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

Tillamook Stakeholder Meeting 2/7/18

Agenda

1. **Setting the Stage- Background & Context**
2. **Findings from Phase 1:**

   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 Phase 2: Based on your community-level data, OPIP proposal for where to focus the improvement pilots**
   - Pilot sites
   - Proposed pathways

   ✓ **Group-Level Input and Guidance on the Proposal**

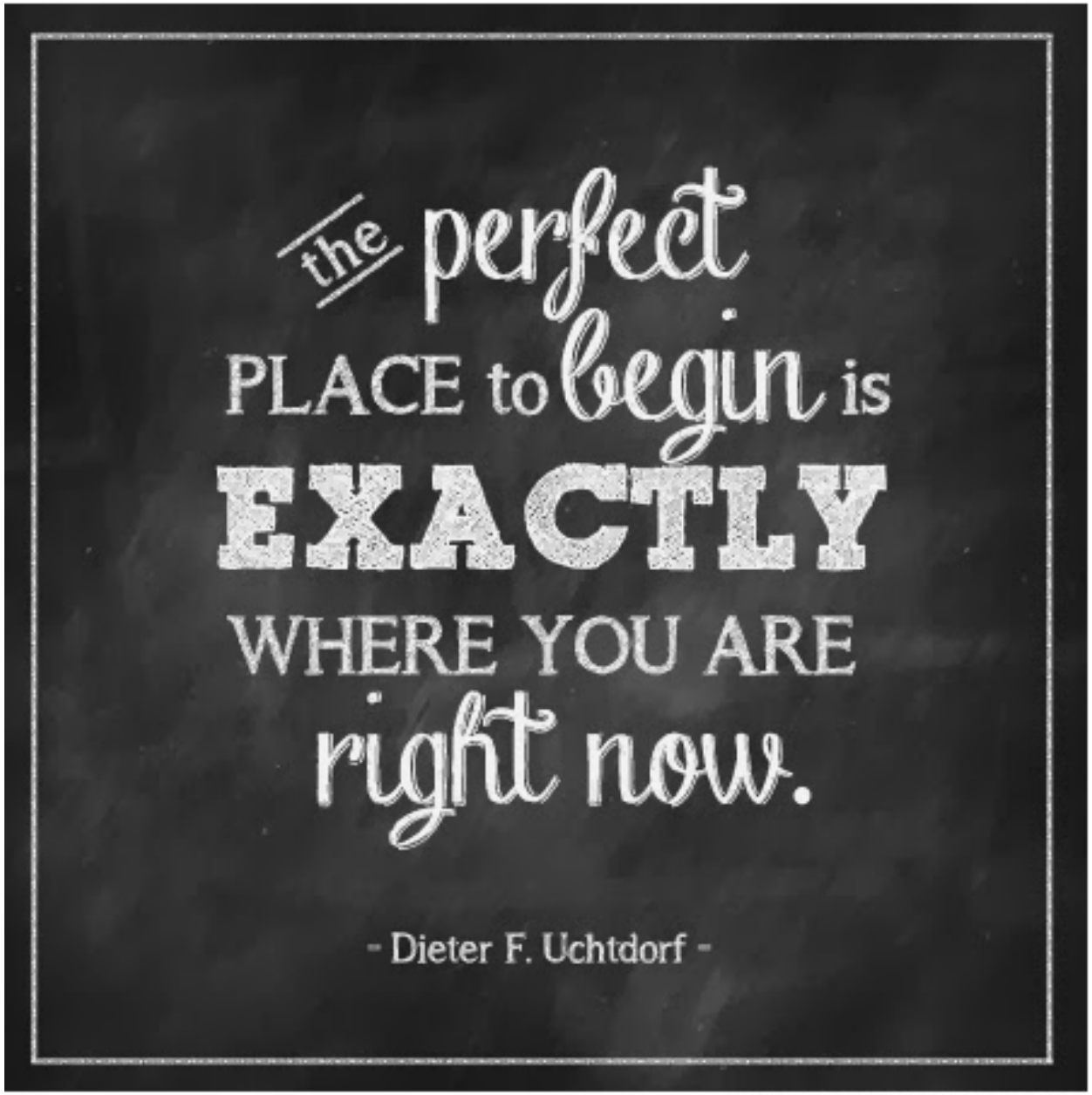
   ✓ **Confirmation of Focus for Improvement Pilot**
4. **Next Steps**

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

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: Primary Care Practice, Early Intervention (NWESD – Tillamook), Connection to Early Learning
- 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



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 Phase 1:

- Stakeholder engagement
  - Group-level meetings to gather input and guidance
  - Recruitment of parent advisors for the project
  - Individual stakeholder interviews (Qualitative data)
- Coordinated Care Organization (Quantitative Data)
- Early Intervention Data (Quantitative Data)
- Pilot Site: Primary Care Practice

Stakeholder Engagement in Tillamook County
Informing Community Asset Mapping

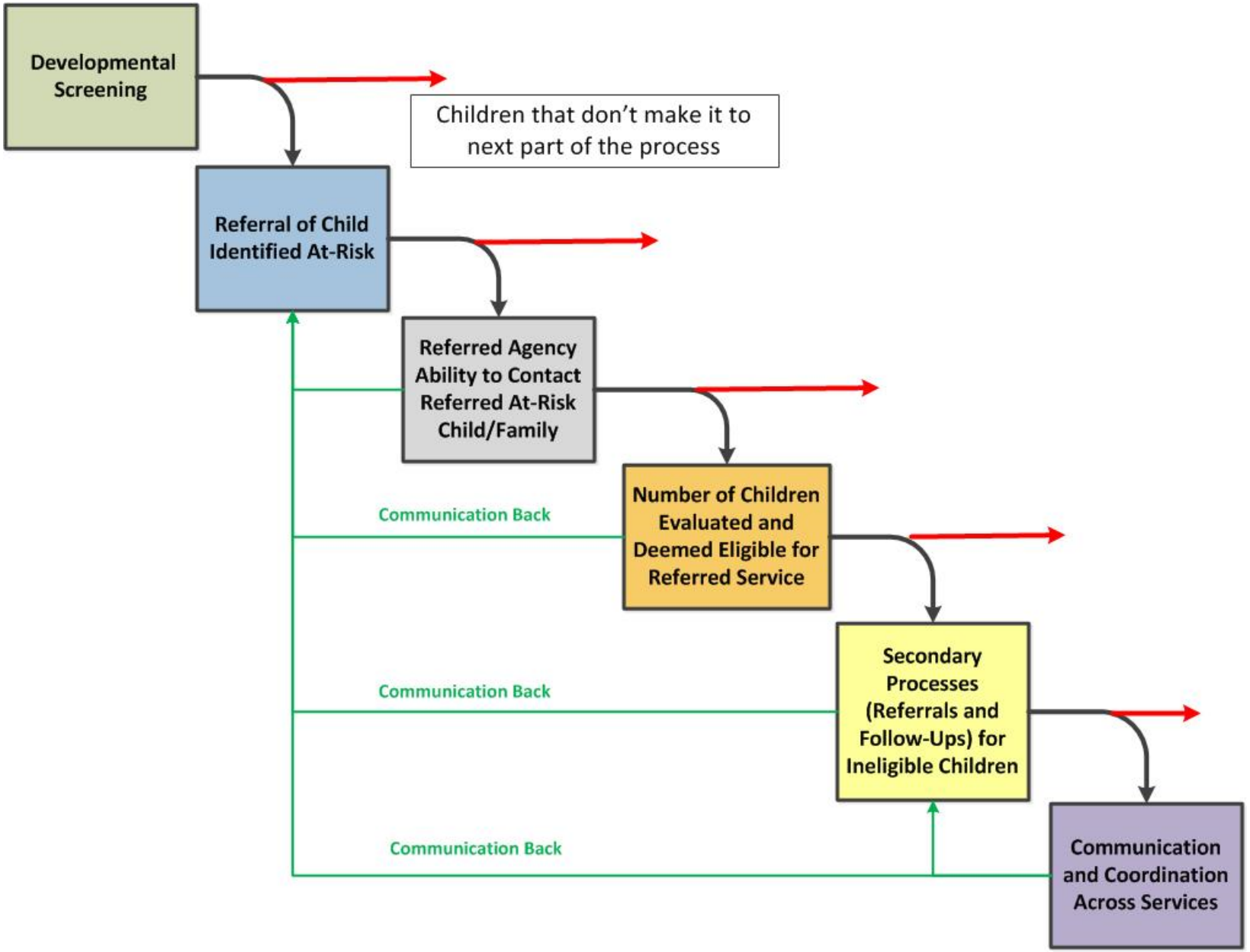
CPCCO	Primary Care	Interdisciplinary Teams that include Health Care:	EI & Education	NW Early Learning Hub	Mental Health	Home Visiting & Head Start/ Early Head Start	Child Care and Parenting Supports
Elicia Miller (Clinical Integration Manager) **Maranda Varsik** (Practice QI) **Joell Archibald** (Innovator Agent) **Nicole Jepeal** (Metrics/QI Analytics Supervisor) **Jeanne McCarty & Leslie Ford** (GOBHI)	**TCCHC** **Adventist Health –** Primary Care **Adventist Health –** Rehab Center (OT/PT and Speech) **Adventist Health -** Community health	**Community Connections-Tillamook** • Beverly Goertzen	**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** • Kim Lyon **EI Referral Intake Coordinators** • Misty Burris **EI Lead Evaluators** • Mary Anderson	**Dorothy Spence** (Hub Director) **Rob Saxton** (Governance Council Chair) **Elena Barreto** (Community Navigator) **Eva Manderson** (Early Learning Program Specialist/ Preschool Promise Manager)	**Tillamook Family Counseling Center** • Robyn Herrick • Sheila Zerngast	**Head Start & Healthy Families Home Visiting** • Joyce Ervin • Sunday Kamppi • Julie Lusby • Erin Skaar **Public Health/ CaCoon/ BabiesFirst** • Colleen Schwindt	**Childcare Centers** • Amanda Cavitt (Tillamook Early Learning Center) **NW Parenting** • DeAnna Pearl • Jill Vansant **DHS** • Nate Long • Amy Youngflesh

OPIP's Summary of Where You are Now
Related to Pathways from Screening to Services for Children 0-3

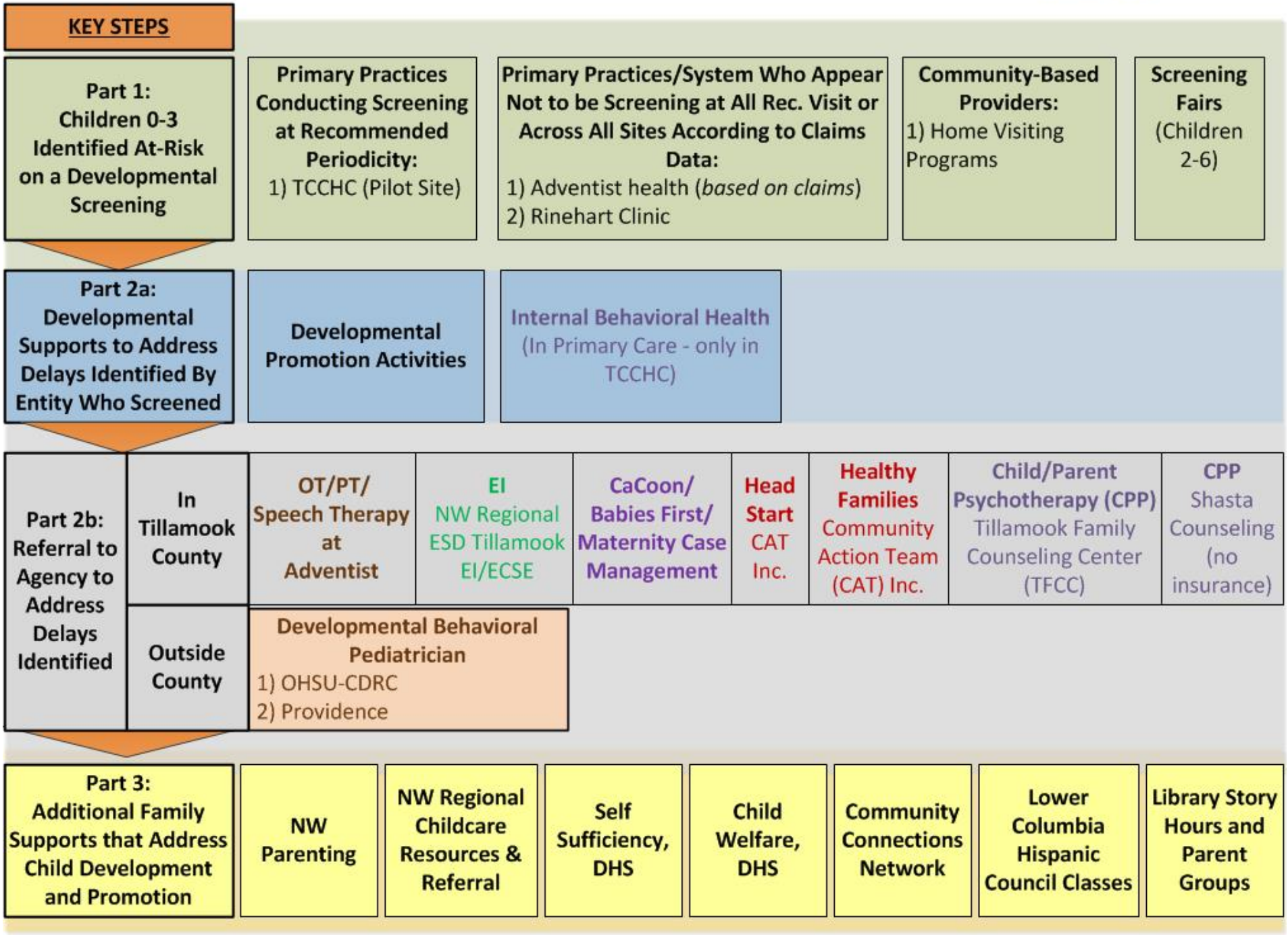
Stakeholder Interviews

- Sharing **learnings most relevant** to inform Phase 2 (improvement pilots) and not repetitive of the last meeting
- **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



