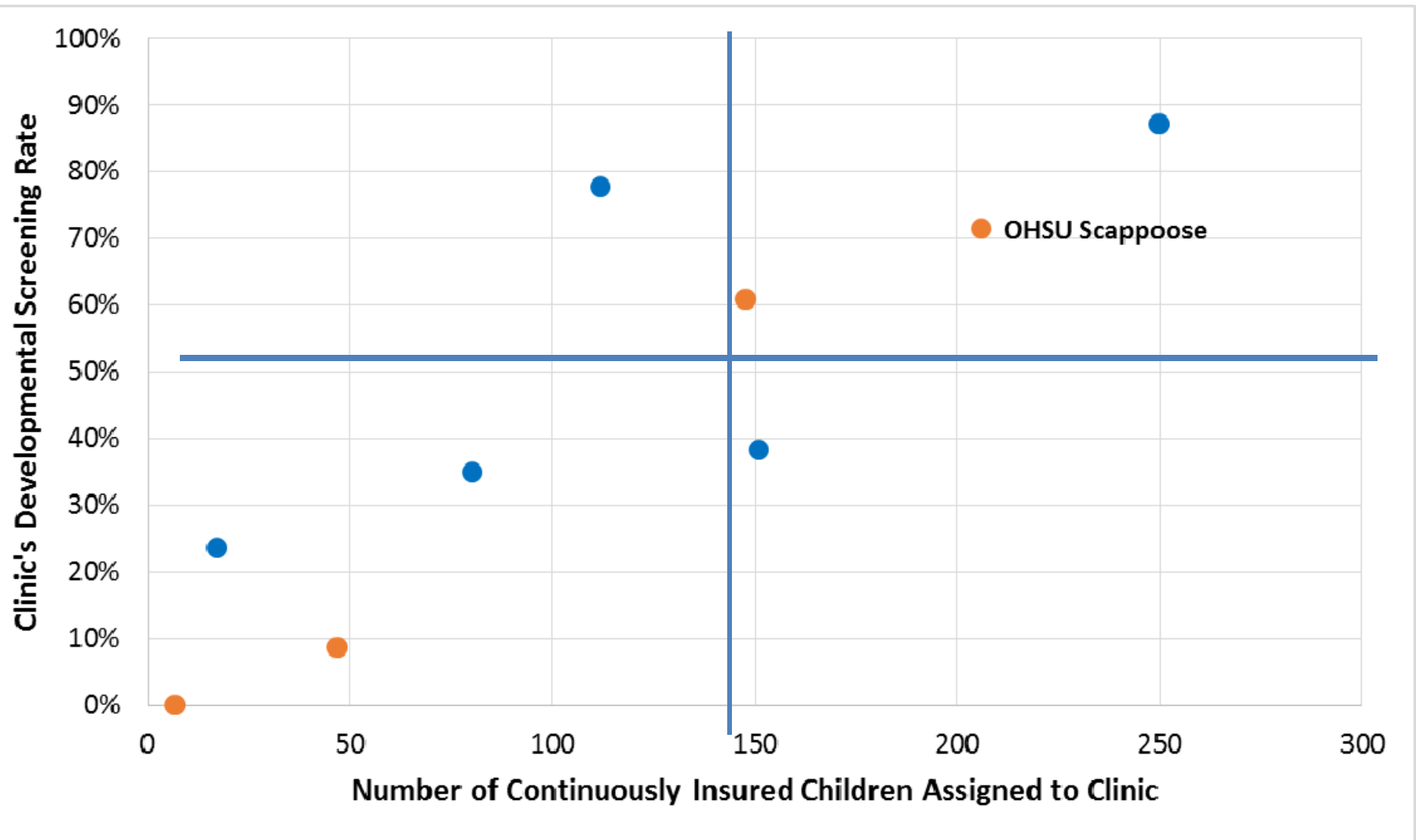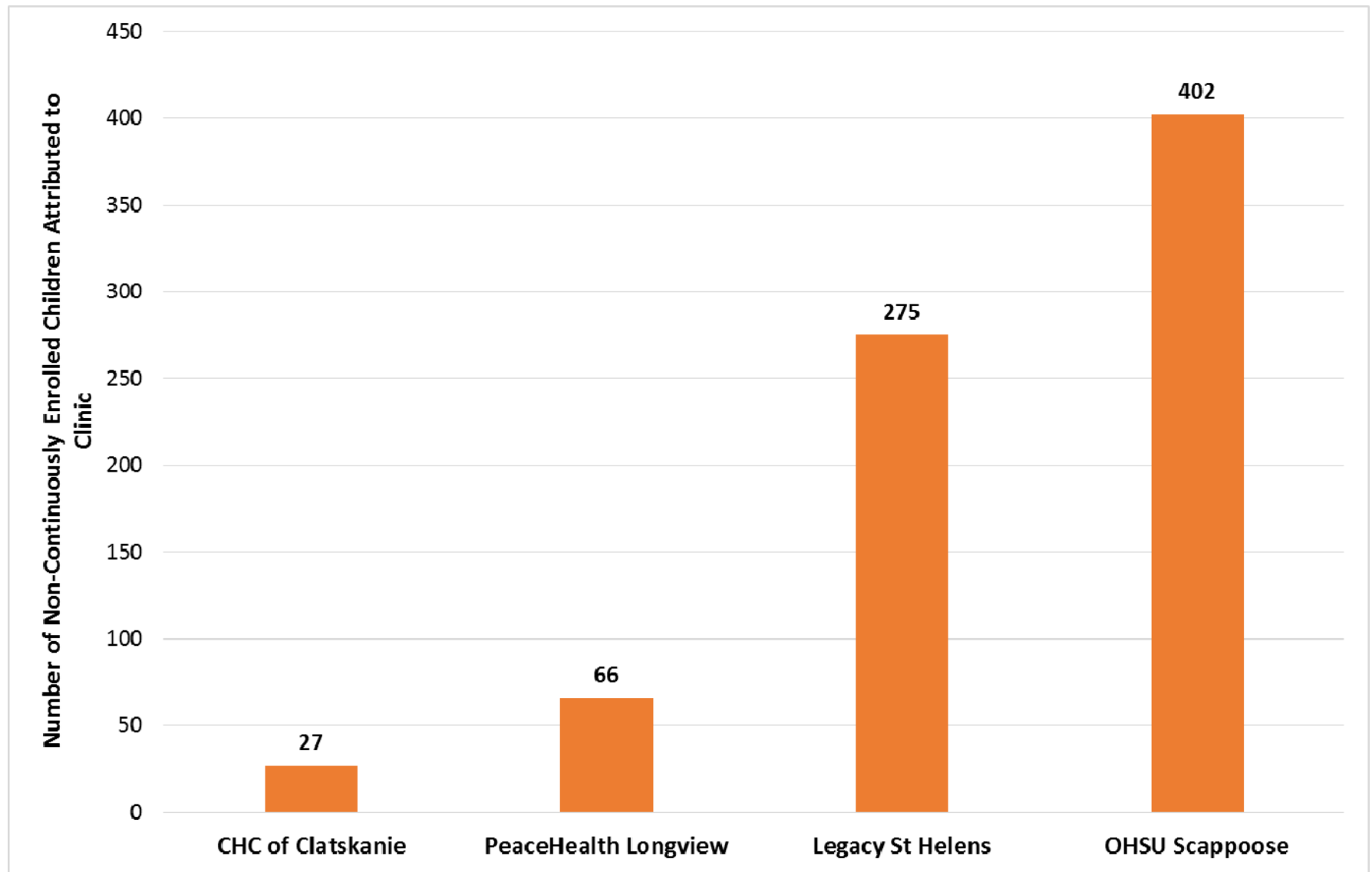

- **●** Practices located in Columbia County
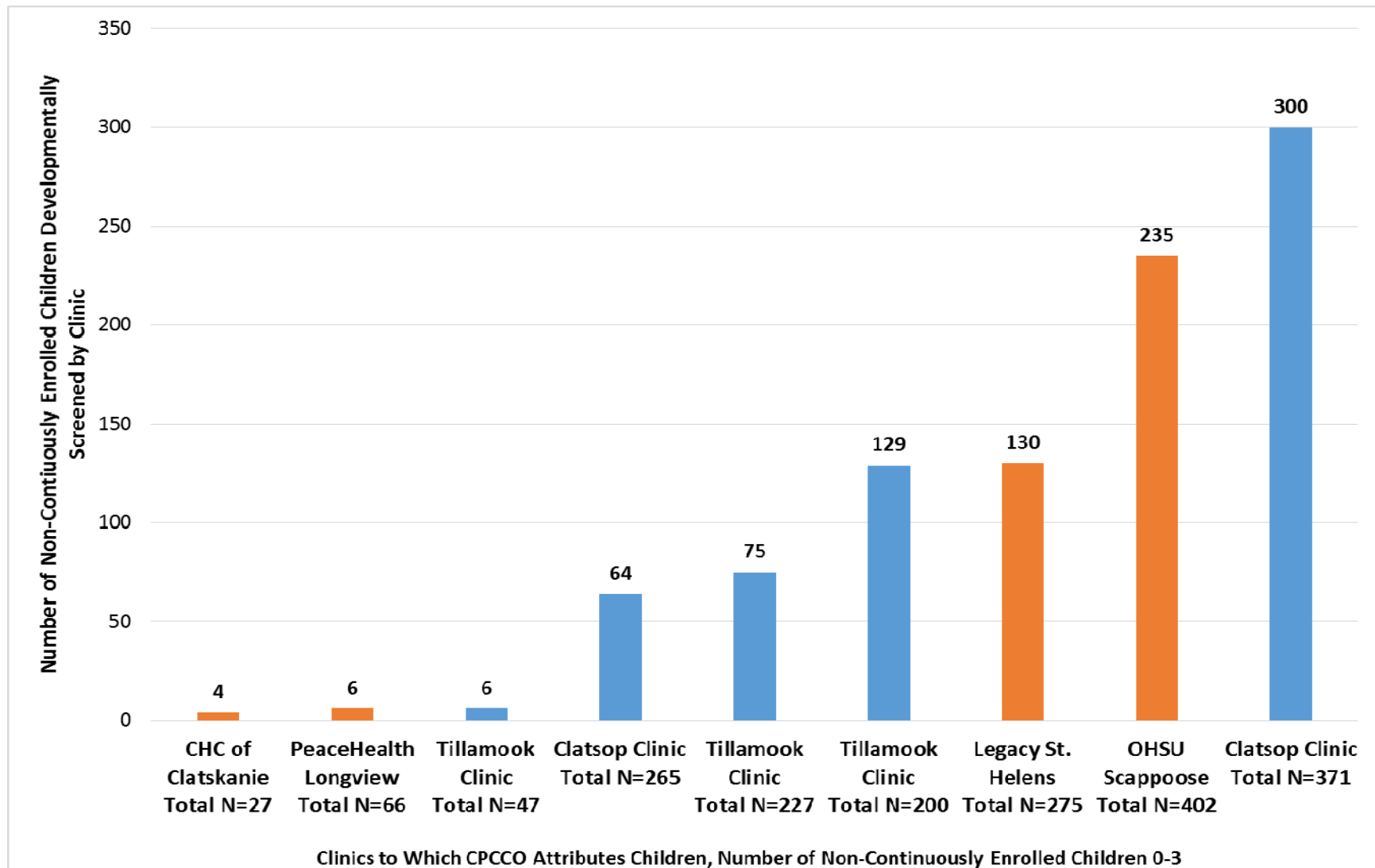- **●** Practices located in Clatsop and Tillamook Counties

Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

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Number of <u>Non-Continuously</u> Enrolled 0-3 Children Attributed to Each Clinic in Columbia County

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Annual Number of Developmental Screens Submitted by CPCCO Clinics in Columbia, Clatsop & Tillamook Counties

Y-axis: Number of Non-Contiuously Enrolled Children Developmentally Screened by Clinic

X-axis: Clinics to Which CPCCO Attributes Children, Number of Non-Continuously Enrolled Children 0-3

Clinic	Value
CHC of Clatskanie Total N=27	4
PeaceHealth Longview Total N=66	6
Tillamook Clinic Total N=47	6
Clatsop Clinic Total N=265	64
Tillamook Clinic Total N=227	75
Tillamook Clinic Total N=200	129
Legacy St. Helens Total N=275	130
OHSU Scappoose Total N=402	235
Clatsop Clinic Total N=371	300

Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

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  Data

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  5. **Pilot Early Learning Provider(Tracking data will be collected for pilot sites to evaluate pilot)**

OPIP

Purpose of the Baseline Data Collection in the Primary Care Pilot Site: OHSU Scappoose

- Baseline Data:
  - Inform **Community-Level Conversations** Meant to Understand Current Population, Referral Patterns, and Opportunities for Improvement -→ Share at the January 8th, 2018 Stakeholder Meeting
    - ✓ General information about number of children see
    - ✓ Screening (Claim- 96110, Documentation in EMR)
    - ✓ Proportion of screened children identified at-risk (Documentation in EMR)
    - ✓ Follow-up steps (Documentation in the EMR)
  - Used to **Compare and Evaluate the Impact** of the Improvement Pilot
- Inform Quality Improvement Efforts
  - Identify potential **improvements in EMR templates**/Smart Phrase aligned with future improved processes and referral pathways for young children
  - Understand current data limitations related to tracking the **quality improvement work** and how it impacts **evaluation measurement**
- Provide **information to CPCCO and other stakeholders related to measurement opportunities and challenges**
  - Follow-up to developmental screening and kindergarten readiness are "on deck" CCO incentive metrics

OPIP

- Large teaching practice
  - N=21 Faculty Providers, Many of Whom are Part-time in the Clinic
  - Residents that rotate (Currently 7)
- Electronic Medical Record (EMR)
  - OCHIN EPIC
- Developmental Screening Processes
  - Screen at Well-Visits
    - Before 1: 6 and 9 month well-visit
    - Before 2: 12 and 18 month well visit
    - Before 3: 24 months well-visit

    (Also screen at 36 month well visit - outside scope of data)
  - Variation in provider-level use of the 15 month appointment, but if scheduled will administer a developmental screen at that visit
  - Do not OFFER 30 month visit