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



Stakeholder Interviews Findings:
Developmental Screening – Punchlines

- **Screening rate for Tillamook County is 53%. 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 across providers or across visits at which screening is recommended.
- **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 is happening at Tillamook Early Learning Center for this age group
- **Group 4: Screening Fair:** Robust screening at fairs. That said, the population of children 2-3 is relatively small and most of the children had also accessed primary care sites screening.
- **Sharing of screening results is not standardized or routinely in place in any group**

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 PCPs do not have a deep **understanding of services** available to young children in the community.
- **Perceptions about EI eligibility** and evaluation processes can impact **whether and who they refer**
- Limited and **inconsistent use of community based mental health (TFCC)** and concerns of capacity
- **Barriers to referrals to behavioral health at TCCHC (Clark) from Adventist providers**
- 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

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

- **Tillamook Early Learning Center does do some referring to EI when appropriate. Works with family to determine best process.**

Group 4: Screening Fair: Some of the follow-up resources are at the Screening Fair, however there is no communication to primary care about services the child/family may receive

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**
  - Some stakeholders reported difficulty engaging families in these referrals- and noted hesitance at times 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**

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 EI-Ineligible Children
    - Provide a packet with local 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 and signatures, but not sure they are sending what providers actually want (***there is some 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

Punchline for Improvement Pilots:

Need to better address follow-up for children identified at-risk that includes secondary steps for when a child is referred to one resource and then not found eligible

- 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 underutilized
  - EI
  - Behavioral health and mental health

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: Children 0-3 identified on developmental screening tools as at-risk for developmental, behavioral or social delays

Data

- **Data Available That will be Examined**
  1. **Census Data – How many children 0-3**
  2. **Columbia Pacific Coordinated Care Organization (CPCCO) 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: TCCHC (Primary Care Pilot Site)**
     - Children practice saw for well-child care
     - Children who received a developmental screening
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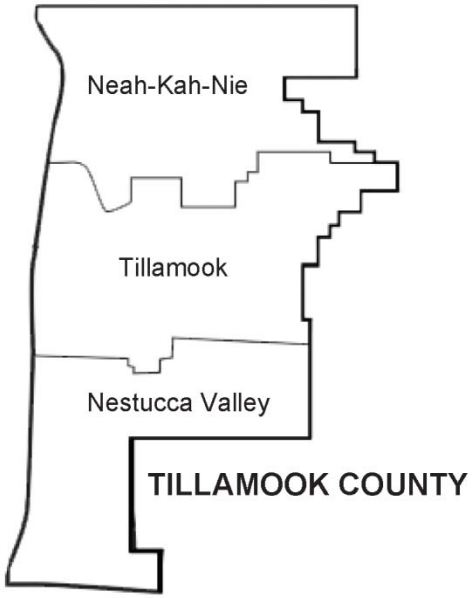
5. **Early learning providers – Home Visiting Data**
6. **Pilot Early Learning Provider(Tracking data will be collected for pilot sites to evaluate pilot)**

Children 0-3 in Tillamook County

2016 Census Data under 3 years:

- **Children 0-3: Tillamook: 655**
- **N=474 Children Covered by CPCCO in Tillamook**
  - **Proportion of children 0-3 Publicly Insured: 72%**
- **N= 280 Children Continuously Enrolled for 12 months**



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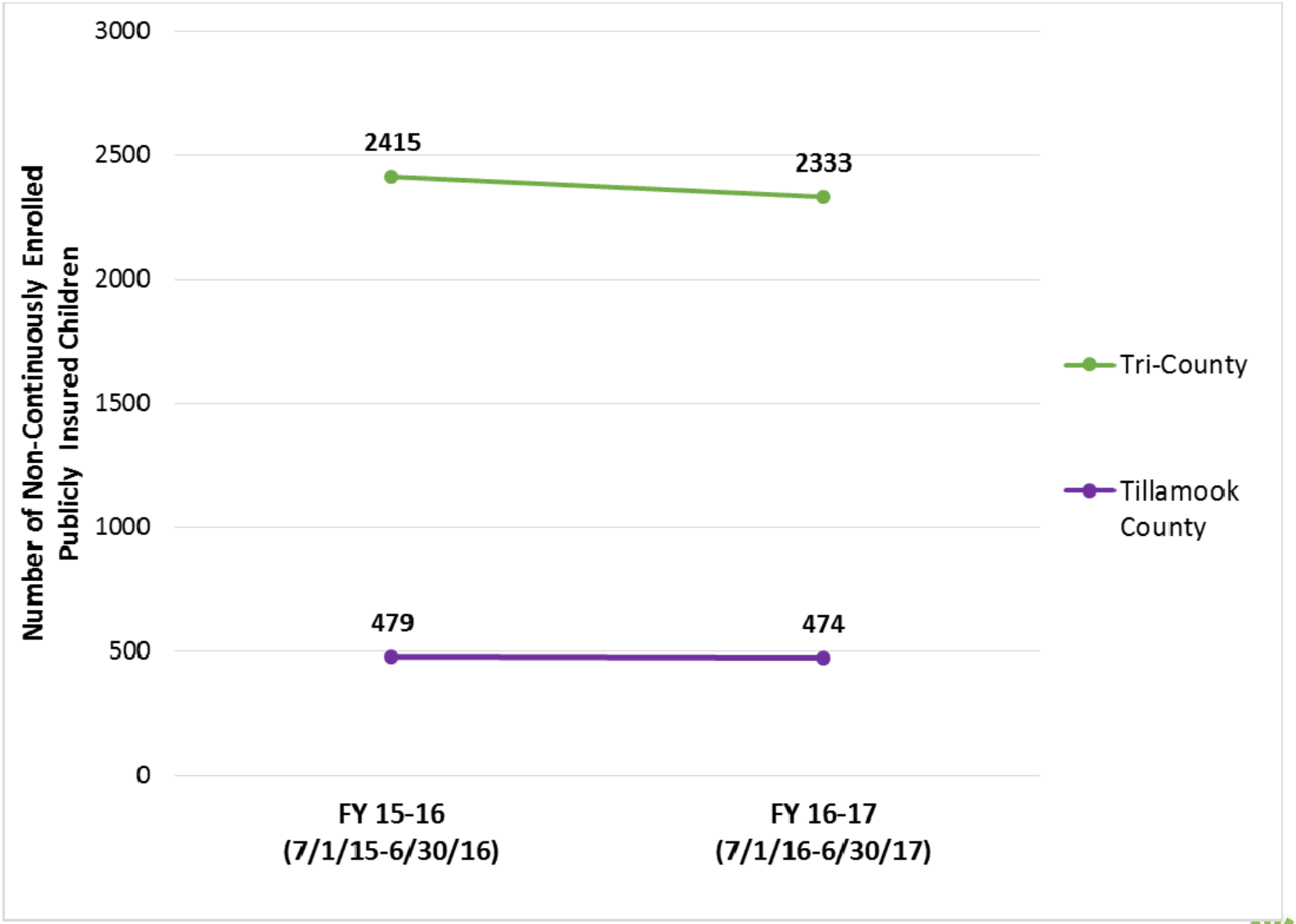
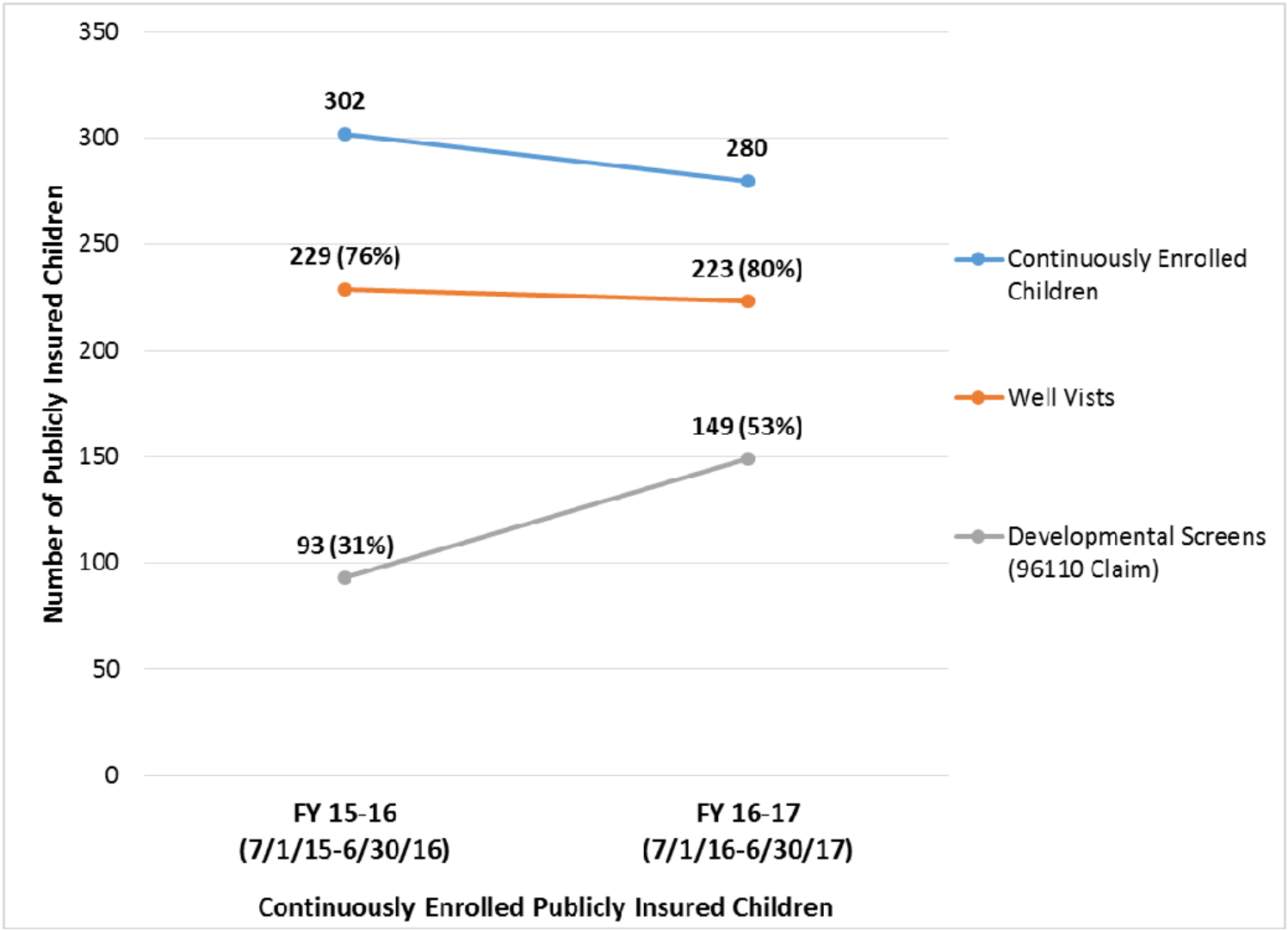
Number of Children 0-3 Continuously Publicly Insured in CPCCO



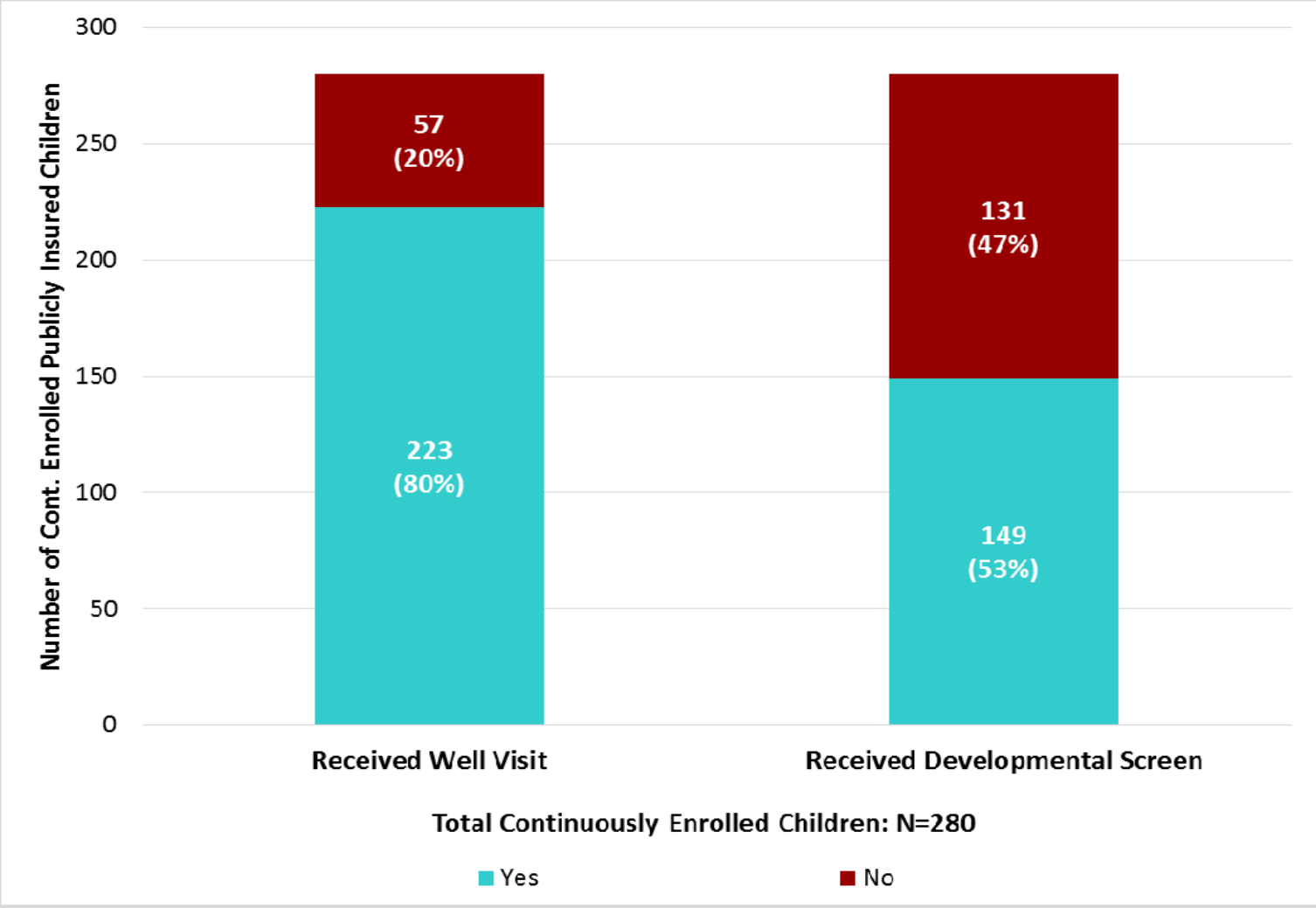
Data Source: Provided by CPCCO, October 2017

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



Data Source: Provided by CPCCO, October 2017

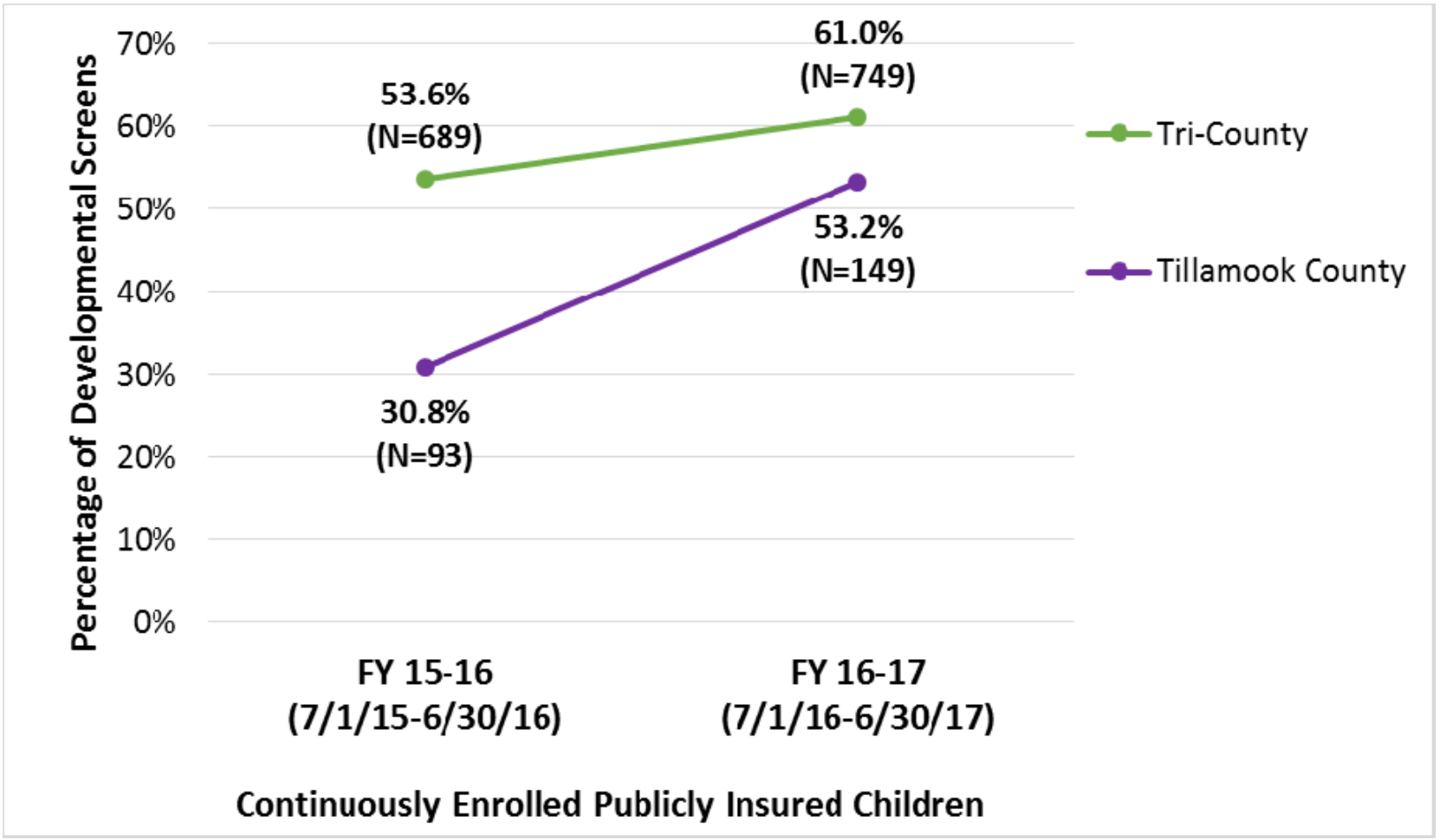
Proportion of Continuously Enrolled, Publicly Insured Children Who had a Well-Visit and Developmental Screen in the Last Year



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

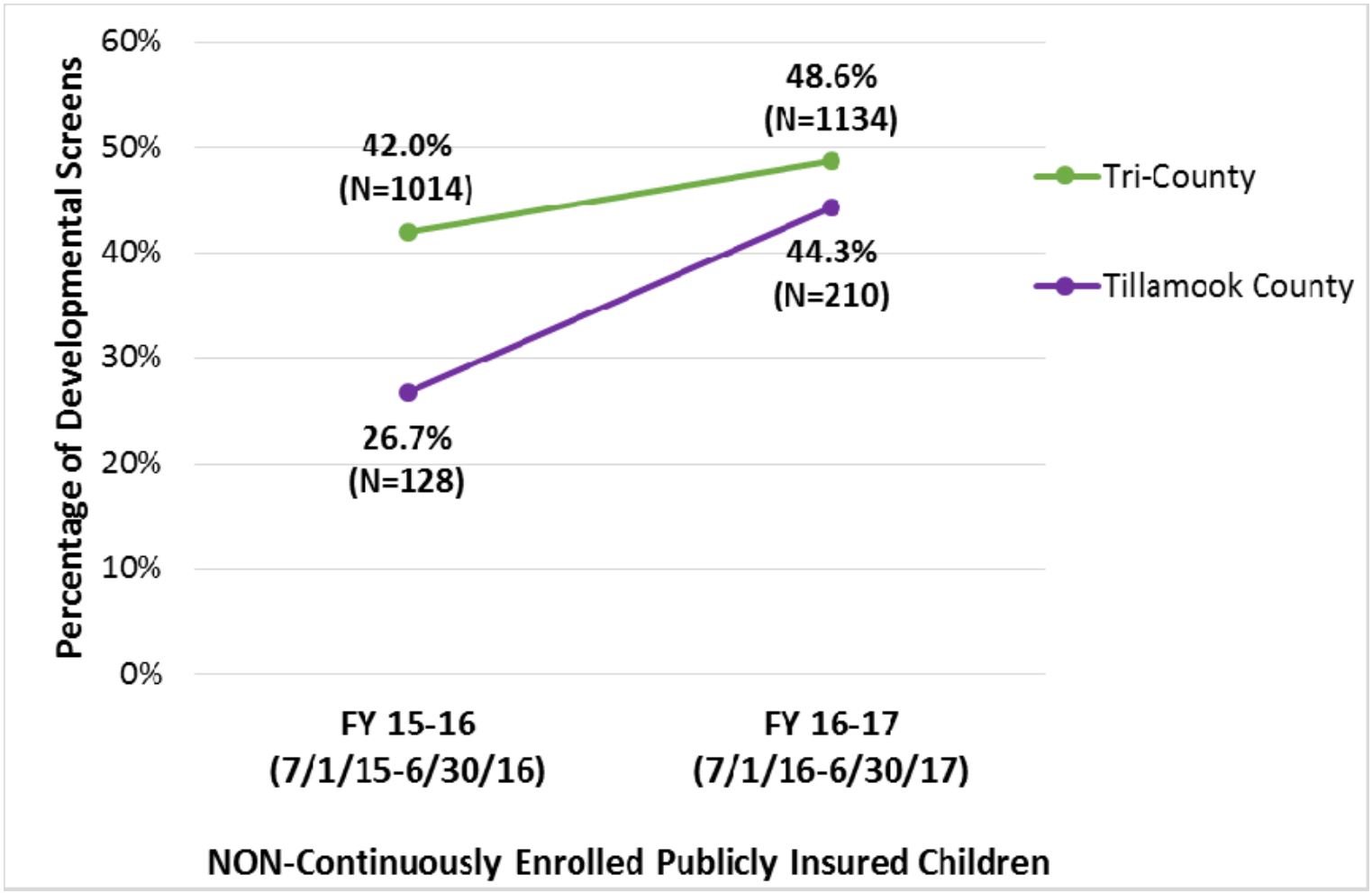
OPIP

Developmental Screening Rate for Tillamook County and the Tri-County CPCCO Regions (Clatsop, Columbia, Tillamook)