OPIP

- **Baseline Time Period:** 7/1/16 - 6/30/17 (One Year)
- Children of Focus: **Children Under 3** (1 day-35.99 months)
- Data Sources:
  1 Report related to panel size, well-visits, use of the developmental screening flowsheet, 96110 claim, searchable fields within the ASQ flowsheet (Domain level scores)
  - Panel, **well-visits, screening** rates, proportion of screens with a 96110 claim, proportion of screens **identifying a child-at risk**
  2) Chart Review of **ASQ Flowsheets** that Identified the Child At-Risk
    (1 or more domains in black and/or 2 or more domains in grey)
    - Used to identify **follow-up to developmental screening** currently documented in the chart
      o OCHIN Follow-Up Interpretation (Above Cut Off, Close to Cut Off, Below Cut Off)
      o Specific Referrals
        ▪ Referral to Early Intervention
        ▪ Referral to OT/PT
        ▪ Referral to Speech Therapy (ST)
        ▪ Referral to Developmental Behavioral Pediatrician
        ▪ Referral to External Mental Health
    - Follow-Up (FU) Steps **Not Included** in Due to Documentation Limitations, But is Follow-Up
      o Developmental Promotion
      o Rescreen of child (Assumed done at every visit, however a schedule of an earlier visit would be recommended for two year olds)
      o Internal mental health
      o Referrals to other resources: CaCoon/Babies First/Home Visiting, Healthy Families, Head Start, Parent Child Interaction Therapy, and Parenting Classes
- Data examined by age of child, provider, insurance
- Data examined at screen-level AND at a child-level (looking across screens)
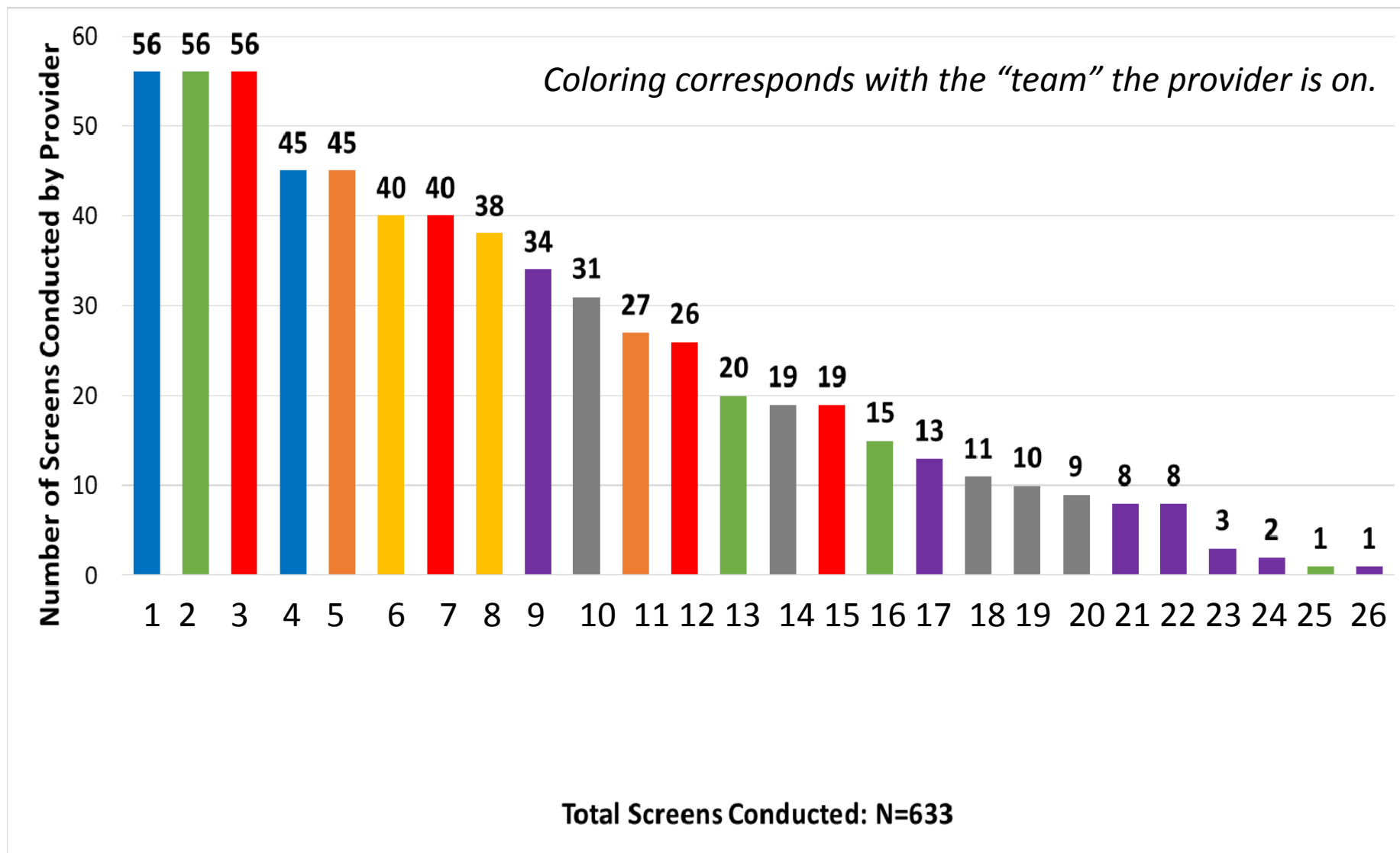
38

- Number of Providers in OHSU Scappoose that Interpreted a Developmental Screen
  - o N=26 Providers completed an ASQ flow sheets for a child under 3 (Includes Residents)
- Panel of Children Under 3: N=**497**
  - o Children Who had a Well-Visit in Last Year: **N=477**
  - o Of the Visits with a Developmental Screen: 62% are for children with Medicaid
- Developmental Screens for Children Under 3
  - o Number of Screens Completed According Practice's EMR (ASQ Flowsheet): **N=633**
    - ✓ Of these, Screens Administered at a Well-Visit (616/633)
    - ✓ Screens administered at an "urgent visit" – likely a rescreen (17/633)
    - ✓ By Age:
      - » Under 1: N=285
      - » 1-2 yrs: N=266
      - » 2-3 yrs: N=82
  - o Number of 96110s Billed: N=344
    - • 54% of the time a 96110 claim was submitted when a screen done
  - o Number of Multiple Screens: N=298
- Child-Level Screening
  - o Number of Children Screened: **N=335**
  - o Number of Children with Multiple Screens N=183 (54%)
    - ✓ Nearly all the children with multiple screens are the younger children due to the periodicity of screening in OHSU

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OHSU Scappoose – Number of Developmental Screens Done in One Year for Children Under 3: By Billing Provider

Coloring corresponds with the "team" the provider is on.

Total Screens Conducted: N=633

40

OPIP

- Scoring of "At-Risk" Based on the Ages and Stages Questionnaire
  - At Risk=   1 or more in the Black (2 STD from Normal) AND/OR
    2 or more in the Grey (1.5 STD from Normal)
- Bright Futures Recommendation for **Follow-Up for At-Risk**
  - Screen at 9, 18 and 30 month visit (or 24 if not doing the 30)
  - Refer all to Early Intervention and Developmental and Behavioral Pediatrician (DB Peds)
- For the analysis shown:
  - Given OHSU Scappoose is screening multiple times, used the risk level for the last screen conducted
    - Under 1: 6 and 9 month well-visit
    - 1-2: 12 and 18 month well visit
    - 2-3: 24 months well-visit
  - That said, we ran all analyses by screen as well

41

OPIP

OHSU Scappoose – Characteristics of Risk Identified on the ASQ in Children 0-3
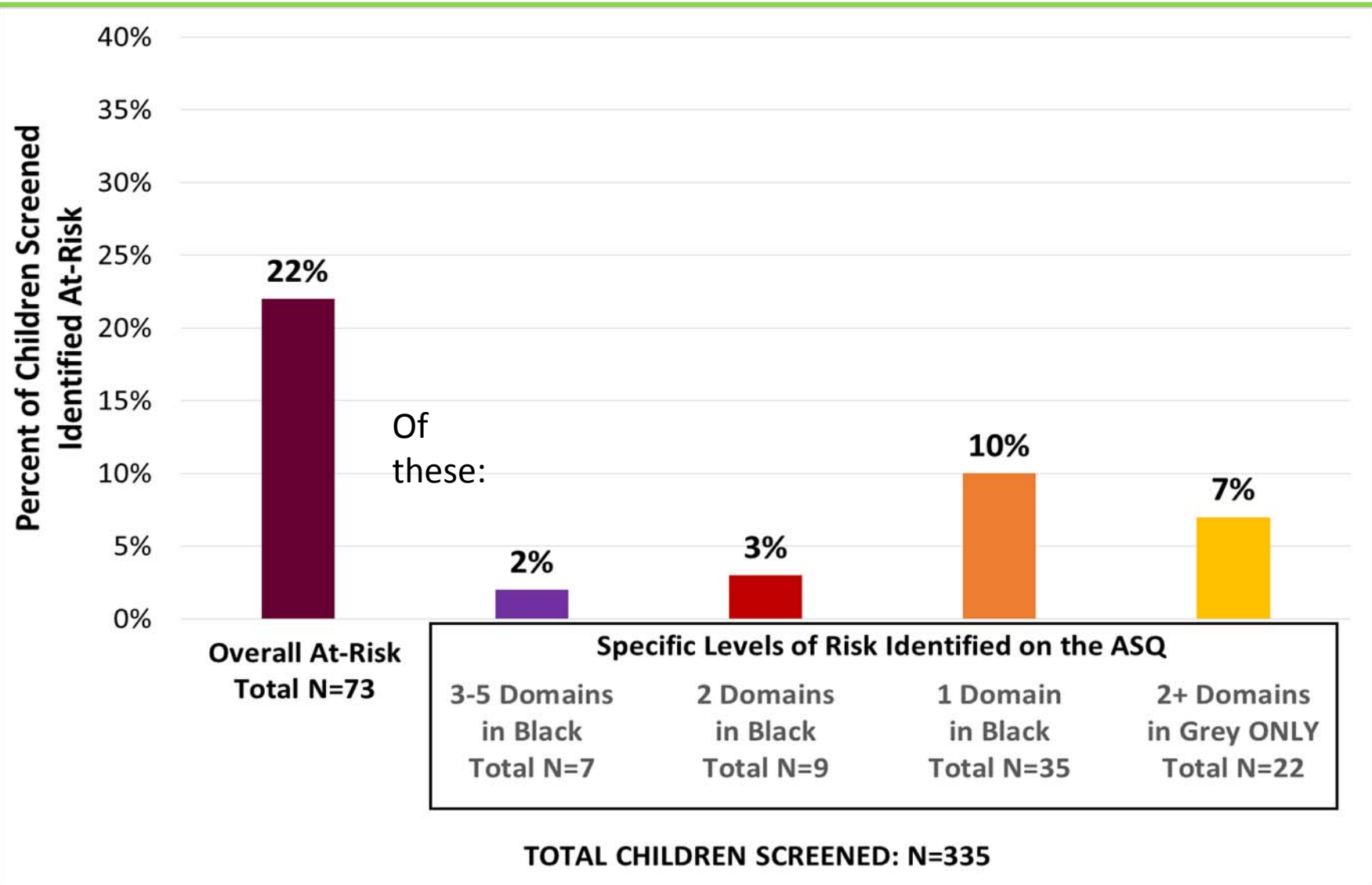
Of these:

Specific Levels of Risk Identified on the ASQ

Overall At-Risk Total N=73 — 22%

3-5 Domains in Black Total N=7 — 2%

2 Domains in Black Total N=9 — 3%

1 Domain in Black Total N=35 — 10%

2+ Domains in Grey ONLY Total N=22 — 7%

Y-axis: Percent of Children Screened Identified At-Risk (0% – 40%)

TOTAL CHILDREN SCREENED: N=335

OPIP

OHSU Scappoose –Proportion of __CHILDREN__ Screened Identified At-Risk on the ASQ: BY Age-Categories
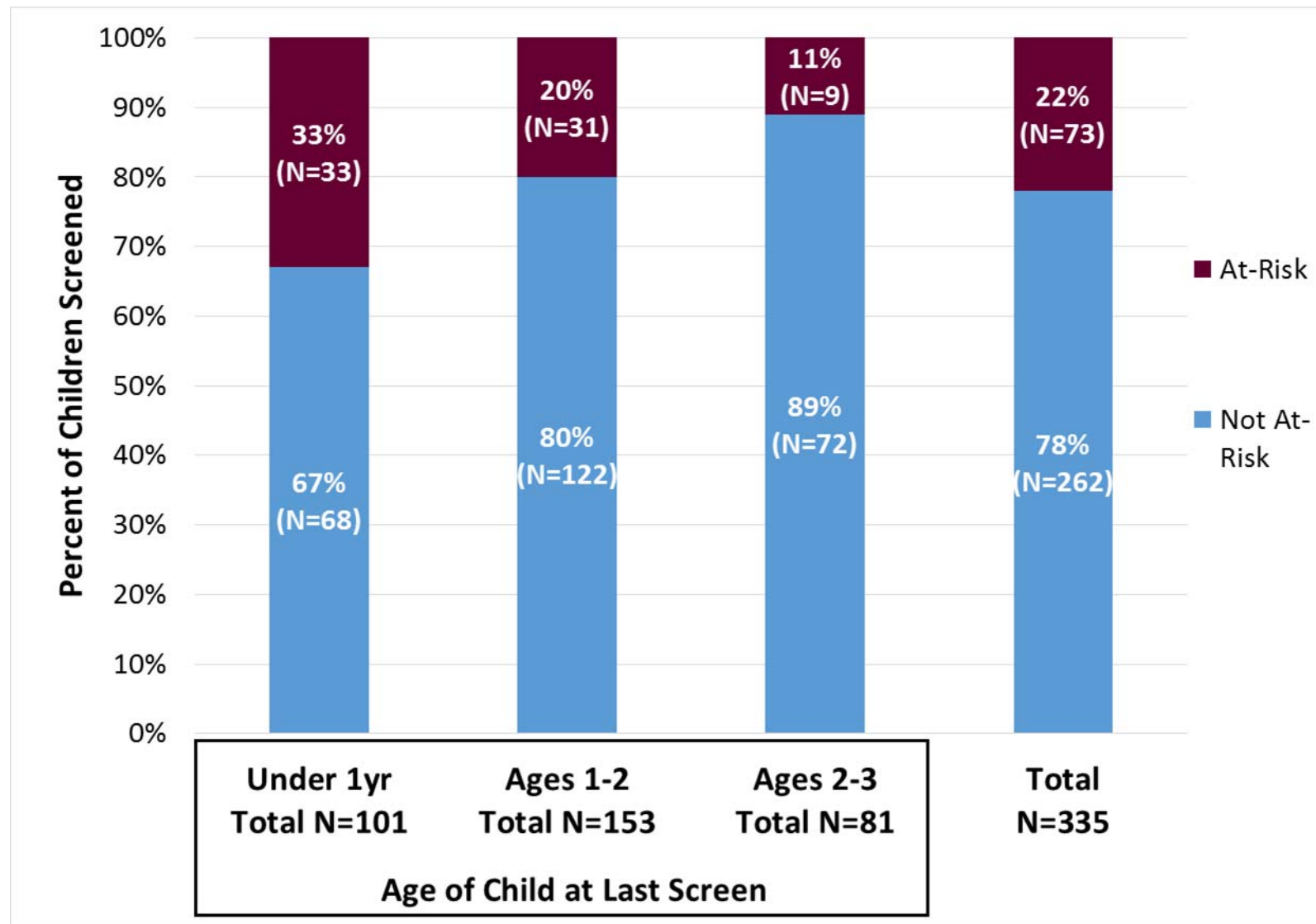
Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented in the EMR. If a child had multiple screens, the most recent screen result was used to determine risk level.