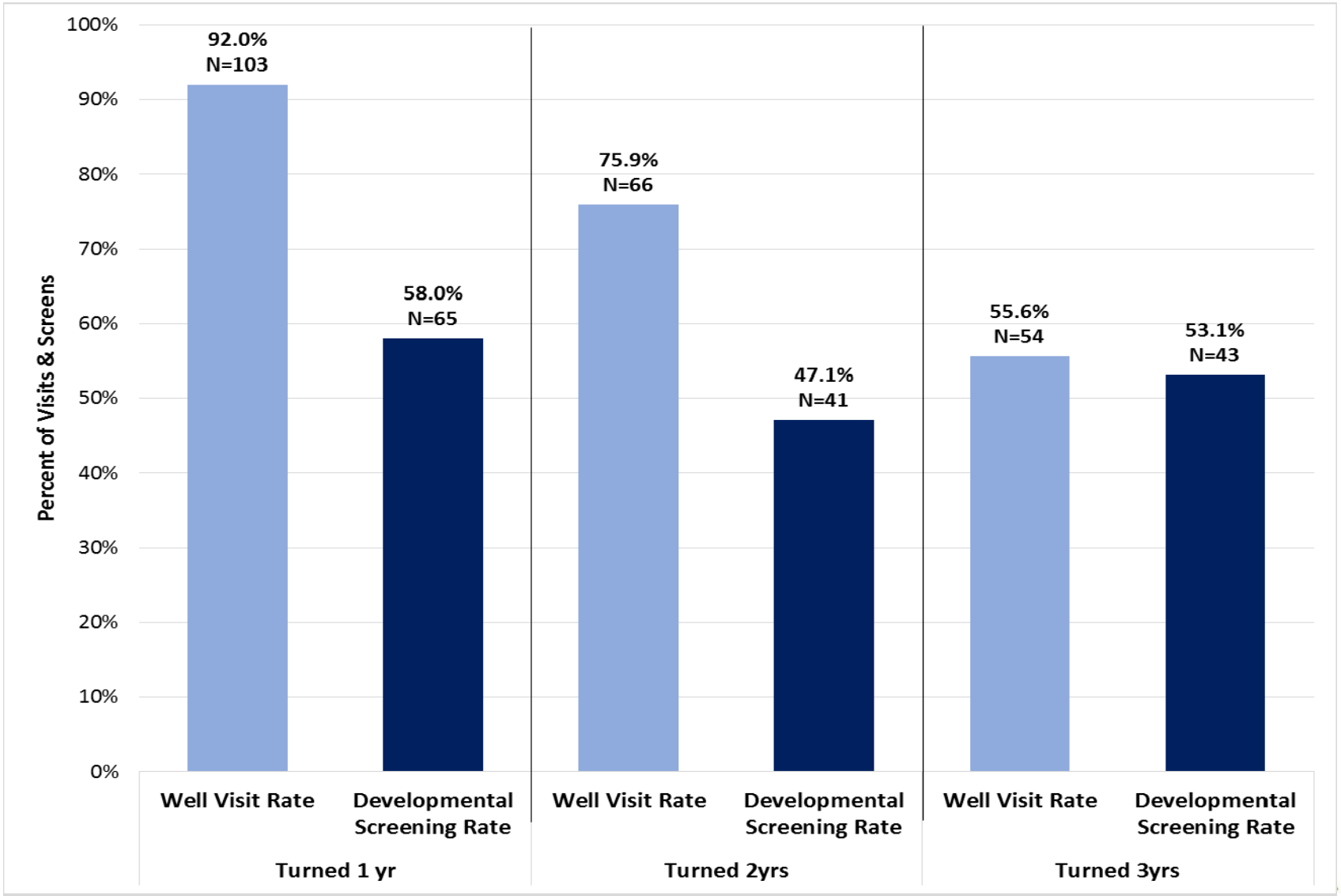
Data Source: Provided by CPCCO, October 2017

Developmental Screening Rate for Columbia County and the Overall CPCCO Region for NON-Continuously Enrolled Children



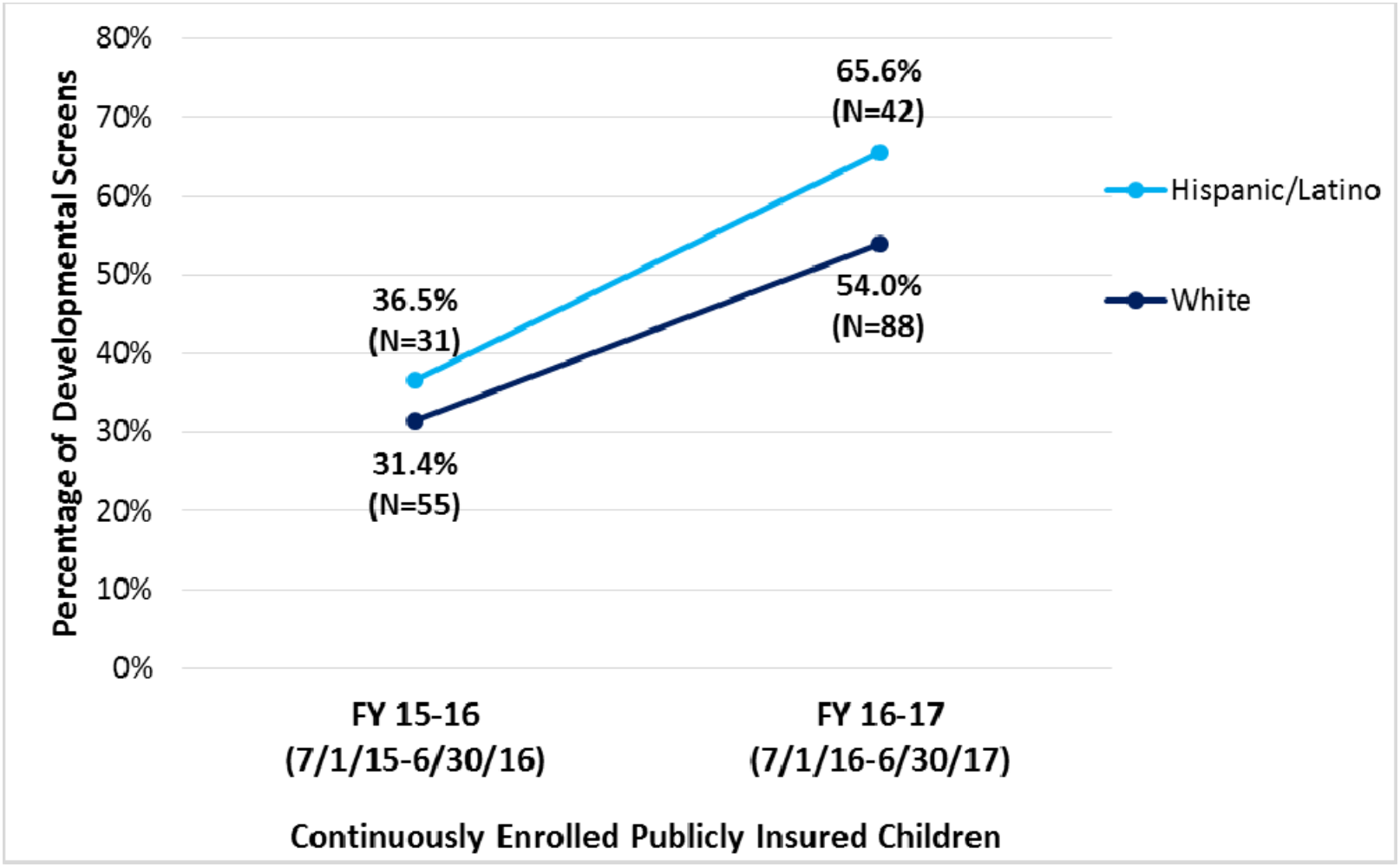
Data Source: Provided by CPCCO, October 2017. Developmental Screens according to 96110 Claims.

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



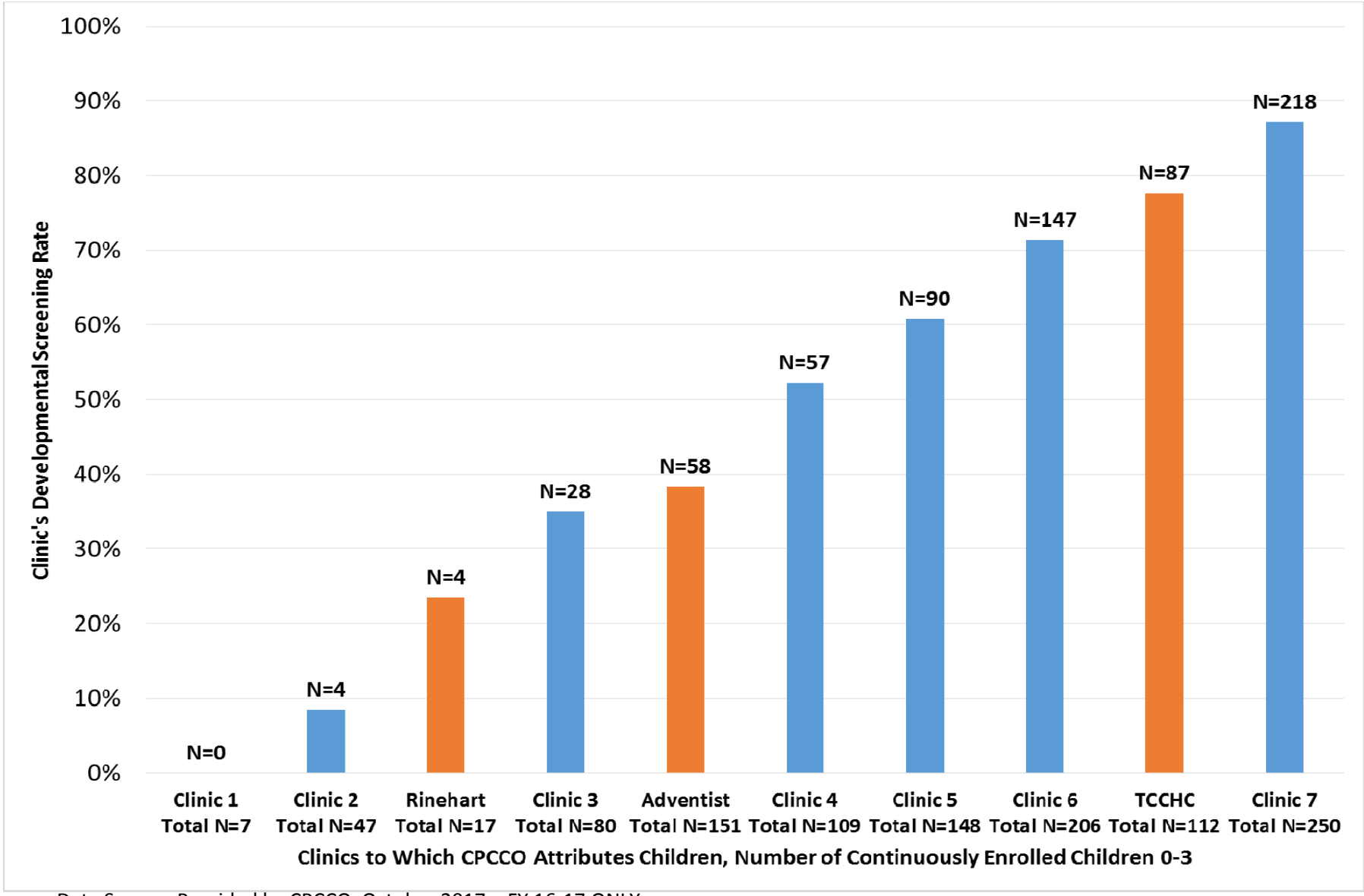
Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

Developmental Screening Rates by Race/Ethnicity – CONTINUOUSLY ENROLLED CHILDREN



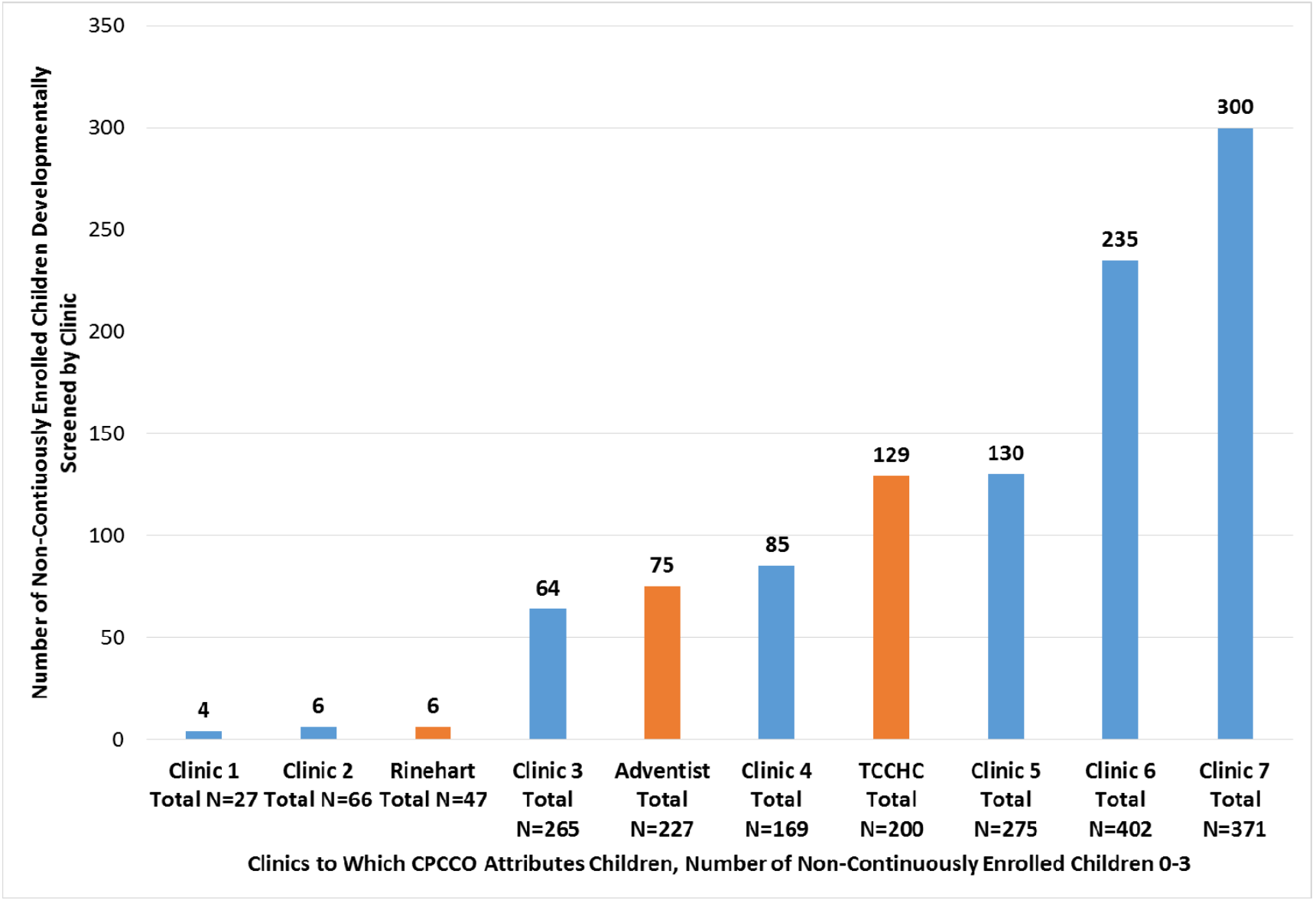
Data Source: Provided by CPCCO, October 2017

Developmental Screening Rates in CPCCO Clinics in Columbia, Clatsop & Tillamook Counties



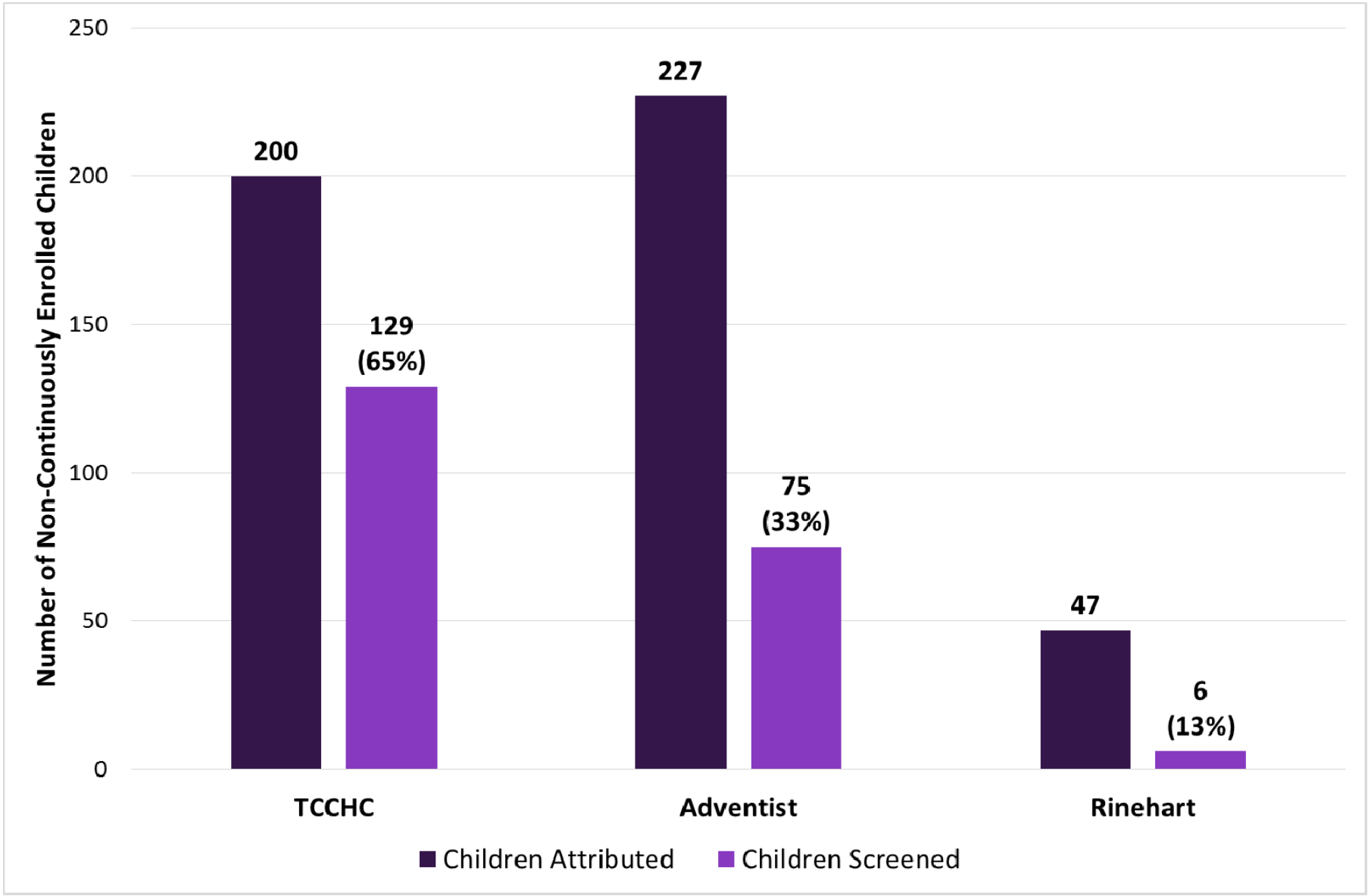
Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

Annual Number of Developmental Screening Rates in CPCCO Clinics in Columbia, Clatsop & Tillamook Counties



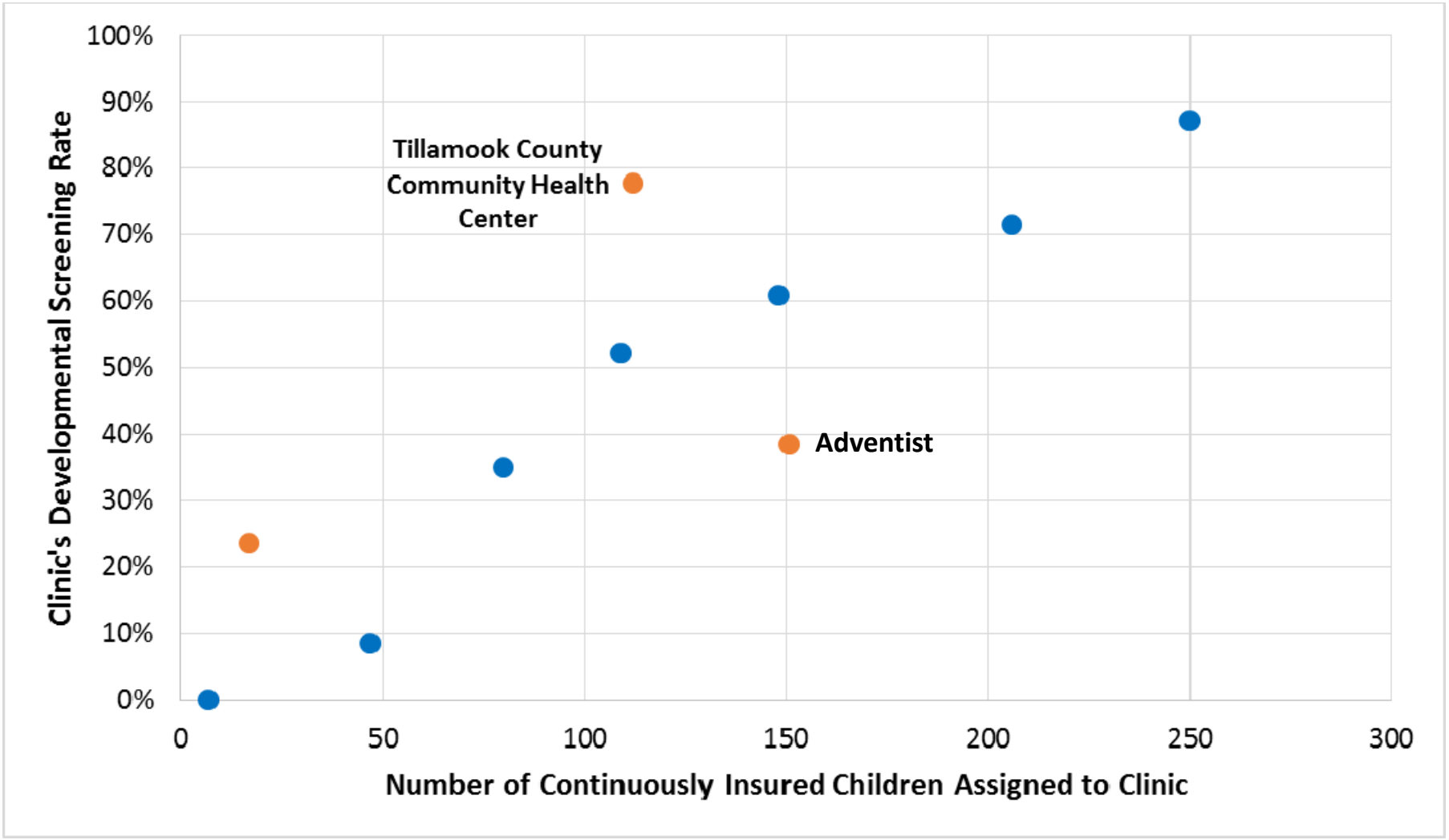
Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

Children Under Three Attributed to the Practice and Number of Developmental Screens