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Examining Follow-Up to Developmental Screening for Those Identified At-Risk

Aspects of **follow-up to developmental screening** able to examined in the chart, if documented in the note or referral tracked:

– Specific Referrals

o Referral to Early Intervention (Bright Futures Recommendation)

o Referral to OT/PT

o Referral to Speech Therapy (ST)

o Referral to Developmental Behavioral Pediatrician (Bright Futures Recommendation)

o Referral to External Mental Health

Follow-Up Steps **Not Included** in Baseline Data Due Documentation Barriers

o Developmental Promotion

o Rescreen of child (Assumed done at every visit, however a schedule of an earlier visit would be recommended for two year olds)

o Internal mental health

o Referrals to of other resources: CaCoon/Babies First/Home Visiting, Health Families, Head Start, Parent Child Interaction Therapy, and Parenting Classes

Follow-Up Documented in Chart:
1 in 3 At-Risk Children Received Some Level of Follow-Up
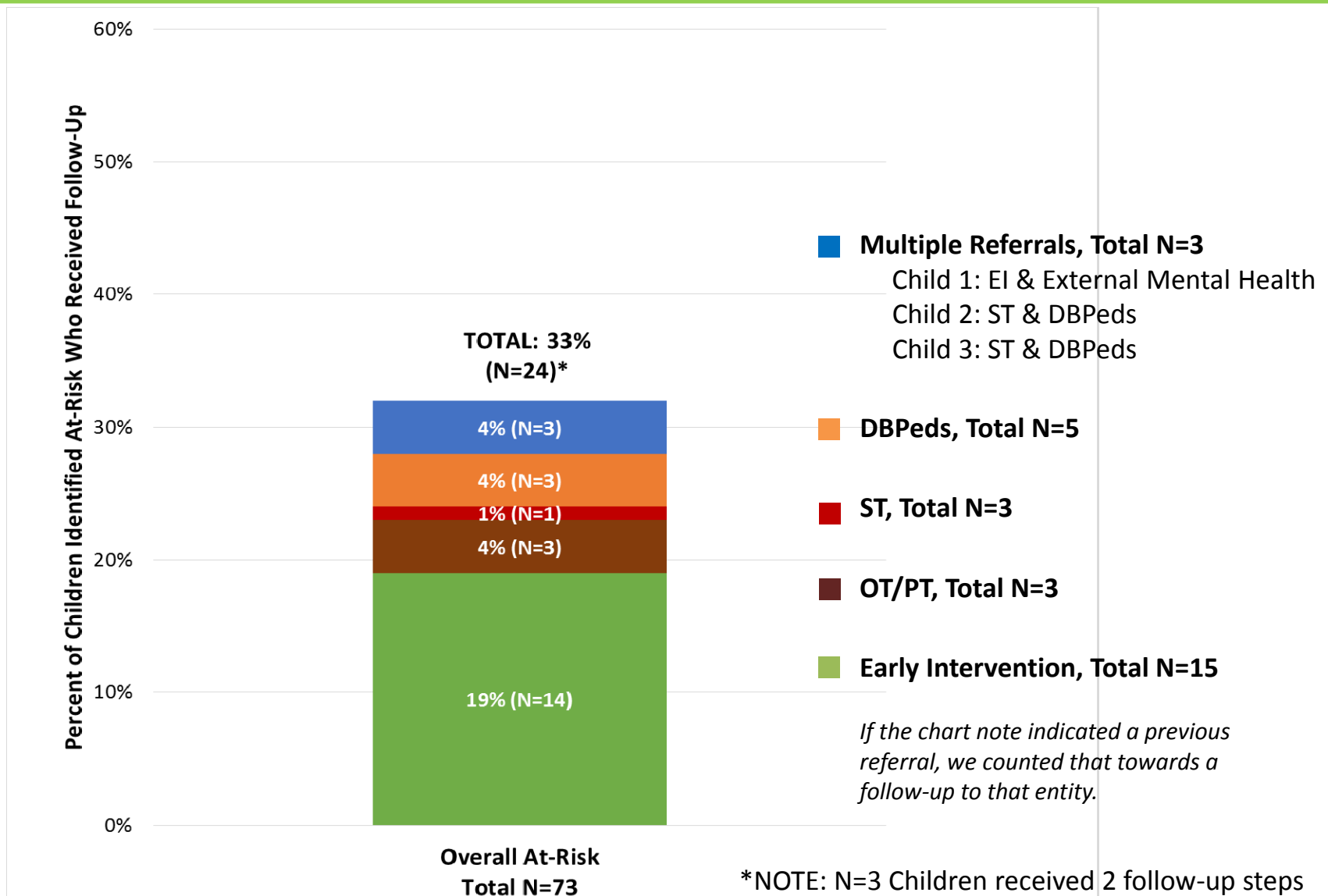
Percent of Children Identified At-Risk Who Received Follow-Up

TOTAL: 33%
(N=24)*

4% (N=3)
4% (N=3)
1% (N=1)
4% (N=3)

19% (N=14)

Overall At-Risk
Total N=73

Multiple Referrals, Total N=3
Child 1: EI & External Mental Health
Child 2: ST & DBPeds
Child 3: ST & DBPeds

DBPeds, Total N=5

ST, Total N=3

OT/PT, Total N=3

Early Intervention, Total N=15

If the chart note indicated a previous referral, we counted that towards a follow-up to that entity.

*NOTE: N=3 Children received 2 follow-up steps

Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented in the EMR. If a child had multiple screens, the most recent screen result was used to determine risk level. Documented follow-up based on chart review.

45

OPIP

Follow-Up for At-Risk Children Documented in Chart: By Levels of Risk Identified

Percent of Children Identified At-Risk Who Received Follow-Up

Overall At-Risk
Total: 33% (N=24)*
- 4% (N=3)
- 4% (N=3)
- 1% (N=1)
- 4% (N=3)
- 19% (N=14)

Overall At-Risk Total N=73

Specific Levels of Risk Identified on the ASQ

3-5 Domains in Black Total N=7
Total: 14% (N=1)
- 14% (N=1)

2 Domains in Black Total N=9
Total: 33% (N=3)
- 11% (N=1)
- 22% (N=2)

1 Domain in Black Total N=35
Total: 43% (N=15)*
- 9% (N=3)
- 9% (N=3)
- 3% (N=1)
- 3% (N=1)
- 20% (N=7)

2+ Domains in Grey ONLY Total N=22
Total: 23% (N=5)
- 23% (N=5)

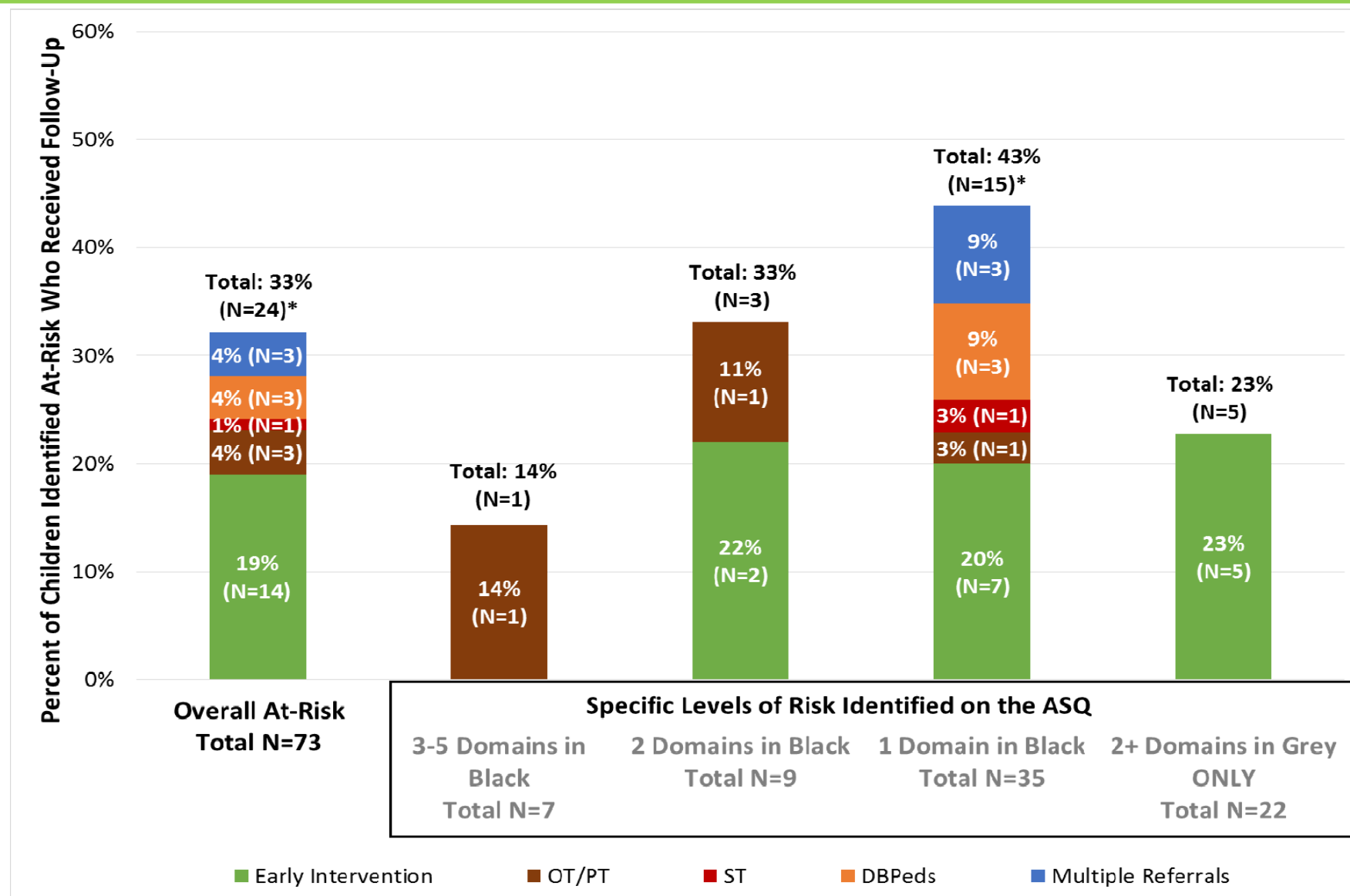Legend: ■ Early Intervention ■ OT/PT ■ ST ■ DBPeds ■ Multiple Referrals

Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented in the EMR. If a child had multiple screens, the most recent screen result was used to determine risk level. Documented follow-up based on chart review.

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OPIP

Examining Quantitative Data to Understand
The Pathway of Screening to Services for Young

- **Population of Focus for the Project:** <u>Children 0-3</u> identified on developmental screening tools as at-risk for developmental, behavioral or social delays
Data

- **Data Available That will be Examined**

  1. <u>Census Data</u> – How many children 0-3

  2. **Columbia Pacific Coordinated Care Organization (<u>CPCCO</u>) for Publicly Insured (Funder)**
     - **Children covered, Continuously enrolled**
     - **Children who have a visit**
     - **Children who receive a developmental screening, according to claims submitted**

  3. **Primary Care Practice Data: OHSU Scappoose (Pilot Site)**
     - **Children practice identifies as their patient; Of those, number seen**
     - **Children who received a developmental screening**
     - **Children identified at-risk on developmental screen**
     - **Children identified at-risk who received follow-up**

  4. **Early Intervention: According to Bright Futures Data, A Referral for All Children Identified At-Risk (A Pilot Site)**
     - **Referrals**
     - **Referred children able to be evaluated**
     - **Of those evaluated, eligibility**

  5. **Pilot Early Learning Provider(Tracking data will be collected for pilot sites to evaluate pilot)**

OPIP

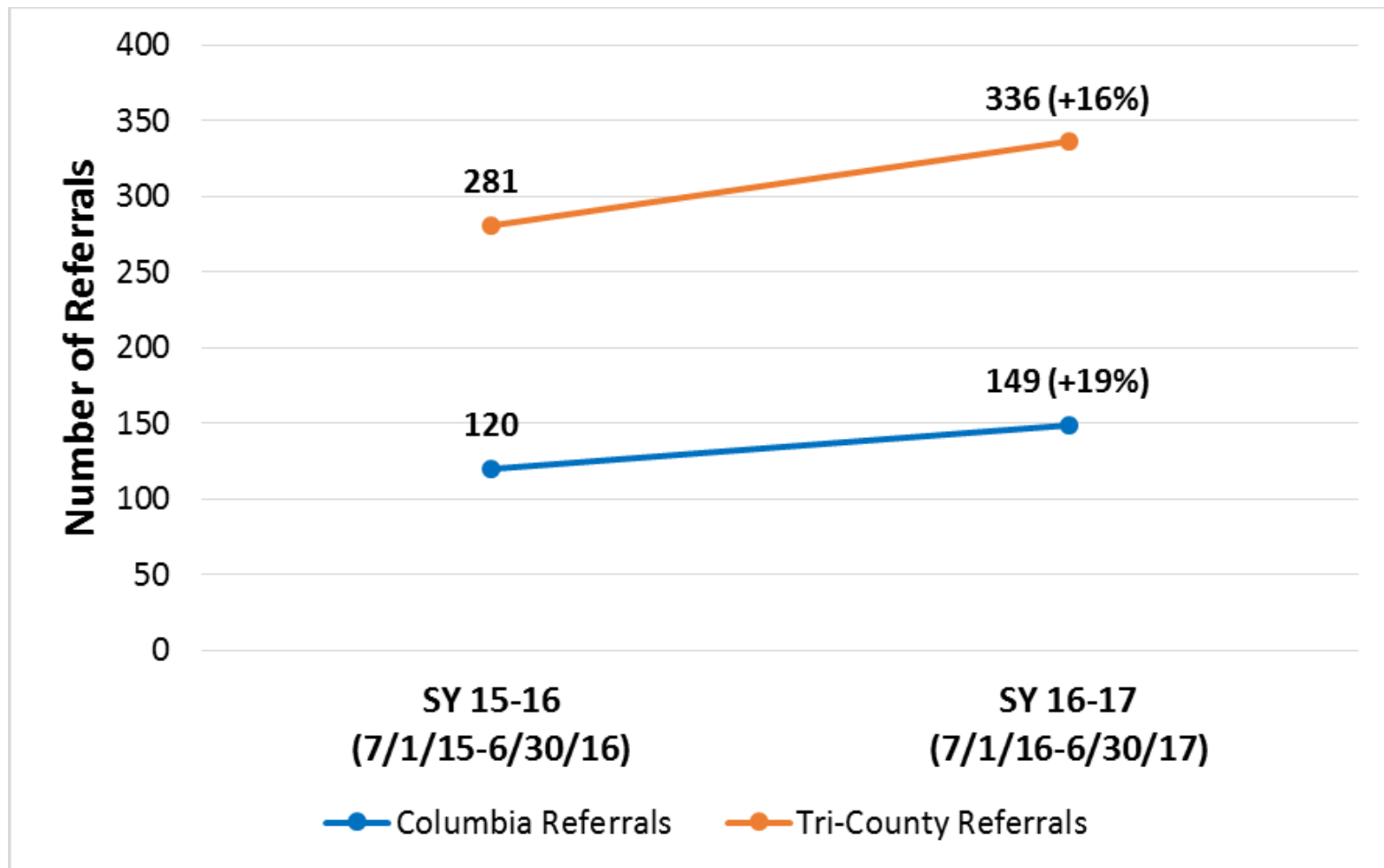# Value of Data from NWRESD on Early Intervention to Inform This Pilot

#1: Indication of Follow-Up to Developmental Screening

- Bright Futures (BF) recommends that all young children identified **at-risk for developmental, behavioral and social delays** on a developmental screening tool (*aka the focus of this project*) **should be referred to Early Intervention** at a minimum
  - EI referrals & children served by EI is an indication of **referral and follow-up**
    - If **increases** in developmental screening **and follow-up are occurring**, then an indication of this would be:
      - ✓ **Increase in referrals** and/or
      - ✓ Increase in **referred children found eligible** (indication of better of referrals)
  - Acknowledgement of **issues with the BF Recommendation**, given realities of administration in primary care practice AND Oregon's EI **eligibility criterion**
    - Value of descriptive data about **kids that fail the ASQ that are then found ineligible for EI**

#2: Data to Inform Processes for At-Risk Children, But EI Ineligible

- A proportion of **at-risk children** referred to EI, will be found ineligible
  - The goal for this project is to ensure that at-risk children receive follow-up
  - Therefore, a focus of this project is <u>secondary referrals of EI ineligible children</u>
    - Value of descriptive information about these ineligible in order to inform secondary and follow-up services

OPIP

Number of Early Intervention Referrals in Columbia & NWRESD Tri-County Region (Tillamook, Clatsop and Columbia)

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation

OPIP

Number of Early Intervention Referrals in Columbia vs Number of CHILDREN Referred in Columbia
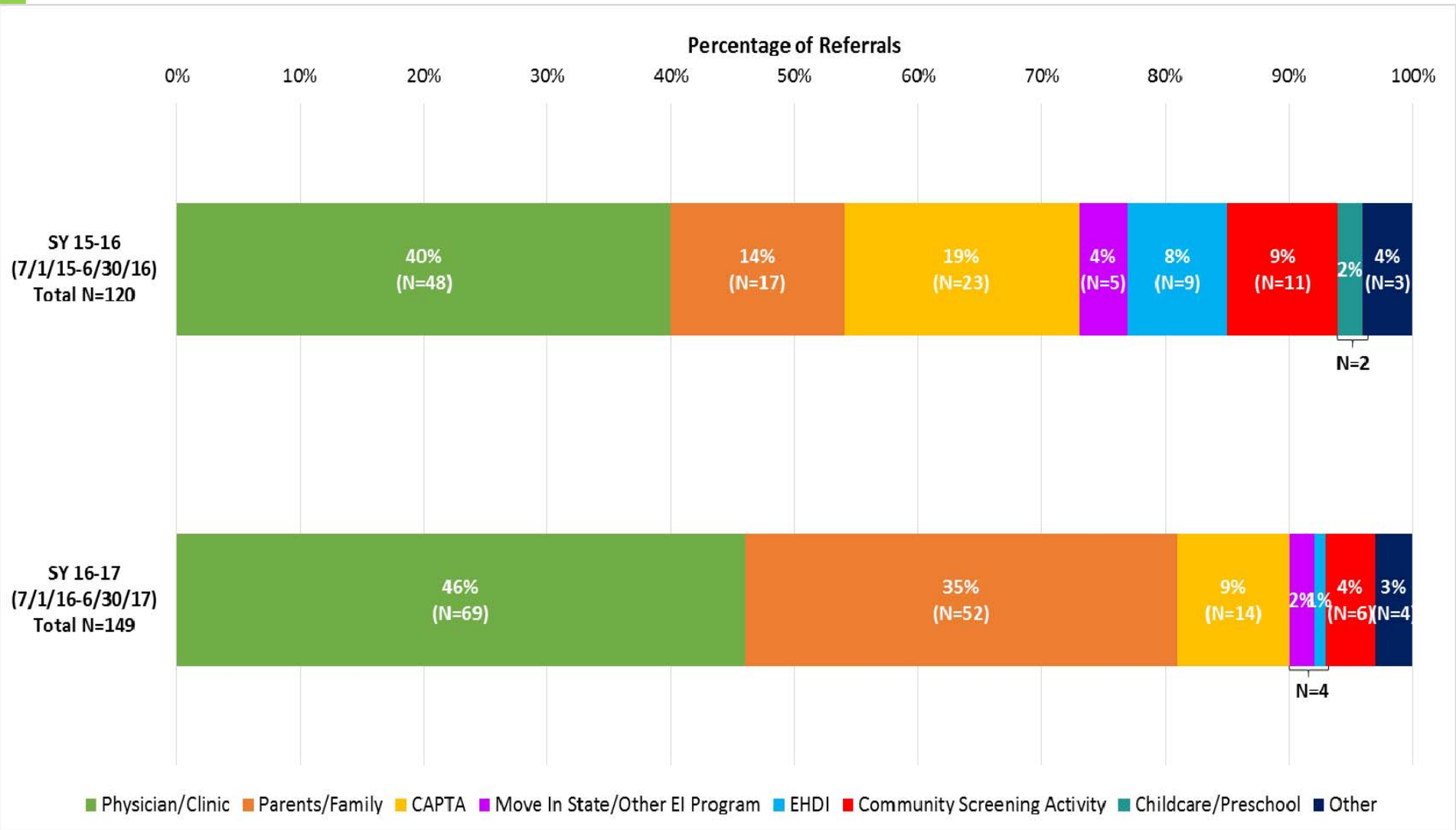
OPIP
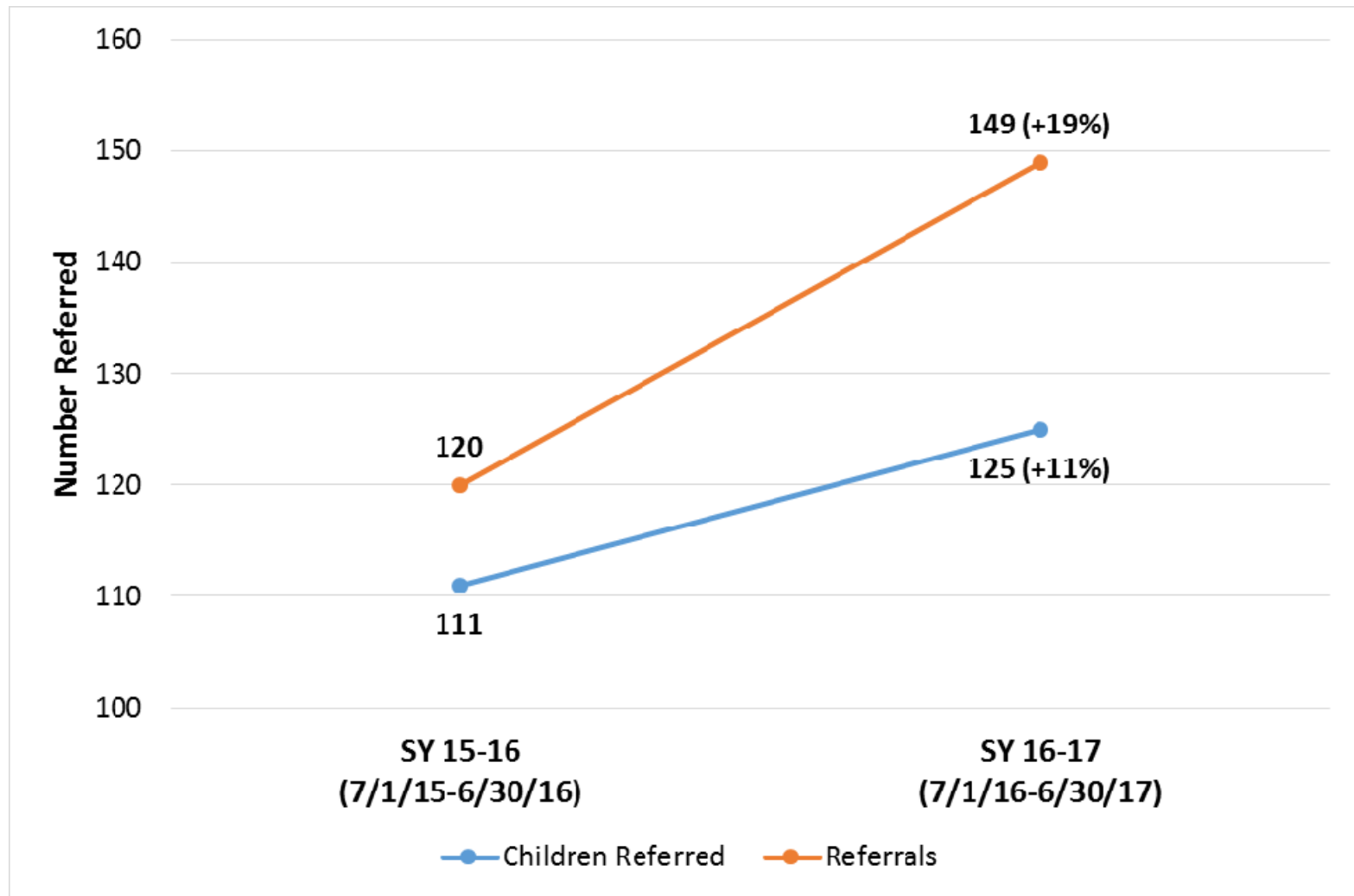
Columbia Early Intervention (EI) Referrals by Age of Child

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

OPIP
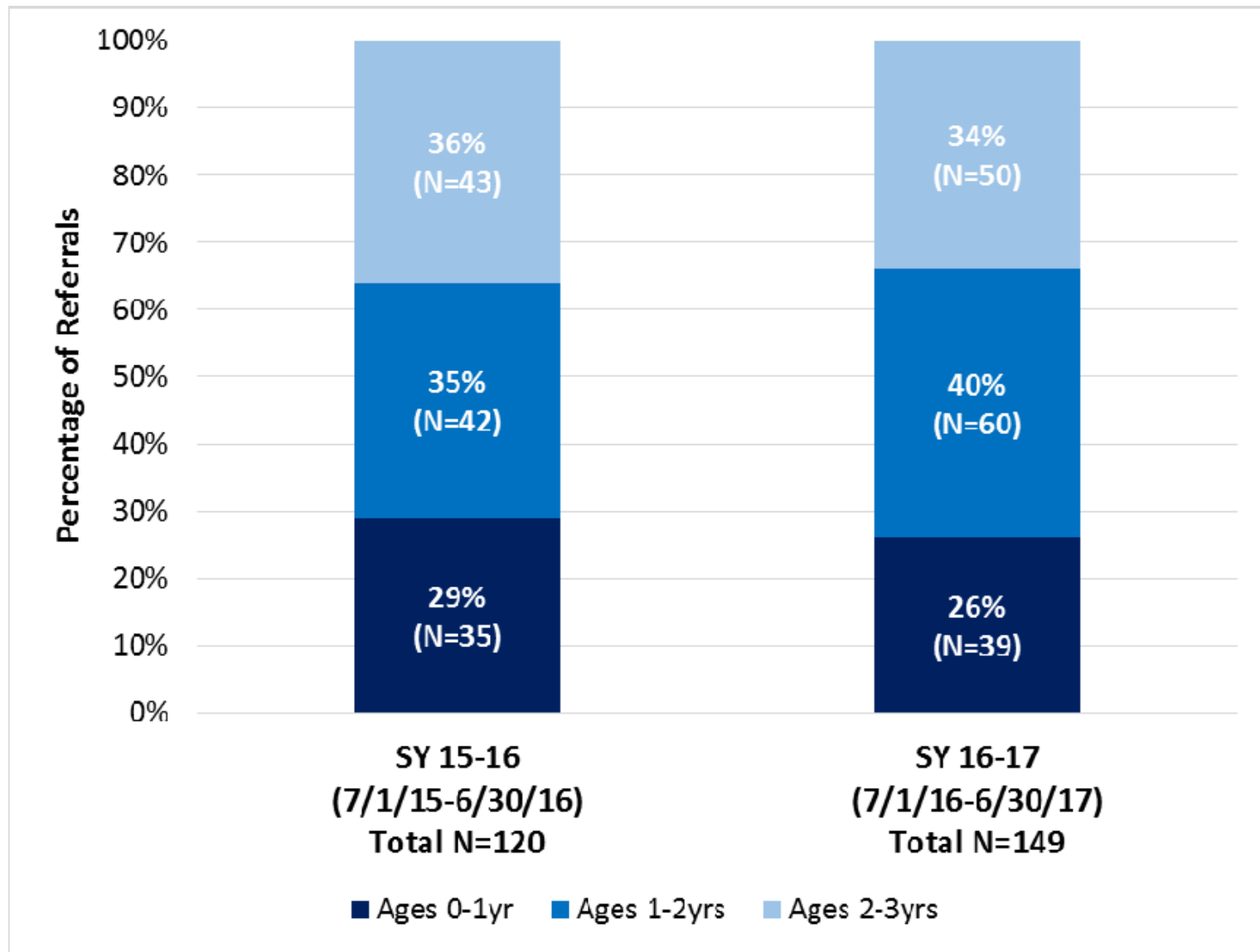
Columbia EI Referrals by Referral Source As Documented in EC Web

Percentage of Referrals

SY 15-16 (7/1/15-6/30/16) Total N=120
- Physician/Clinic: 40% (N=48)
- Parents/Family: 14% (N=17)
- CAPTA: 19% (N=23)
- Move In State/Other EI Program: 4% (N=5)
- EHDI: 8% (N=9)
- Community Screening Activity: 9% (N=11)
- Childcare/Preschool: 2% (N=2)
- Other: 4% (N=3)

SY 16-17 (7/1/16-6/30/17) Total N=149
- Physician/Clinic: 46% (N=69)
- Parents/Family: 35% (N=52)
- CAPTA: 9% (N=14)
- Move In State/Other EI Program: 2%
- EHDI: 1%
- Childcare/Preschool: N=4
- Community Screening Activity: 4% (N=6)
- Other: 3% (N=4)

Legend: Physician/Clinic | Parents/Family | CAPTA | Move In State/Other EI Program | EHDI | Community Screening Activity | Childcare/Preschool | Other

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation

OPIP

Columbia EI Referrals by Whether Child Has Medicaid
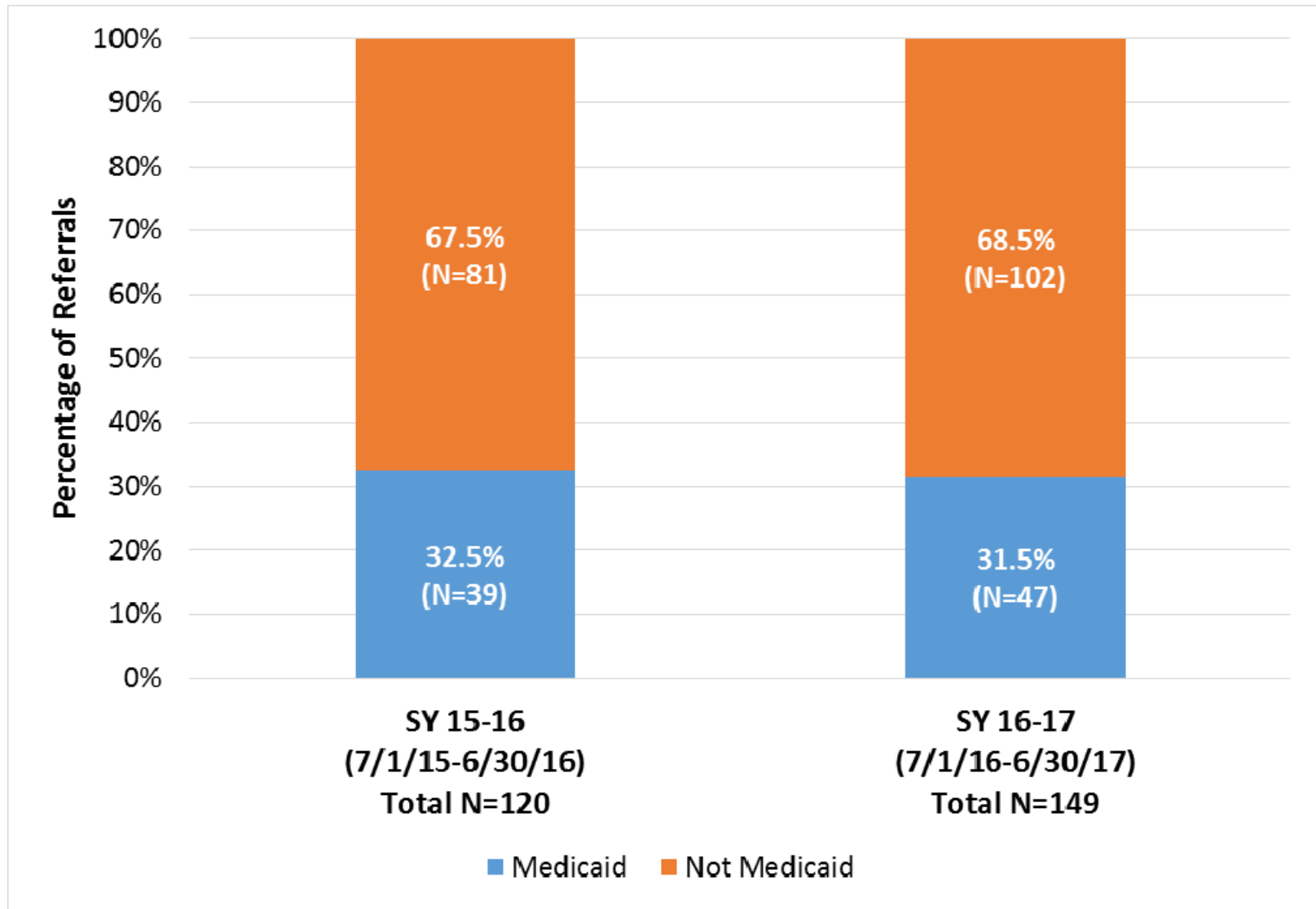
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation