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

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



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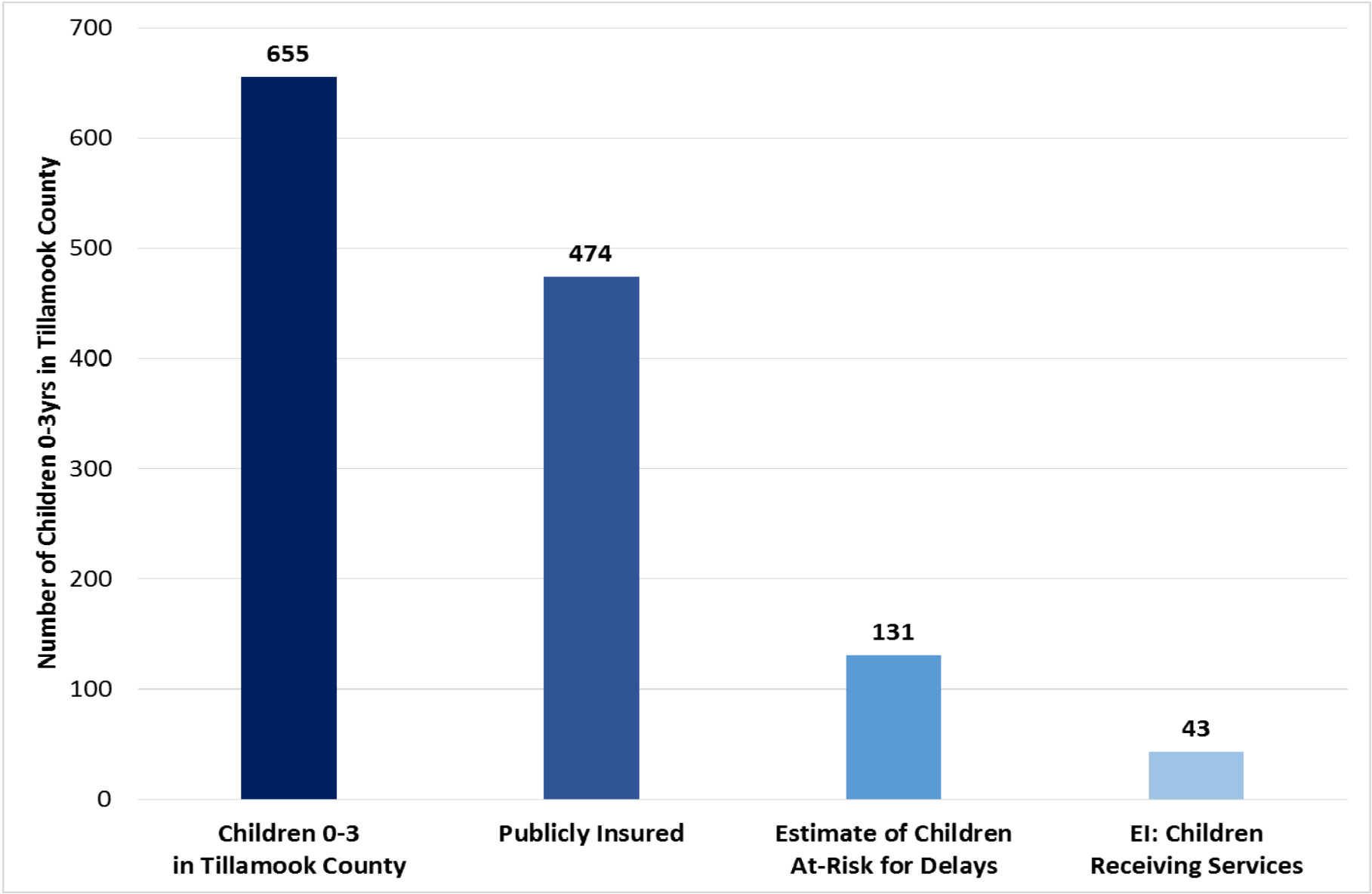
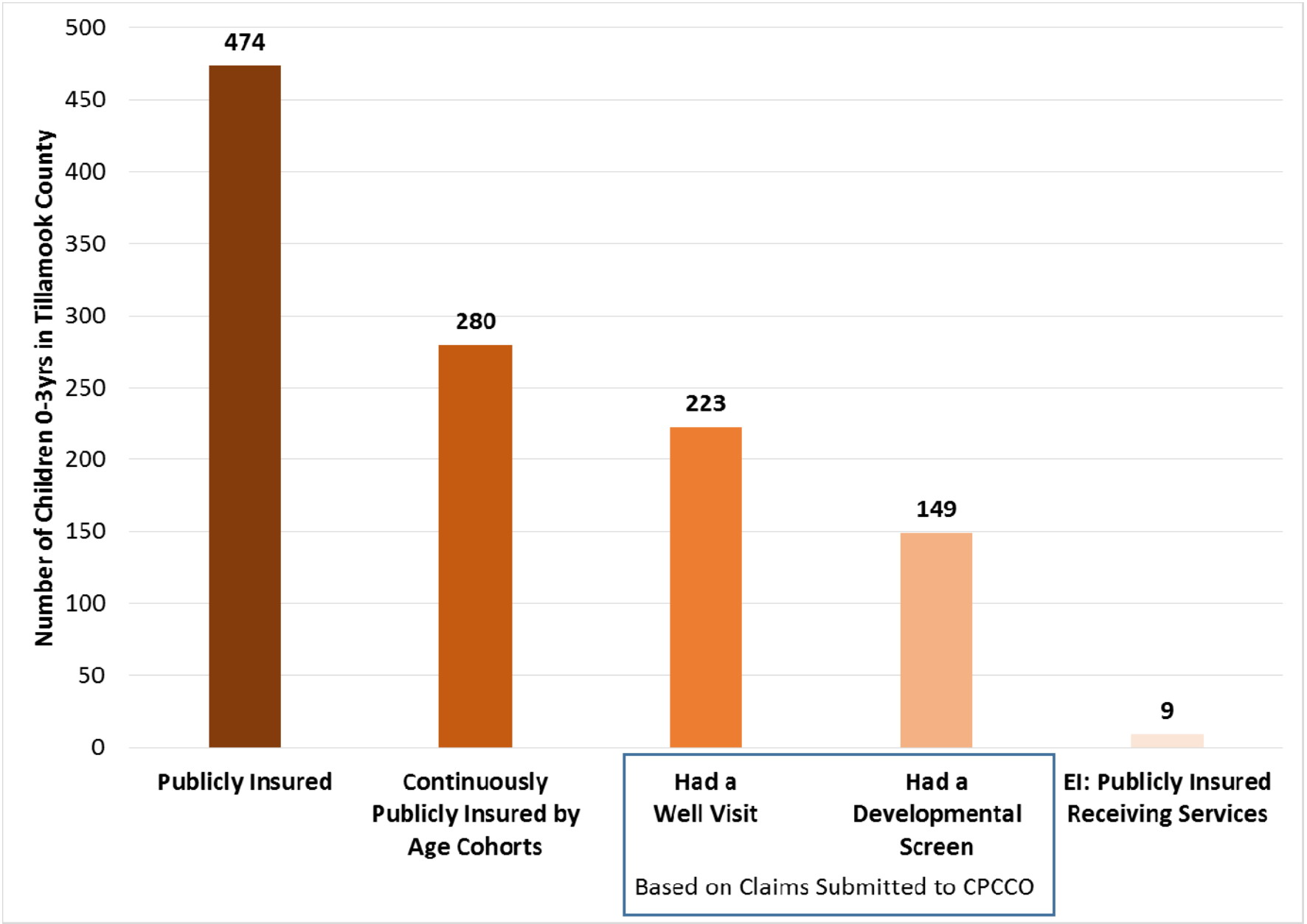
The Story of Young Children in the Tillamook County



The Story of Publicly Insured Young Children in the Tillamook County



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

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     - **Children covered, Continuously enrolled**
     - **Children who have a visit**
     - **Children who receive a developmental screening, according to claims submitted**
  3. **Primary Care Practice Data: Tillamook County Community Health Centers (Pilot Site #1) Data for All Patients *(Public and Privately Insured, Uninsured)***
     - **Children who receive well-child care**
     - **Children who received a developmental screening**
     - **Children identified at-risk on developmental screen**
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  4. **Early Intervention: According to Bright Futures Data, A Referral for All Children Identified At-Risk (A Pilot Site)**
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Purpose of the Baseline Data Collection in the Primary Care Pilot Site: TCCHC

- 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 (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

TCCHC Baseline Data

- **Baseline Time Period:** 7/1/16 - 6/30/17 (One Year)
  - Include the providers that were there during this time period.
- Children of Focus: **Children Under 3** (6 months-35.99 months)
- Data Sources:
  - **Chart Review** of Children seen during time period to determine well-visits and Screens completed. ASQ domain-level scores recorded to Identify 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
      - Specific Referrals
        - Referral to Early Intervention
        - Referral to OT/PT
        - Referral to Speech Therapy (ST)
        - Referral to Home Visiting
    - Follow-Up Steps **Not Included** in Baseline Data Due to Limitations, But Will Be Part of QI
      - Internal & External mental health
      - Referrals to other resources: Healthy Families, Head Start, Parent Child Interaction Therapy, and Parenting Classes
      - Developmental Promotion
      - Rescreen of child (Assumed done at every visit, however a schedule of an earlier visit would be recommended for two year olds)
- Data examined by screen vs. at a child-level (looking across screens), age of child, provider, insurance

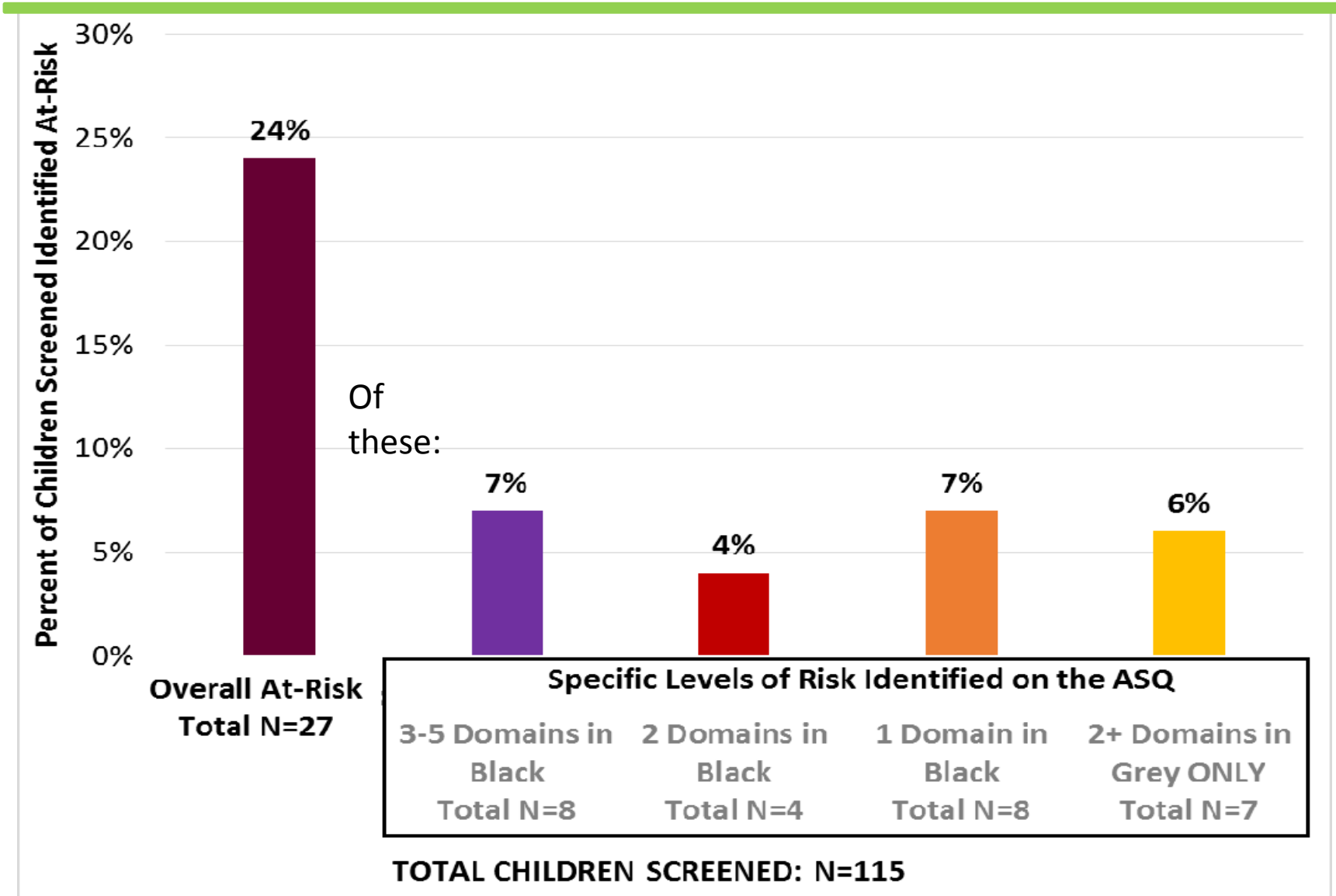
TCCHC Baseline Data

- Number of Providers in TCCHC that Interpreted a Developmental Screen
  - N=4 Providers completed an ASQ flow sheets for a child under 3
- Panel of Children Under 3: N=150 children
  - Children 0-3 had a Well-Visit in Last Year: N=138
  - Of the Visits with a Developmental Screen: 82% are for children with Medicaid
- Developmental Screens for Children Under 3
  - Number of Screens Completed According Practice's EMR (ASQ Flowsheet): **N=202**
    - ✓ By Age:
      - » Under 1: N=64
      - » 1-2 yrs: N=103
      - » 2-3 yrs: N=35
  - Number of 96110s billed: **N=180** (89%)
  - Number of Multiple Screens: **N=87**
- Child-Level Screening
  - Number of Children Screened: **N=115**
  - Number of Children with Multiple Screens N=50 (43%)
    - ✓ Nearly all the children with multiple screens are the younger children due to the periodicity of screening in TCCHC

Children Identified At-Risk on the ASQ & Recommendations Related to Follow-Up

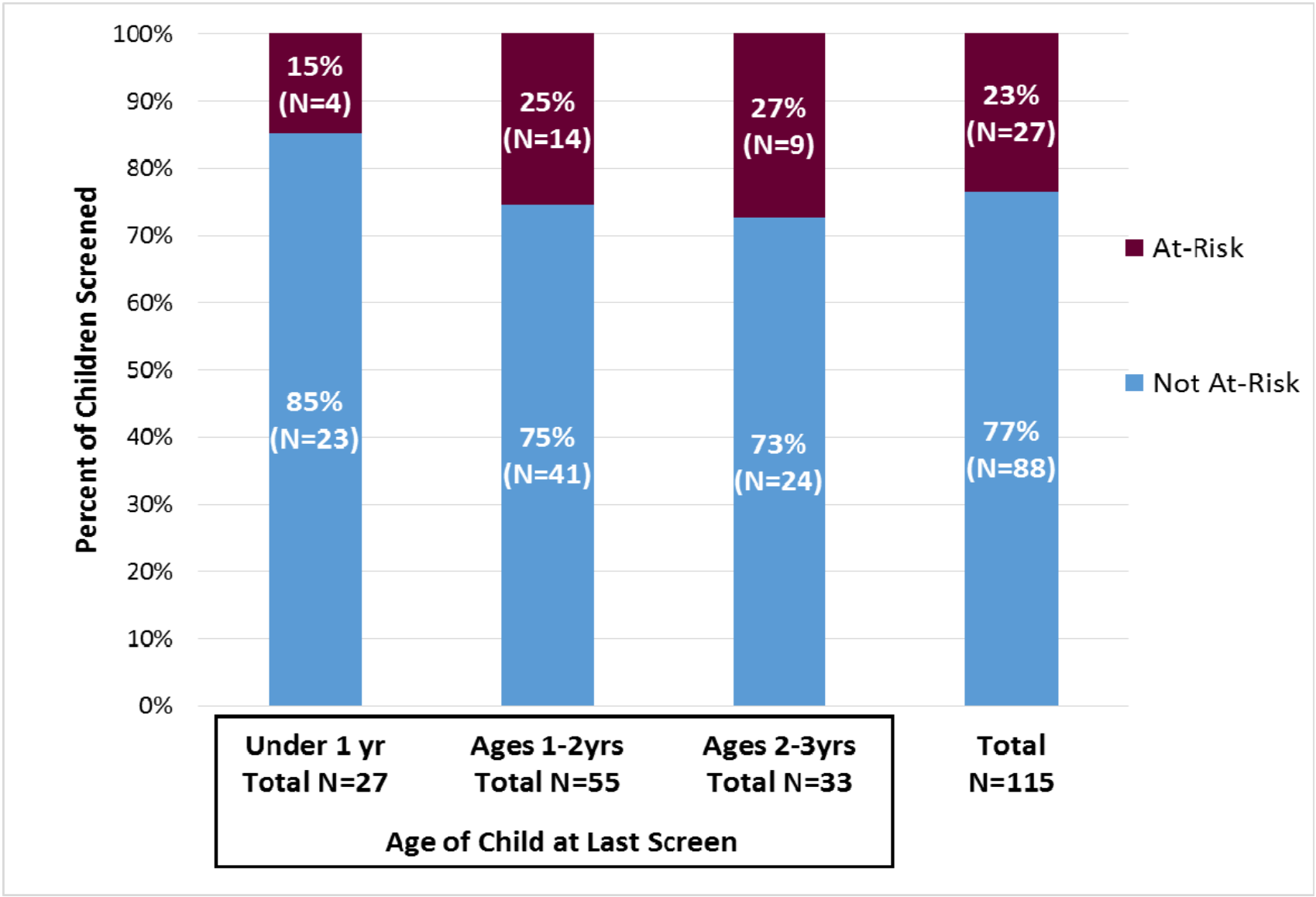
- Scoring of "At-Risk" Based on the Ages and Stages Questionnaire
  - At Risk= 1 or more in the Black (2 STD from Normal) AND/OR
    2 or more in the Grey (1.5 STD from Normal)
- Bright Futures Recommendation for **Follow-Up for At-Risk**
  - Screen at 9, 18 and 30 month visit (or 24 if not doing the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

TCCHC CHILD-LEVEL– Characteristics of Risk Identified on the ASQ in Children 0-3



Data Source: Provided by TCCHC, November 2017. Charts reviewed for children seen between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented. If a child had multiple screens, the most recent screen result was used to determine risk level.

TCCHC–Proportion of CHILDREN Screened Identified At-Risk on the ASQ: BY Age-Categories



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

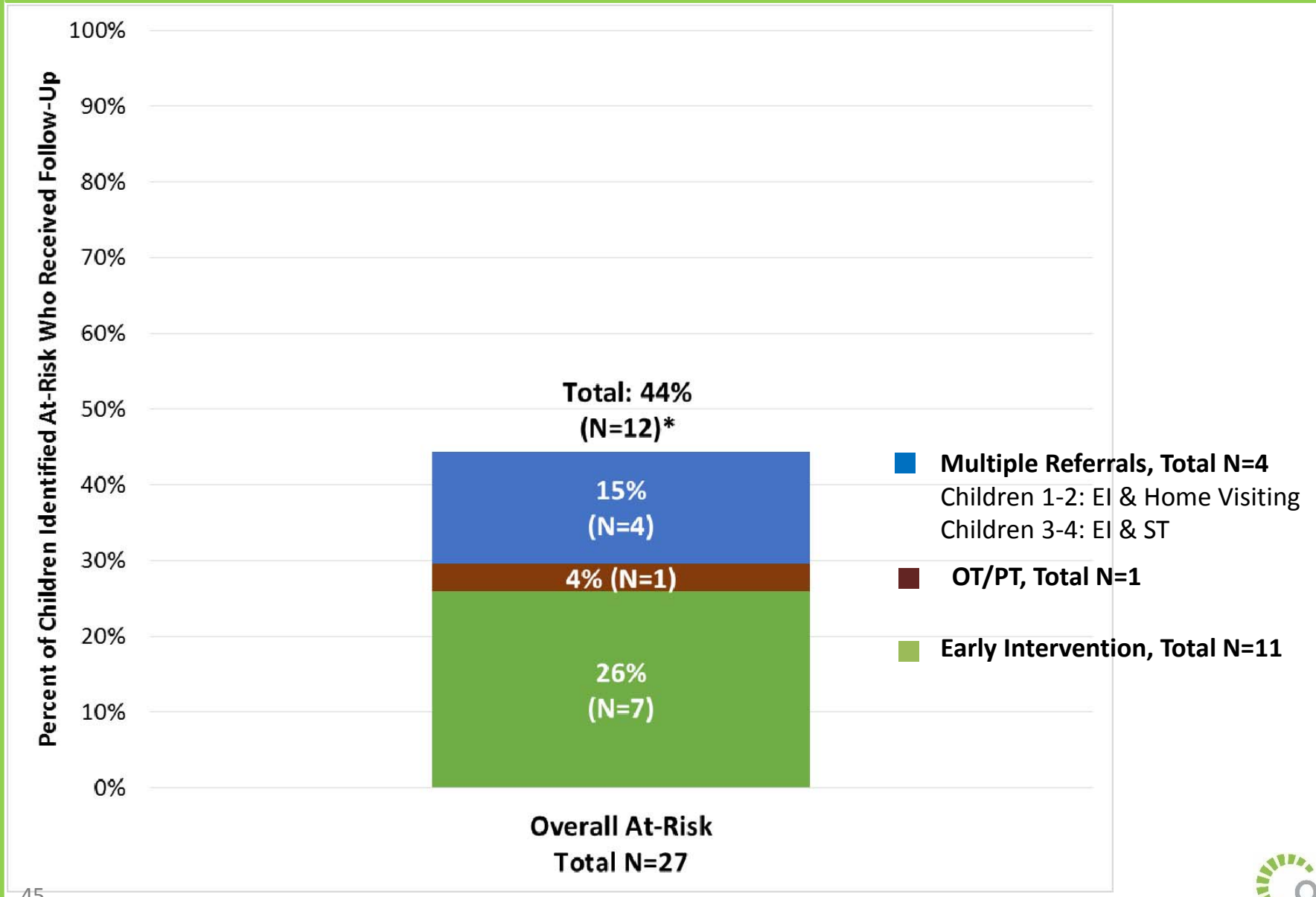
Aspects of **follow-up to developmental screening** able to examined in the chart, if documented in the note or referral tracked:

- Specific Referrals
  - Referral to Early Intervention (Bright Futures Recommendation)
  - Referral to OT/PT
  - Referral to Speech Therapy (ST)
  - Referral to Home Visiting
  - Referral to Developmental Behavioral Pediatrician – But there were none in the chart note, so examining a barrier.

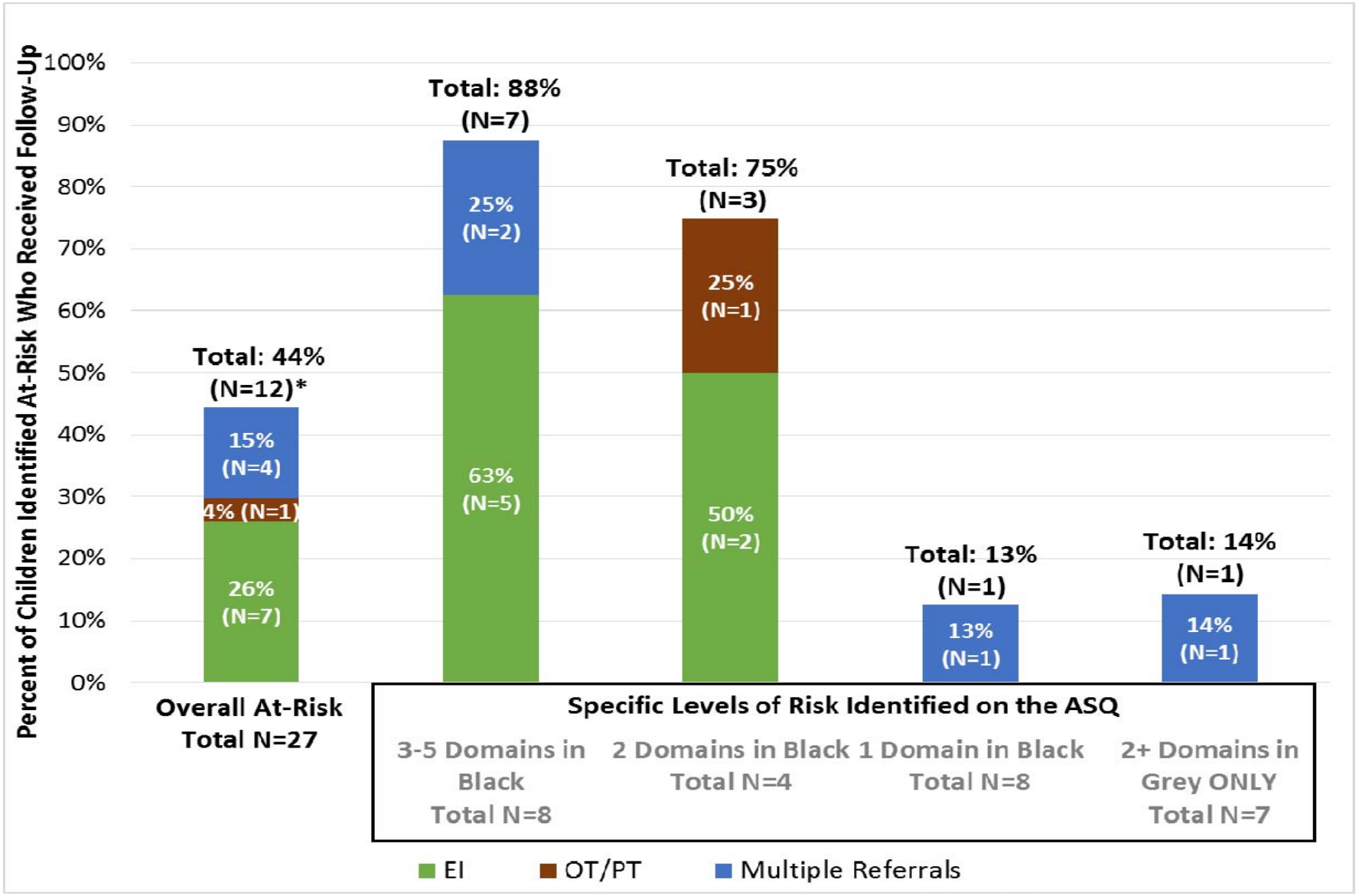
Follow-Up Steps **Not Included** in Baseline Data Due to Limitations, But Will Be Part of QI