Data from NWRESD on Early Intervention Referral and Evaluation Outcomes to Be Shared Today
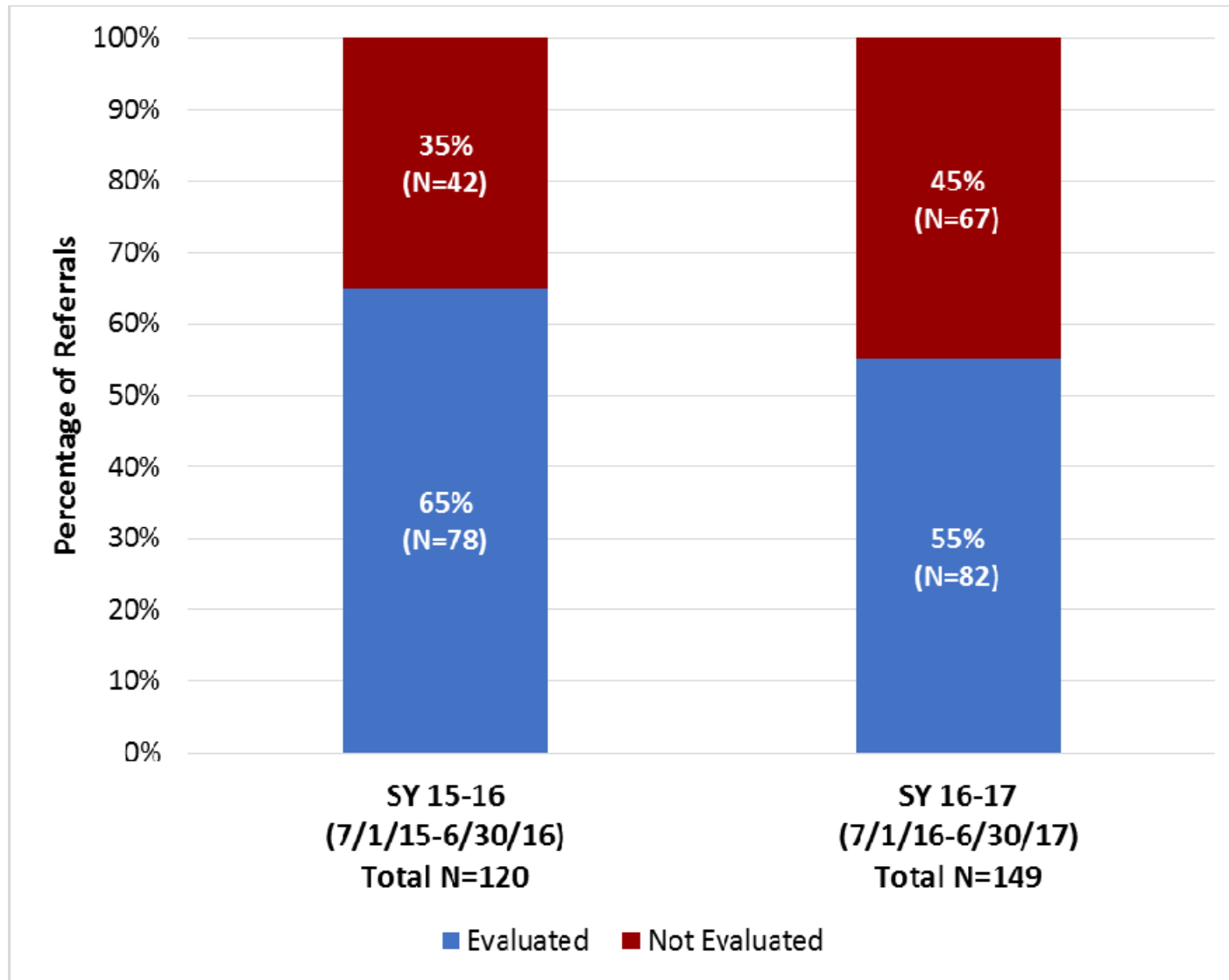
#1: Indication of Follow-Up to Developmental Screening

- Child find rates
- Numbers of Referrals
- Number of Referrals Able to be Contacted AND Evaluated
- Outcome of referrals (Eligible, Ineligible)

#2: Data to Inform Processes for At-Risk, But EI Ineligible Children

- Evaluation Outcome Results by Referral and Child Characteristics

OPIP

Percentage of Columbia EI
Referrals Able to Be Evaluated by EI

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation

OPIP

Columbia EI Evaluations By Insurance

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

Do not reproduce without proper OPIP citation

OPIP

Data from NWRESD on Early Intervention Referral and Evaluation Outcomes to Be Shared Today

#1: Indication of Follow-Up to Developmental Screening

- Child find rates
- Numbers of Referrals
- Number of Referrals Able to be Contacted AND Evaluated
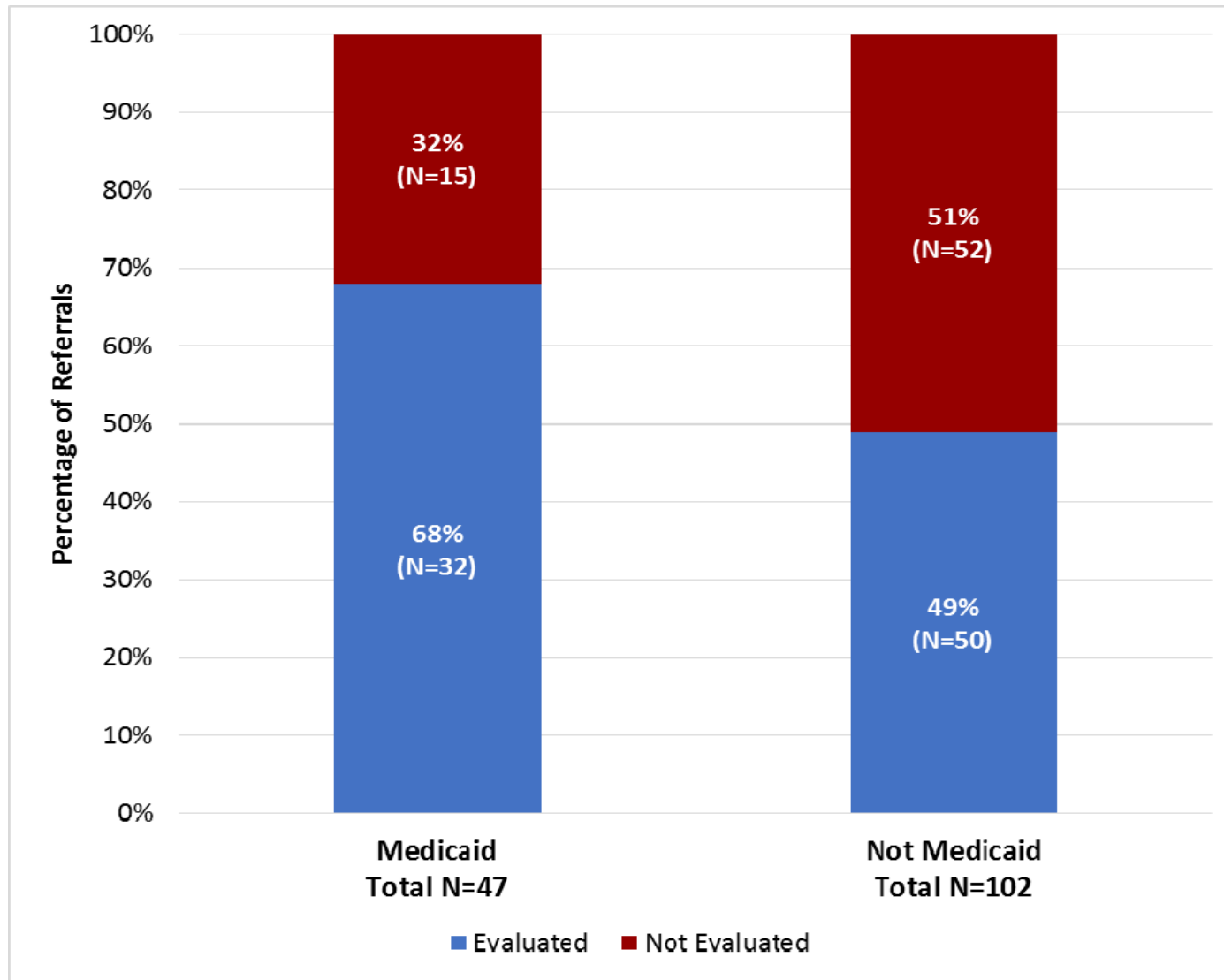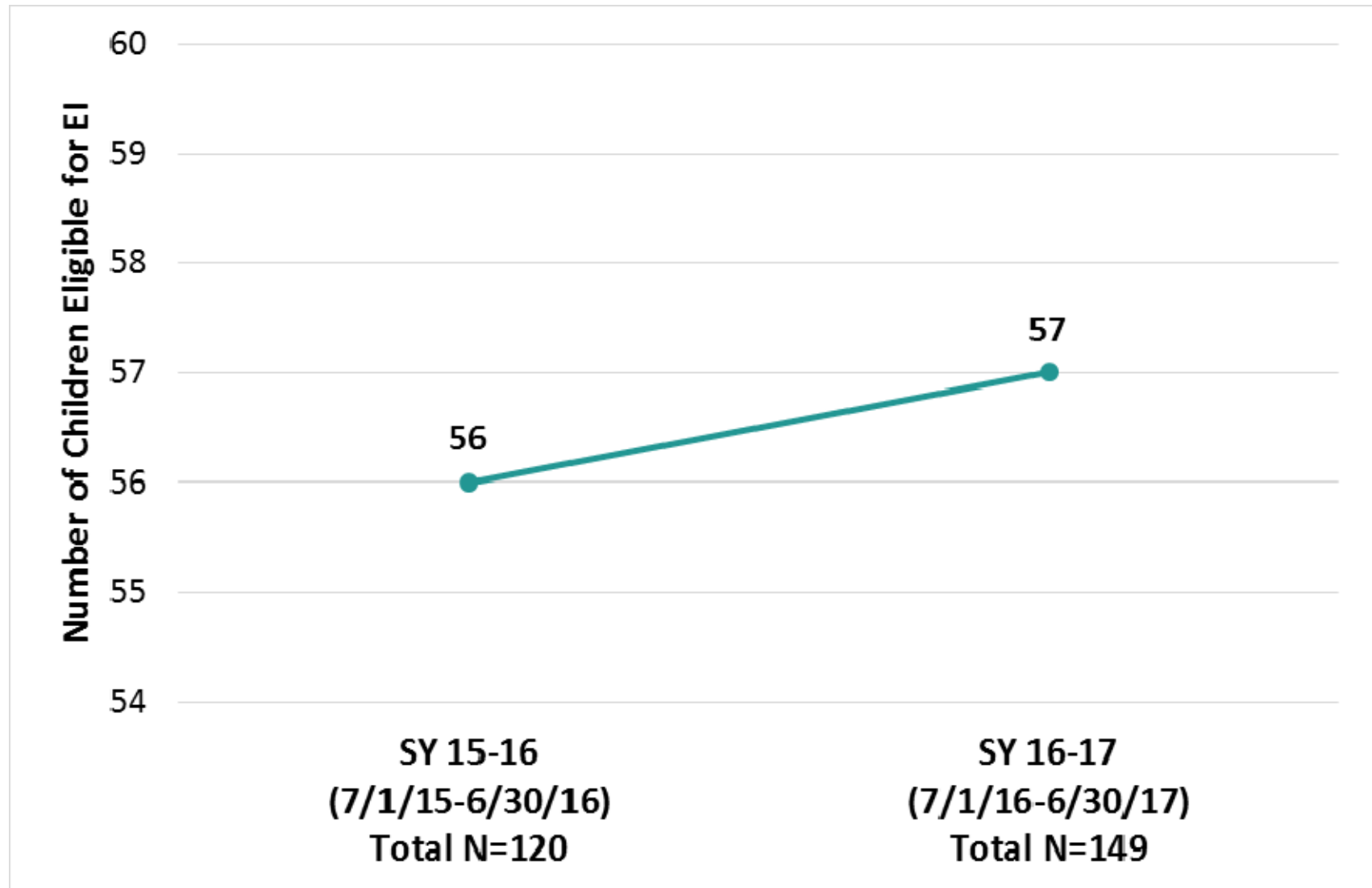- Outcome of referrals (Eligible, Ineligible)

#2: Data to Inform Processes for At-Risk, But EI Ineligible Children

- Evaluation Outcome Results and Characteristics of Ineligible

OPIP

Number of Children Found Eligible in Columbia

Percent Improvement from 2016 vs. 2017: 2% (N=1)

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

OPIP

Percentage of Columbia EI Referrals
Able to Be Evaluated & Eligible for EI

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation
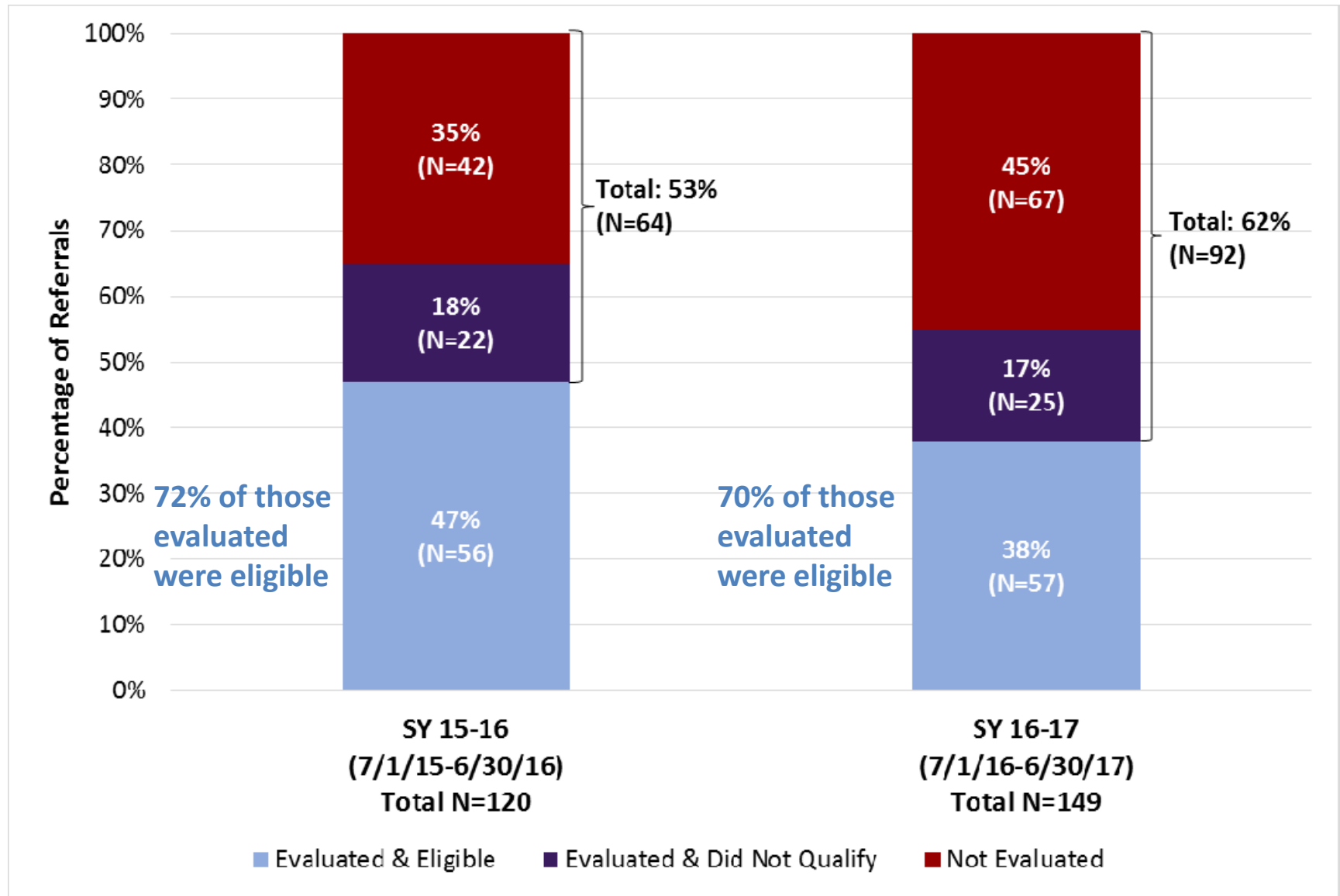
Columbia EI Referral Outcomes by Medicaid Eligibility

Percentage of Referrals

Medicaid bar (Total N=47):
- Not Evaluated: 32% (N=15)
- Evaluated & Did Not Qualify: 2% (N=1)
- Evaluated & Eligible: 66% (N=31)
- Total: 34% (N=16)
- 97% of those evaluated were eligible

Not Medicaid bar (Total N=102):
- Not Evaluated: 51% (N=52)
- Evaluated & Did Not Qualify: 24% (N=24)
- Evaluated & Eligible: 25% (N=26)
- Total: 75% (N=76)
- 52% of those evaluated were eligible

Legend: ■ Evaluated & Eligible ■ Evaluated & Did Not Qualify ■ Not Evaluated

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

OPIP

Columbia EI Referral Outcomes by Age of Child

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

OPIP
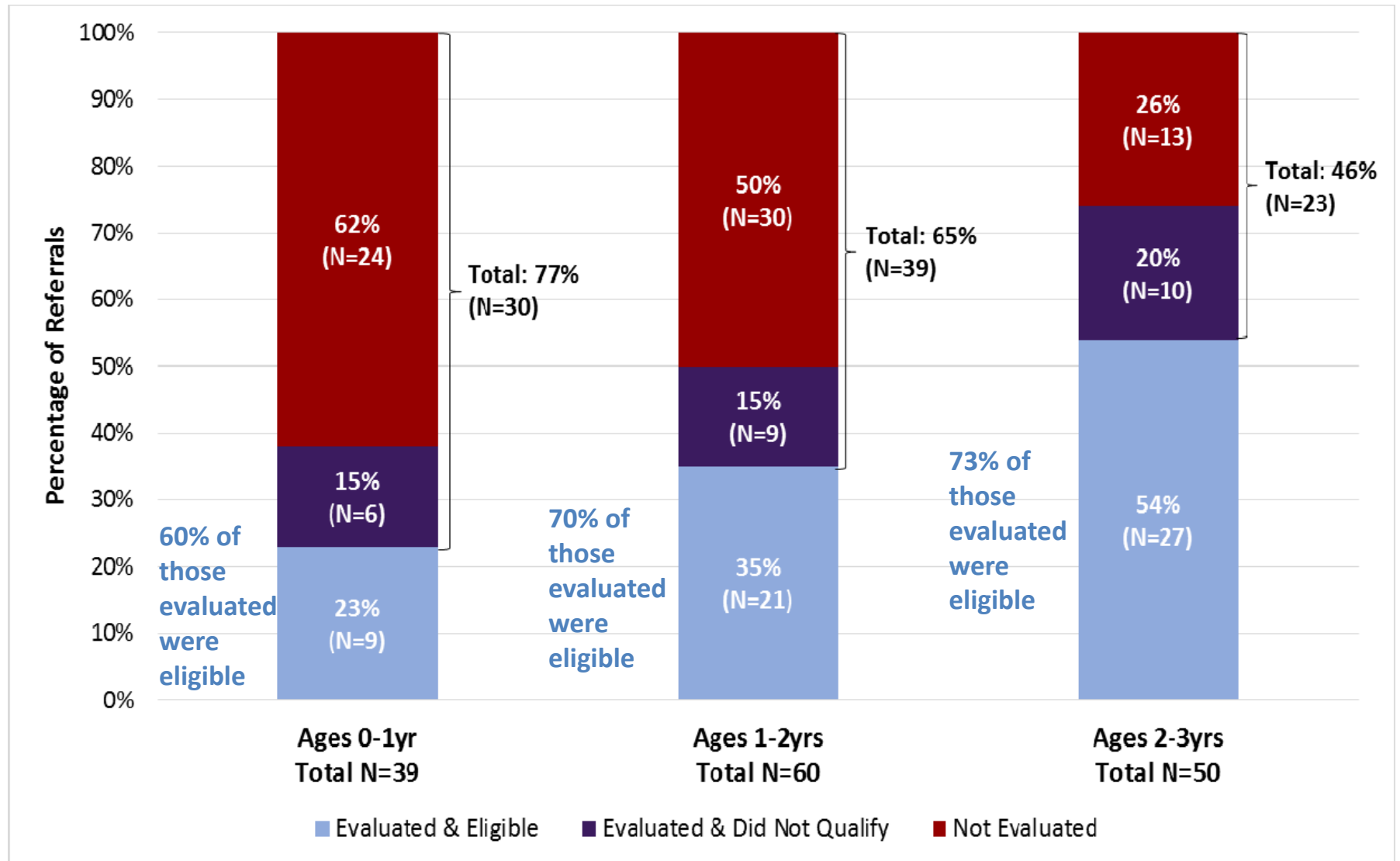
SY 16-17 Outcomes of Evaluation for Columbia By Top Referral Sources

Percentage of Referrals

Physician/Clinic Total N=69
- 35% (N=24) Evaluated & Eligible
- 9% (N=6) Evaluated & Did Not Qualify
- 56% (N=39) Not Evaluated
- Total: 65% (N=45)

Parents/Family Total N=52
- 46% (N=24) Evaluated & Eligible
- 25% (N=13) Evaluated & Did Not Qualify
- 29% (N=15) Not Evaluated
- Total: 54% (N=28)

CAPTA Total N=14
- 21% (N=3) Evaluated & Eligible
- 21% (N=3) Evaluated & Did Not Qualify
- 58% (N=8) Not Evaluated
- Total: 79% (N=11)

Community Screening Activity N=6
- 33% (N=2) Evaluated & Eligible
- 33% (N=2) Evaluated & Did Not Qualify
- 33% (N=2) Not Evaluated
- Total: 79% (N=11)

Legend: Evaluated & Eligible ■ Evaluated & Did Not Qualify ■ Not Evaluated ■

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

OPIP

If follow-up to developmental screening is occurring, the slope of the lines should be similar?
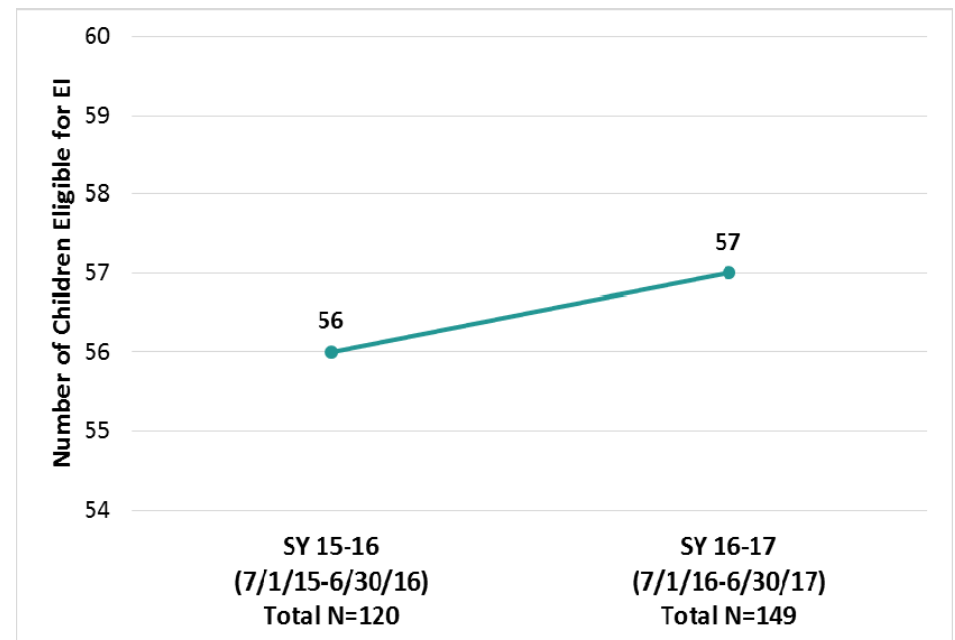
OPIP

Number of Children 0-3yrs Screened (According to 96110) in CPCCO
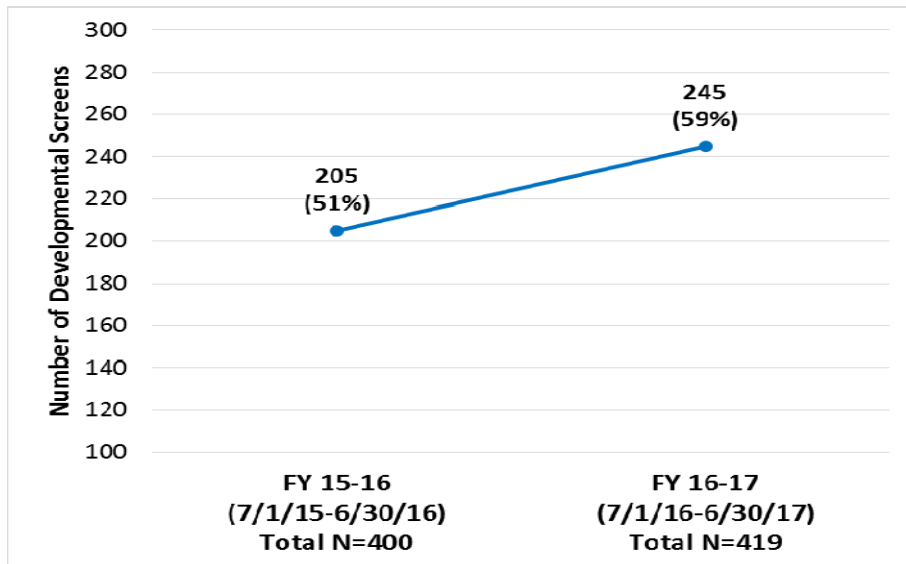
2016 vs. 2017:

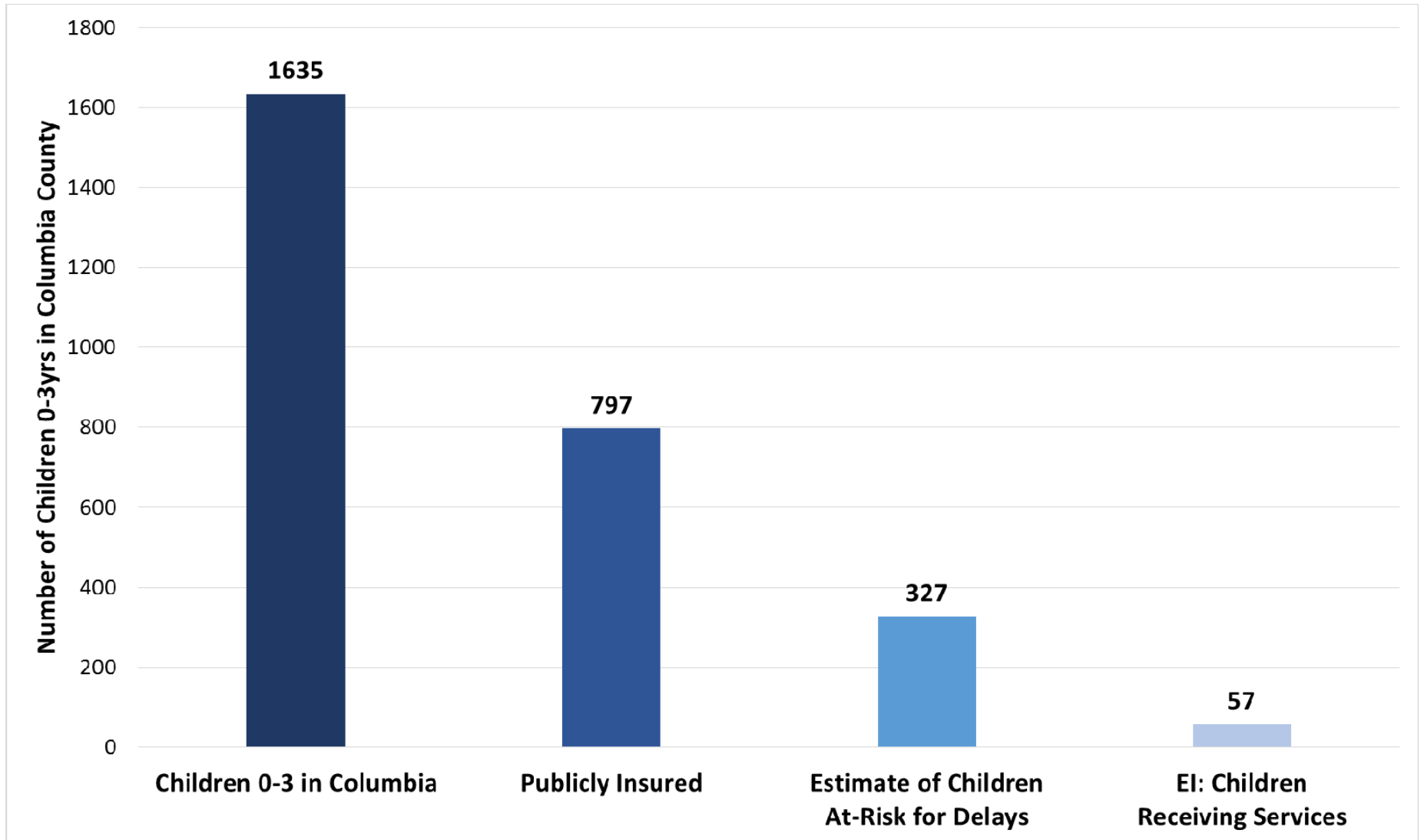**Total Improvement: 8% (N=40 Children)**

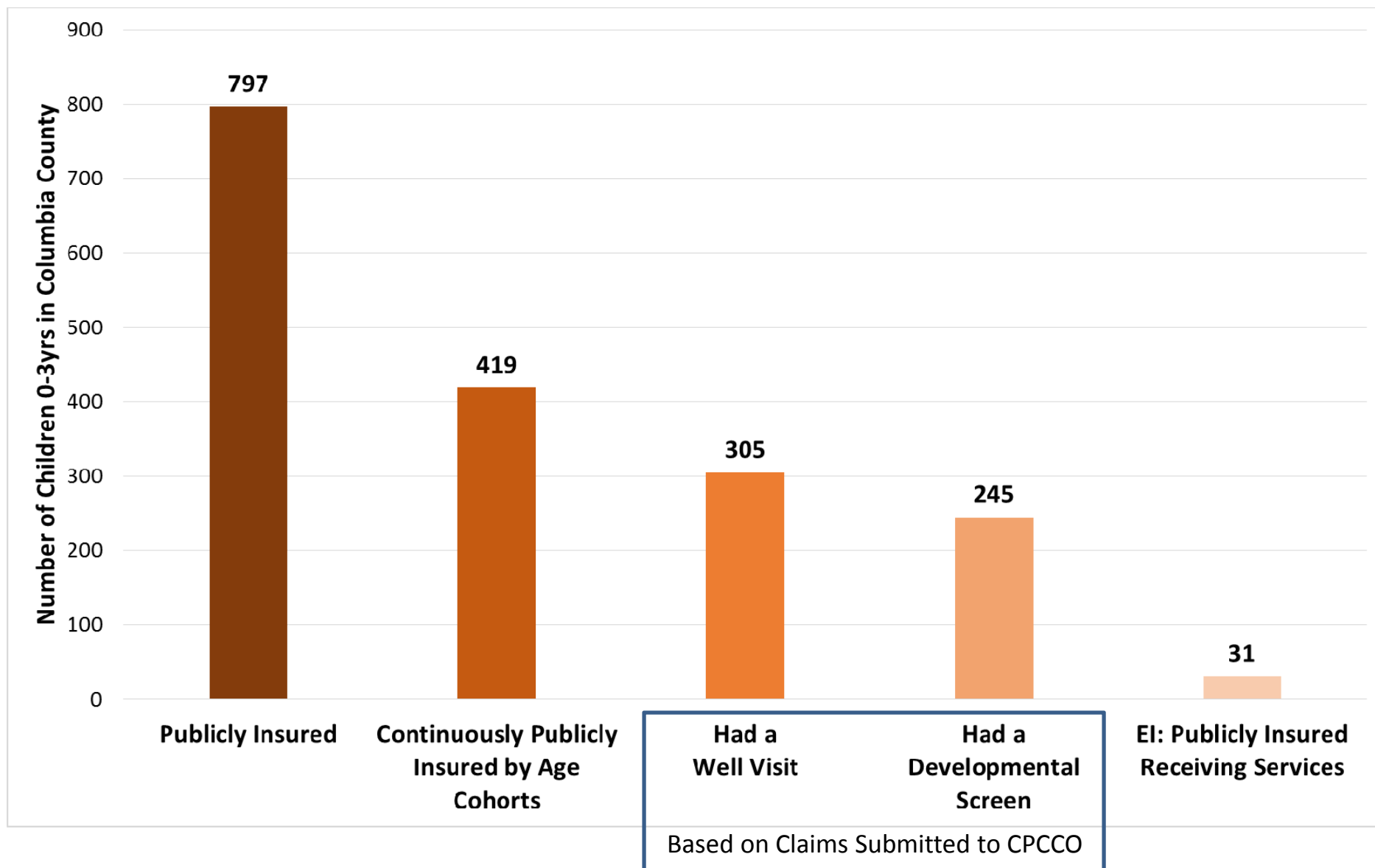**Number of Children Found Eligible To Receive EI Services in Columbia**

2016 vs. 2017:

Total Improvement: 2% (N=1 Child)

63

The Story of Young Children in Columbia County

Chart: Number of Children 0-3yrs in Columbia County

- Children 0-3 in Columbia: 1635
- Publicly Insured: 797
- Estimate of Children At-Risk for Delays: 327
- EI: Children Receiving Services: 57

The Story of PUBLICLY INSURED Young Children in Columbia County

Chart: Number of Children 0-3yrs in Columbia County

- Publicly Insured: 797
- Continuously Publicly Insured by Age Cohorts: 419
- Had a Well Visit: 305
- Had a Developmental Screen: 245
- EI: Publicly Insured Receiving Services: 31

Based on Claims Submitted to CPCCO

OPIP

Phase 2: Improvement Pilots

- Sites that will **pilot the improved processes (as defined by CPCCO project)** are:

  1. **One primary care practice** serving a large number of publicly insured children residing in this county: **OHSU Scappoose**

  2. **Early Intervention** – Northwest Regional Early Service District

  3. Priority **Early Learning Provider** identified as a priority pathway in the community for this specific population (0-3 identified at-risk on screening tool)

- Sites will receive **improvement and transformation tools**, monthly **implementation support**, and refinements to the improvement tools will be made based on lessons learned and barriers identified

  OPIP → Primary Care & Referrals from Primary Care

  NWELH → EI and Early Learning

- At the end toolkits will be developed to **spread to other stakeholders** *(e.g. other primary care practices in the region)*

NOTE: We know there are other pathways stakeholders wish existed. Focus of the project to quantify and describe needs to the funder (CPCCO) and NWELH Leadership as part of the project reports.

Proposal for Focus of Improvement Pilots in Columbia County

Part 1: Pilot Primary Care Site (OHSU)

- General education on value of developmental promotion and what makes kids ready for school
- For children identified at-risk:
  - Enhanced provision of specific developmental promotion that families can do at home
  - Enhanced referrals for best match set of services based on assets in the community & practice and child and family factors, standardization across providers
- Coordination of care and family support in accessing services

Part 2: Spread To Other Primary Care Sites Who See a Large Number of Children and Are Conducting Developmental Screening: Offer an On-Site Training

Early Intervention (NWESD-Columbia)

- For Children Referred, Not Able to be Evaluated: Enhanced communication and coordination for referred children not able to be evaluated, Outreach strategies
- For Ineligible Children: Communication Back to PCP to Inform Secondary Steps; If applicable, referral to early learning supports, pilots of referral to CCMH.
- For Eligible Children: Communication about Services Provide to Inform Applicable Secondary Supports

Early Learning

Proposal for Pathway in Early Learning to Focus Pilots of Improved Connections:

Columbia County Mental Health (CCMH) – Infant and Early Childhood Mental Health

- Pilot new ways, in collaboration with Pilot PCP & EI, to engage and connect families with mental health and PCIT

- *Breadth Strategies*
  - Strategies that engage the most number of children that engage with primary care practice
  - General communication about value of developmental promotion
  - General communication about building blocks of kindergarten readiness
  - General communication about what it means to be identified at-risk on the ASQ (Parent education sheet)

- *Depth Strategies*
  - Ensuring follow-up for children identified at-risk and most vulnerable and needing referral for follow-up
  - EI Ineligible
  - Children whose development impacted by trauma in the home or lack of attachment

- *Components of Each Improvement Pathway*
  - Standardized referral
    - ✓ How (Referral Form)
    - ✓ Information to inform warm referral
  - Two-Way Communication and Feedback Loops for All Referral: Whether able to contact, whether able to serve child, general outline of services

Community-Level Input on the Proposed Pilot

- Primary Care Pilot
  - Any input on the current proposed tools or strategies?
  - Any barriers we should make sure to address?
- Early Intervention Pilot
  - Any input on the current proposed tools or strategies?
  - Any barriers we should make sure to address?
- Early Learning
  - Input on the proposed pilot to CCMH?
    - What do you hope is addressed?
    - What barriers should we prepare to proactively address?

Next Steps

- Follow-up to questions or needs for additional information raised today

- Focus on the **priority pathways** discussed today, incorporating refinements noted in our discuss
  - Primary Care Pilot site improvement efforts
  - EI pilot improvement efforts
  - Mental health pilot improvement efforts
  - Asset mapping with community-based providers

- **Next Stakeholder Meeting-** April 9, 2018

Quarterly Columbia County Stakeholder Meetings: Getting Your Insight and Input on Timing

- **April 9, 2018**
  - Review draft pilot tools and strategies, get you input and insight for modifications and improvements
- Fall 2018
  - Update from the pilot, key learnings and implications for future spread, system-level issues and discussions
  - Obtain input and guidance on barriers and how to address
- Late Spring 2019
  - Update from pilot
  - Review of draft tools for Spread, Obtain Input and Guidance to Ensure Useful and Meaningful for the Community
  - Identify key learnings and implications for future spread, system-level issues and discussions

Questions? Want to Provide Input?
You Are Key to the Success of This Work

- Door is always open!

- NWELH Lead

    – Dorothy Spence: dspence@nwresd.k12.or.us

    – 503-614-1682 (office)

    – 410-227-8090 (cell)

- OPIP Contract Lead

    – Colleen Reuland: reulandc@ohsu.edu
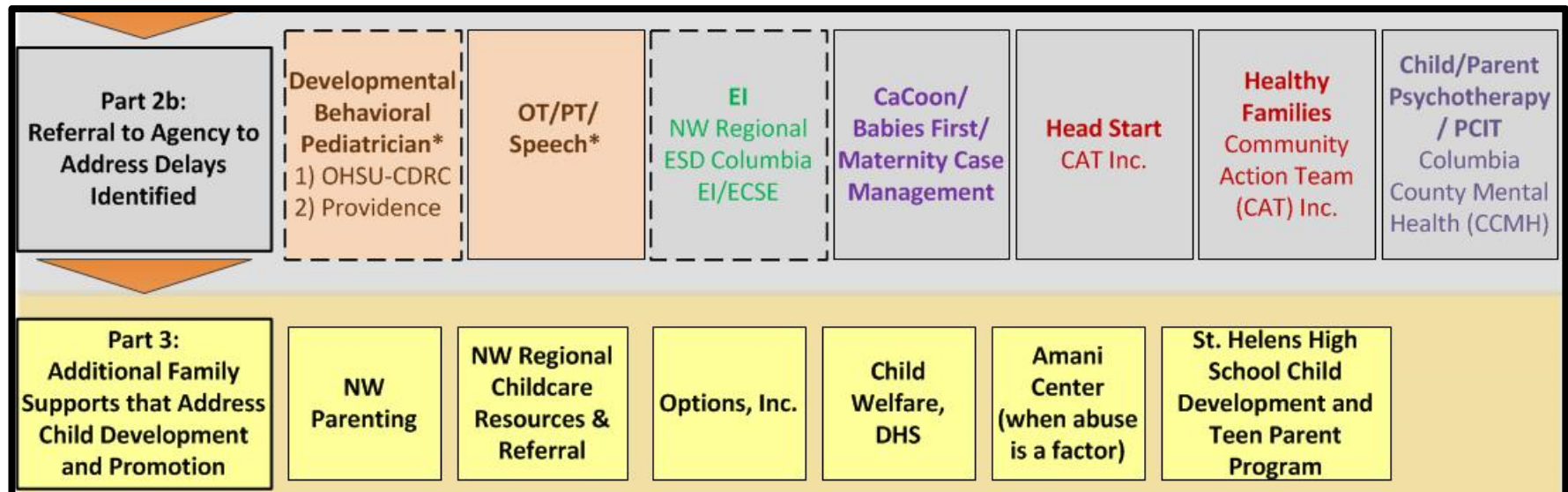
    – 503-494-0456

Slides Providing An Overview of Examples of Supports

That will be Provided:

We Will Prioritize Group Discussion Over Reviewing these Details

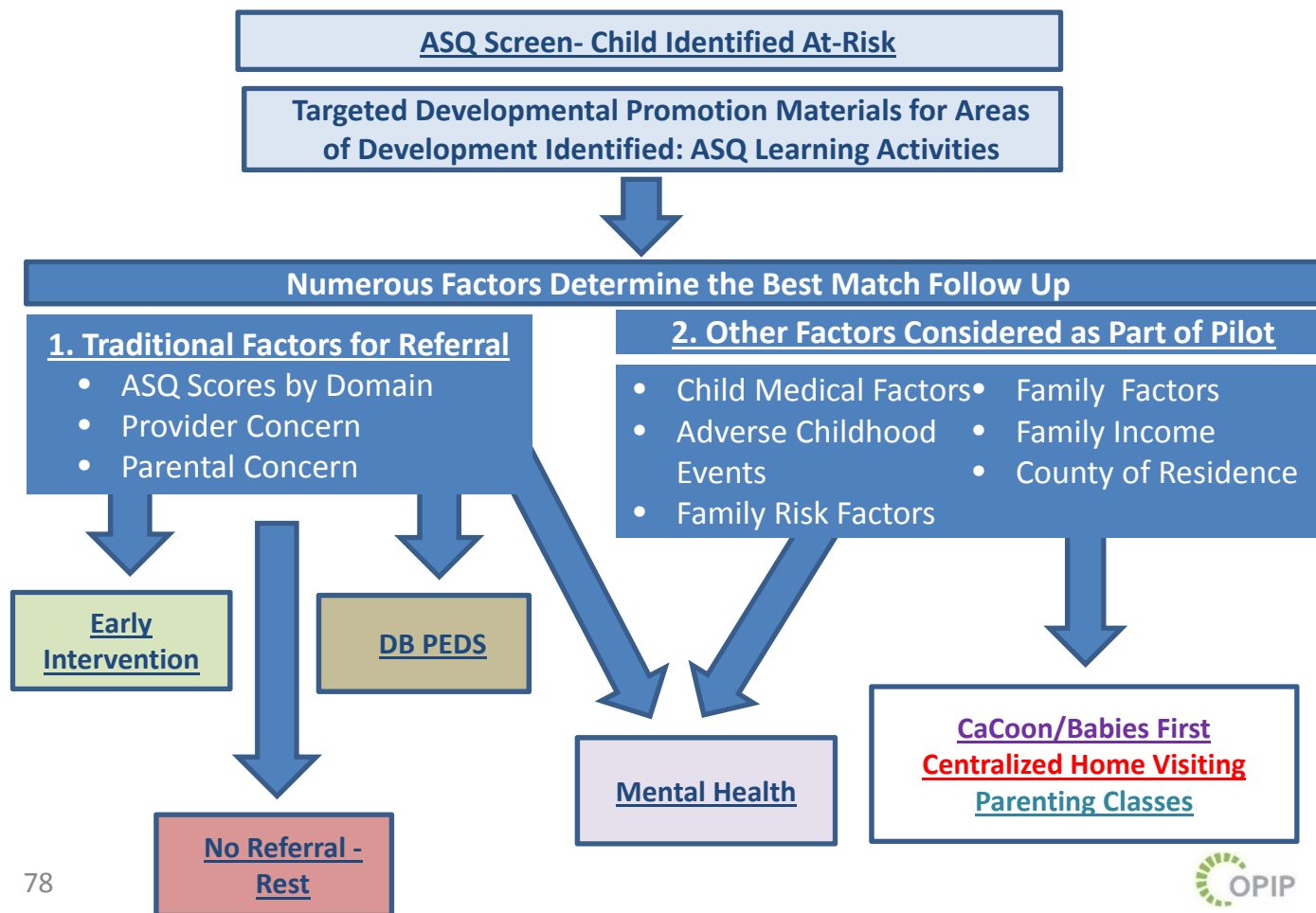# Support to Primary Care Pilot: OHSU SCAPPOOSE

- **OPIP will develop new tools to enhance promotion and follow-up for all children identified at risk:**
  - o Improved **developmental promotion activities** at the time of the visit,
  - o Education tools about concept of "kinder readiness"
  - – **Referral/Getting to Referral**- Improve workflows and processes for referral, including:
  - o Develop a medical decision tree anchored to score and child and family risk factors and mapped to resources in the community
  - o **Develop Parent education materials** to provide at the time of referral
  - o Standardized methods and processes to **support families** in the referral process, Care Coordination
  - o Develop standardized processes related to secondary referral and follow-up steps
- **OPIP Implementation Support**
  - – Improvement and implementation site visits
  - – Provider and staff trainings
  - – Communication and coordination with early learning providers in the community to identify success and barriers and problem solve
  - – Data collection and evaluation to assess impact of the improvement efforts

OPIP

Follow-Up Decision Tree for Primary Care Practices Will Map Best-Match Set of Services for Children and Families to These Services In Your Community

Part 2b: Referral to Agency to Address Delays Identified	Developmental Behavioral Pediatrician* 1) OHSU-CDRC 2) Providence	OT/PT/Speech*	EI NW Regional ESD Columbia EI/ECSE	CaCoon/ Babies First/ Maternity Case Management	Head Start CAT Inc.	Healthy Families Community Action Team (CAT) Inc.	Child/Parent Psychotherapy / PCIT Columbia County Mental Health (CCMH)

Part 3: Additional Family Supports that Address Child Development and Promotion	NW Parenting	NW Regional Childcare Resources & Referral	Options, Inc.	Child Welfare, DHS	Amani Center (when abuse is a factor)	St. Helens High School Child Development and Teen Parent Program

OPIP

Example of Medical Decision Tree from Past Projects

Determining the "Best Match" Follow Up for the Child and Family Which Included Promotion FIRST and Then, Where Applicable, Referral

ASQ Screen- Child Identified At-Risk

Targeted Developmental Promotion Materials for Areas of Development Identified: ASQ Learning Activities

Numerous Factors Determine the Best Match Follow Up

1. Traditional Factors for Referral
- ASQ Scores by Domain
- Provider Concern
- Parental Concern

2. Other Factors Considered as Part of Pilot
- Child Medical Factors
- Adverse Childhood Events
- Family Risk Factors
- Family Factors
- Family Income
- County of Residence

Early Intervention

DB PEDS

Mental Health

CaCoon/Babies First
Centralized Home Visiting
Parenting Classes

No Referral - Rest

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Example of Medical Decision Tree from Past Projects

Pathways for Follow-Up to Development Screening for Children 0-3 in Marion and Polk County

Version 1.0 1/31

Figure 1.0: Decision Tree - Pilot to Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks
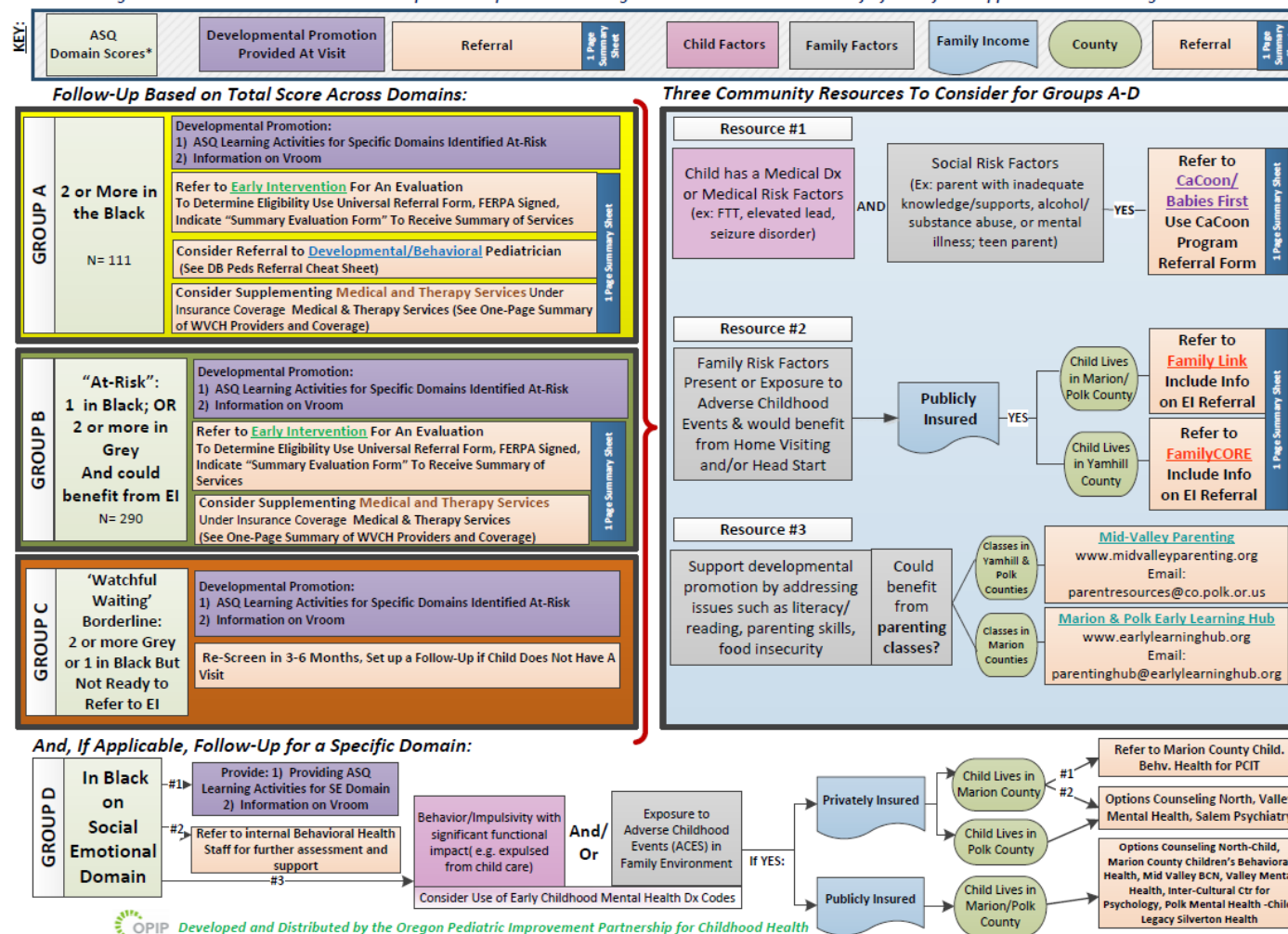
Family Supports in <u>Navigating Referrals</u>

Informed by parent advisors, developed tools and practice-level work flow processes to better support families

- **Education sheet** for parent and to support shared decision making

- **Phone follow-up** for children referred

- **Communication back from Early Intervention** when child can't be contacted, Care Coordination support from practice to reach out to the family

Follow-Up to Screening: How We Can Support Your Child

Why did we have you complete a questionnaire about your child's development?

Our goal is to help young brains and bodies develop and grow to their fullest potential. These support services can help prepare your child for kindergarten and beyond.

National recommendations call for specific tools to be used to assess a child's development, such as the one you completed. This tool helps identify kids who may be at-risk for delays. It is important to identify these delays early, as there are services that can address them.

Based on the results, we are referring your child to the services checked below:

☐ Early Intervention (EI)

EI helps babies and toddlers with their development. In your area, Willamette Education Service District (WESD) runs the EI program.

EI focuses on helping young children learn skills. EI services enhance language, social and physical development through play-based interventions and parent coaching. There is no charge (it is free) to families for EI services.

What to expect if your child was referred to EI:

- WESD will call you to set up an appointment for their team to assess your child.

- If you miss their call, you should call back to schedule a time for the evaluation. They have a limited time to set up the appointment. Their phone number is (503) 385-4714.

- The results from their assessment will be used to determine whether or not EI can provide services for your child.

Contact Information:
Tonya Coker, EI Program Coordinator
503-385-4586 | www.ode.state.or.us

☐ Parenting Support

Classes located in Marion County
Veronica Mendoza-Ochoa
(503) 967-1183
earlylearninghub.org

Classes located in Polk County
(503) 623-9664
midvalleyparenting.org

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☐ Family Link

Family Link connects families with early childhood family support programs in Marion and Polk Counties. There is no charge (it is free) to families for Family Link services.

What to expect if your child was referred to Family Link:

The Family Link Referral Coordinator will call you to learn more about your child and family. They will work with you to find available services that best meet your needs, and link you to them based on eligibility.

Contact: Ivette Guevara
Referral Coordinator
503-990-7431 ext.122
familylink@familybuildingblocks.org

☐ CaCoon

CaCoon is a public health nursing program serving families. CaCoon public health nurses work with your family to support your child's health and development. A CaCoon nurse will meet with you in your home, or wherever works best for you and your child. There is no charge (it is free) to families for CaCoon services.

Contact: Judy Cleave, Program Supervisor
503-361-2693
www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm

Why did you sign a consent form?

As your child's primary care provider, we want to be informed about the care your child receives so that we can provide the best care possible. The consent you signed allows the programs to share information back to us. Different programs have different consent requirements. You will likely be asked to sign more of these to give permission for different providers to communicate about your child's care.

Any Questions?

At Childhood Health Associates of Salem, we are here to support you and your child. If you have any questions about the process please call our Referral Coordinators: (503) 364-3170

Medical/Therapy Services

Your child's health care provider referred you to the following:

☐ **Speech Language Pathologist:** Specializes in speech, voice, and swallowing disorders

☐ **Audiologist:** Specializes in hearing and balance concerns

☐ **Occupational Therapist:** Specialize in performance activities necessary for daily life

☐ **Physical Therapist:** Specializes in range of movement and physical coordination

☐ **Developmental-Behavioral Pediatrician:** Specializes in child development areas including learning delays, feeding problems, behavior concerns, delayed development in speech, motor, or cognitive skills

☐ **Child Behavioral Health Services:** Specializes in mental health assessments, individual/family/group counseling, skills training and crisis intervention

☐ **Autism Specialist:** Specializes in providing a diagnosis and treatment plan for children with symptoms of Autism

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For children referred, better parent support and shared decision making

1) Sheet for parents to explain referrals to support shared decision making between primary care provider and parent

2) Phone follow-up within two days

Phone Follow-Up Script for Referred Children

Phone Follow Up within 36 Hours

Hello- May I speak with (name of patient's primary caregiver). My name is (your name) and I'm Dr. XX's (whatever your position is). Your son / daughter, (Name of child) had an appointment with Dr. XX on (time, date, location) for a well visit.

At your appointment, Dr. XX recommended that your child go to (Insert EI program Name i.e Early Intervention at Willamette Education Service District). We realize it can be overwhelming to get a lot of information about next steps at your appointment, so I wanted to call and answer any questions that you have may have had come up since then.

So what questions do you have about why Dr. XX wanted (insert child's name) to go to Early Intervention at Willamette Education Service District, or about what will happen next?

Answer questions (frequent questions or concerns highlighted in blue)

o When completing the referral, you were asked to sign the *consent form*. This gives Early Intervention permission to share information about the evaluation back to us. This helps us to provide the best care for (insert child name)

o *Why go to EI/ What does EI do*: At the appointment Willamette Education Service District will be doing a more detailed evaluation of (insert child's name) development.
Then, based on their assessment they will help us understand what we can do to support (insert child's name) and whether your child may benefit from services.

Can you think of any barriers that might come up for you and your family in getting (insert child)'s name to these services?

- Barrier is *transportation* – discuss TripLink and how to set up a ride as needed

Are there any other questions that you have or anything else I can do to help you in getting to these appointments?

If *no further questions*: Great. You should be getting a call from the Early Intervention Coordinator, their names are Sandra or Gemma, to schedule an appointment.

We are here to support you, so if you have any questions, feel free to contact (insert name) at (phone number).

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Early Intervention Support from NWELH and OPIP

- **General Quality Improvement**
  - o **Support in sharing and use of EI data** for tracking, and community level conversations (This Meeting), Quarterly tracking to assess impact of the project
  - o **EI Participation in development** of updated medical decision tree for providers
  - o **EI Participation in Tri-County EI QI calls** around improvements in data collection and processes/workflows (shared learning from work on this project): NWELH and OPIP Participation
- **Referral/Getting to Referral**- Improve workflows, including:
  - o **Communication** about whether children get into referral, and follow up steps depending on the result
- **Communication/Coordination- Improve/pilot workflows and tools** around evaluation results, eligibility, and services provided
  - o Pilot communication workflows and tools to improve communication/coordination with primary care
- **Secondary Referral- Improve/pilot workflows, tools, and processes** focused on secondary steps for children that are found to be ineligible for EI services
  - o Pilot enhanced processes and follow up steps for children found to be ineligible for EI services, particularly to CCMH.

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Proposal is to Enhance Pathways to Infant and Early Childhood Mental Health:
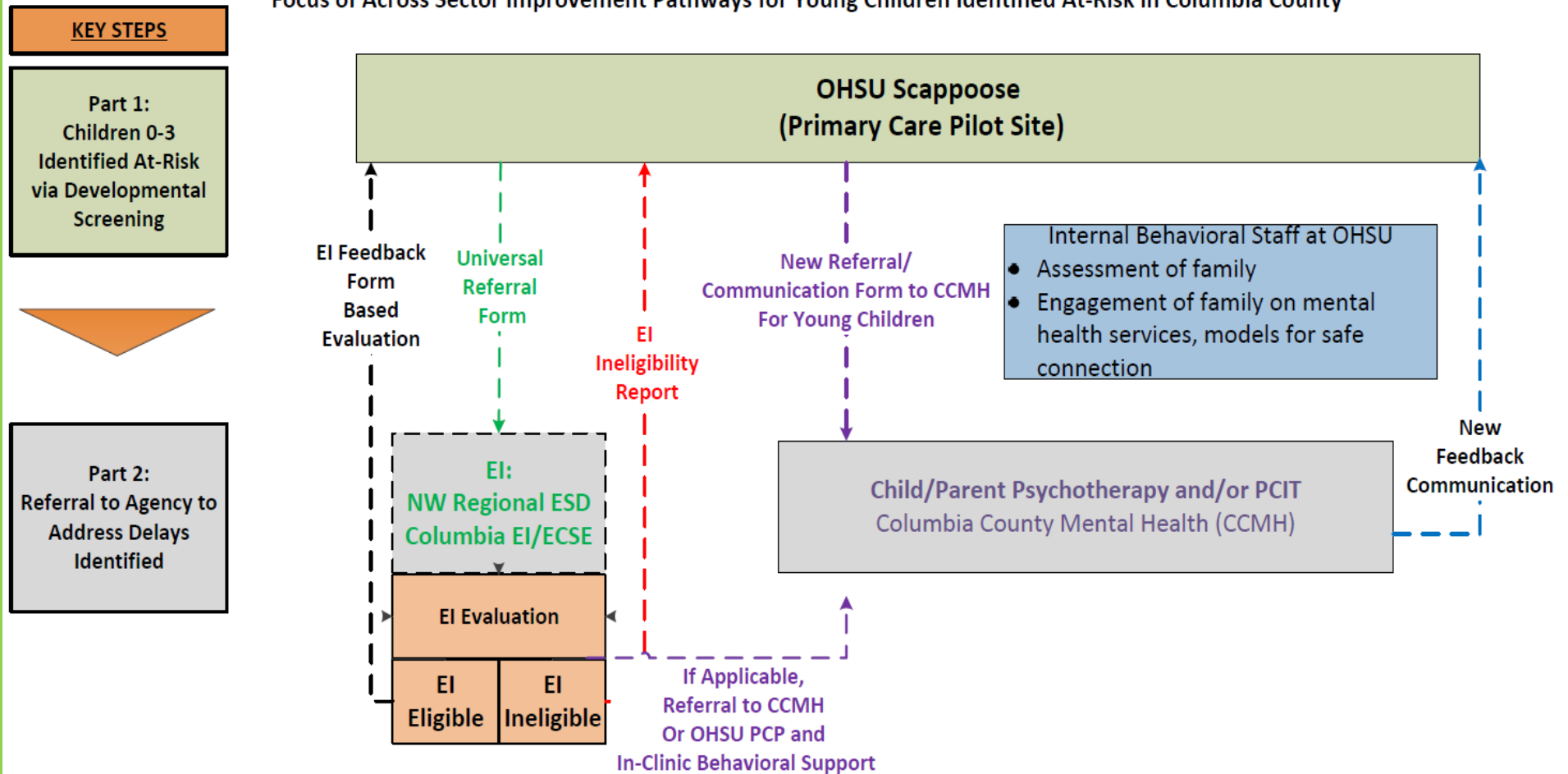
- Addresses an important high-risk population that would be identified on developmental screening and not address fully in current pathways

- Have capacity and expertise for the 0-3 population specifically

  - Child and Parent Psychotherapy

  - PCIT

- Community noted significant barriers and past poor experiences with connection to services

Pilot would include

- **Patients Centered Methods for Engagement and Referral to CCMH from Pilot Primary Care Practice to CCMH (includes secondary referrals for OHSU Scappoose in EI):**

  o **Referral processes-** pilot an improved referral process between Primary Care and CCMH, including workflow utilizing internal behavioral health resources at OHSU Scappoose implementing new processes to expedite CCMH processes, and improved collaboration between the two entities

  o **Referral processes-** pilot an improved referral process between EI and CCMH

  o **Communication/coordination with PCP-** about whether children get into referral, and follow up steps depending on the result. Improved workflows and processes

- **Implementation Support**

  - Meetings with PCP, CCMH and EI to confirm scope and opportunities for pilot

  - Development of engagement, referral and work flow processes, Parent input and insight

  - Data collection to assess impact of the pilot

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Enhanced Pathways for Children Referred by Primary Care to Early Intervention and Engagement in Mental Health

Focus of Across Sector Improvement Pathways for Young Children Identified At-Risk in Columbia County

KEY STEPS

Part 1:
Children 0-3 Identified At-Risk via Developmental Screening

Part 2:
Referral to Agency to Address Delays Identified

OHSU Scappoose
(Primary Care Pilot Site)

EI Feedback Form Based Evaluation

Universal Referral Form

EI Ineligibility Report

New Referral/ Communication Form to CCMH For Young Children

Internal Behavioral Staff at OHSU
- Assessment of family
- Engagement of family on mental health services, models for safe connection

New Feedback Communication

EI:
NW Regional ESD Columbia EI/ECSE

EI Evaluation

EI Eligible | EI Ineligible

If Applicable, Referral to CCMH Or OHSU PCP and In-Clinic Behavioral Support

Child/Parent Psychotherapy and/or PCIT
Columbia County Mental Health (CCMH)

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Early Learning Provider Pathways
Not Proposed But Valuable to Note for the Future

Additional Potential Priority Pathway Pilot (Depends on funding and collaboration of partners)

- **General messaging-** synergistic approaches to addressing existing misperceptions in the community around the importance of screening and developmental promotion in general.

- **Address Stigmas-** Community wide approaches to address existing stigmas impacting families from following through on recommendations around development.

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