- Internal and external mental health
- Referrals to of other resources: Healthy Families, Head Start, Parent Child Interaction Therapy, and Parenting Classes
- Developmental Promotion
- Rescreen of child (Assumed done at every visit, however a schedule of an earlier visit would be recommended for two year olds)

TCCHC: Follow-Up for At-Risk Children Documented in Chart: 2 in 5 Received Some Level of Follow-Up

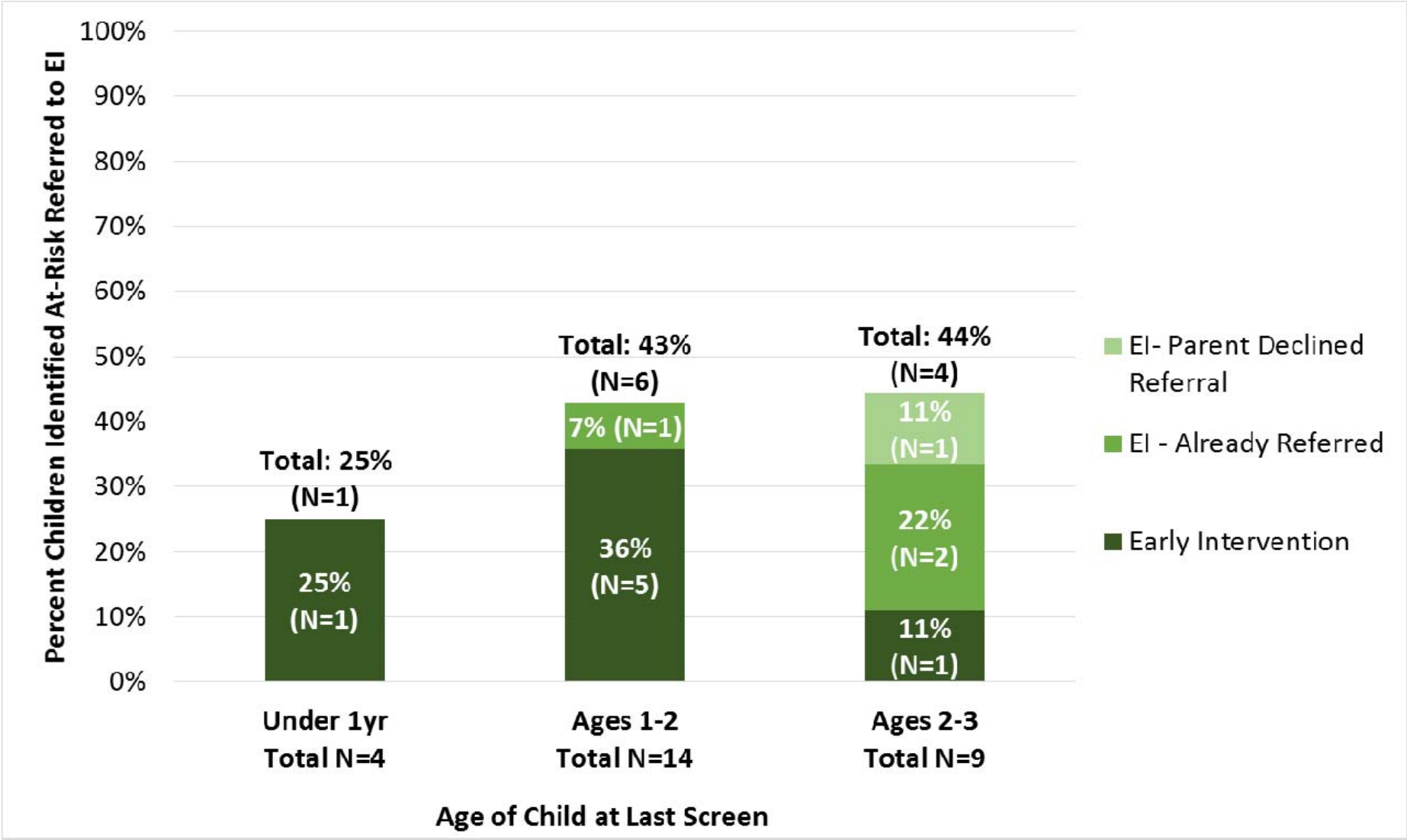


CHILD-LEVEL Follow-Up for At-Risk Children Documented in Chart: By Levels of Risk Identified



Data Source: Provided by TCCHC, November 2017. Charts reviewed for children seen between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented. If a child had multiple screens, the most recent screen result was used to determine risk level.

TCCHC: Proportion of At-Risk Children Referred to Early Intervention



Data Source: Provided by TCCHC, November 2017. Charts reviewed for children seen between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented. If a child had multiple screens, the most recent screen result was used to determine risk level.

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

- **Population of Focus for the Project: Children 0-3 identified on developmental screening tools as at-risk for developmental, behavioral or social delays**
  Data
- **Data Available That will be Examined**
  1. **Census Data – How many children 0-3**
  2. **Columbia Pacific Coordinated Care Organization (CPCCO) 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: TCCHC (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**

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 are identified at-risk on 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

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

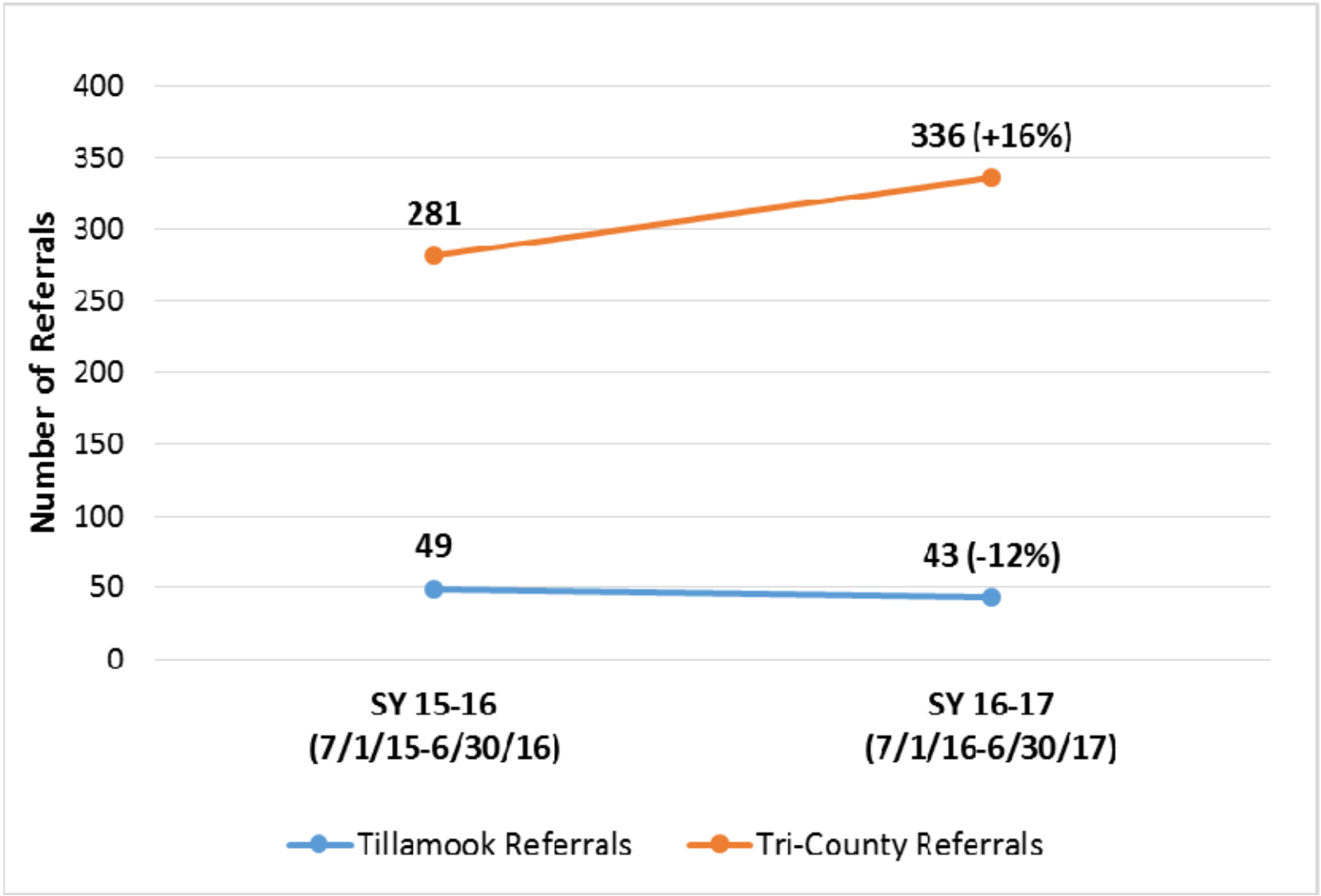
#1: Indication of Follow-Up to Developmental Screening

- 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

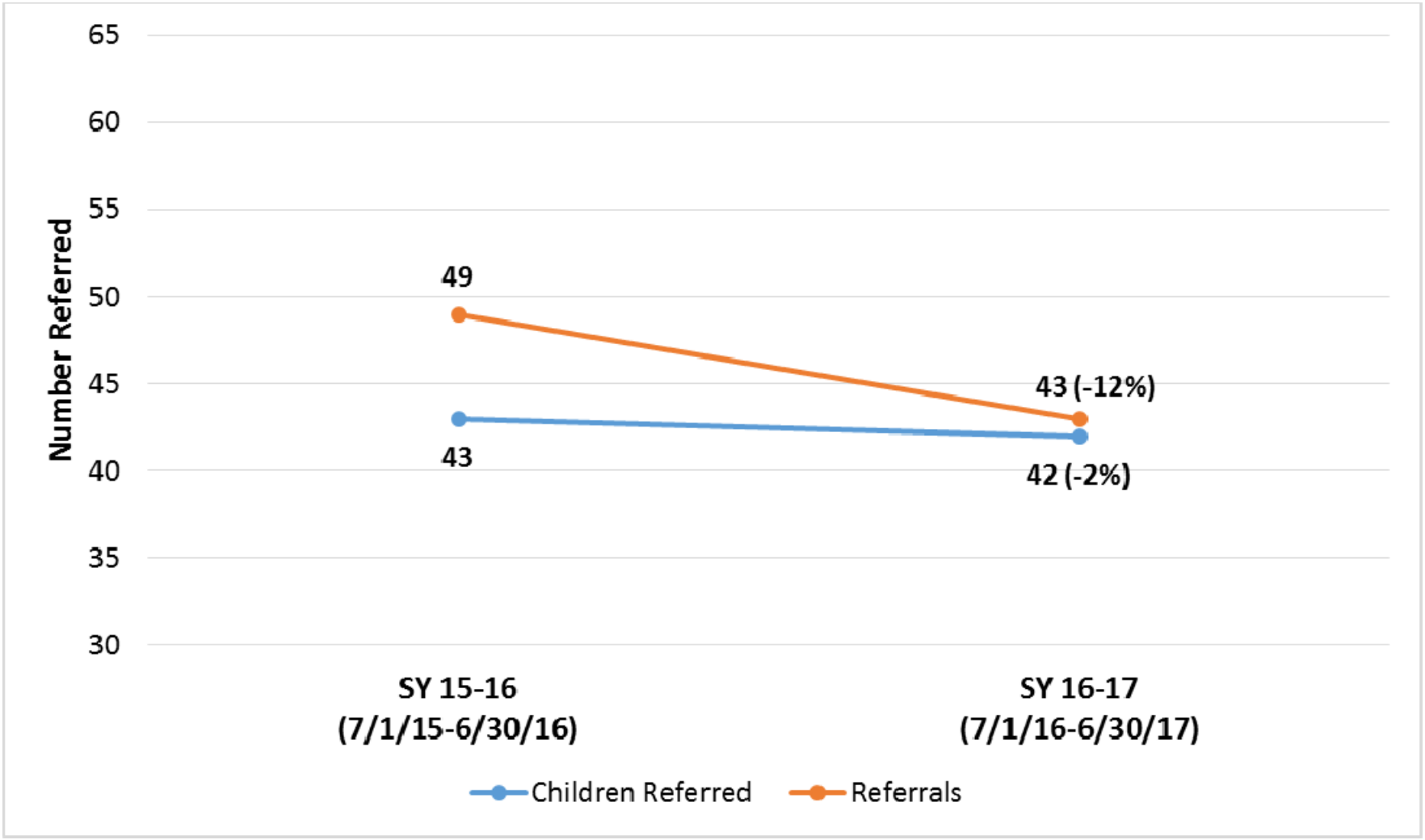
- Evaluation Outcome Results by Referral and Child Characteristics

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



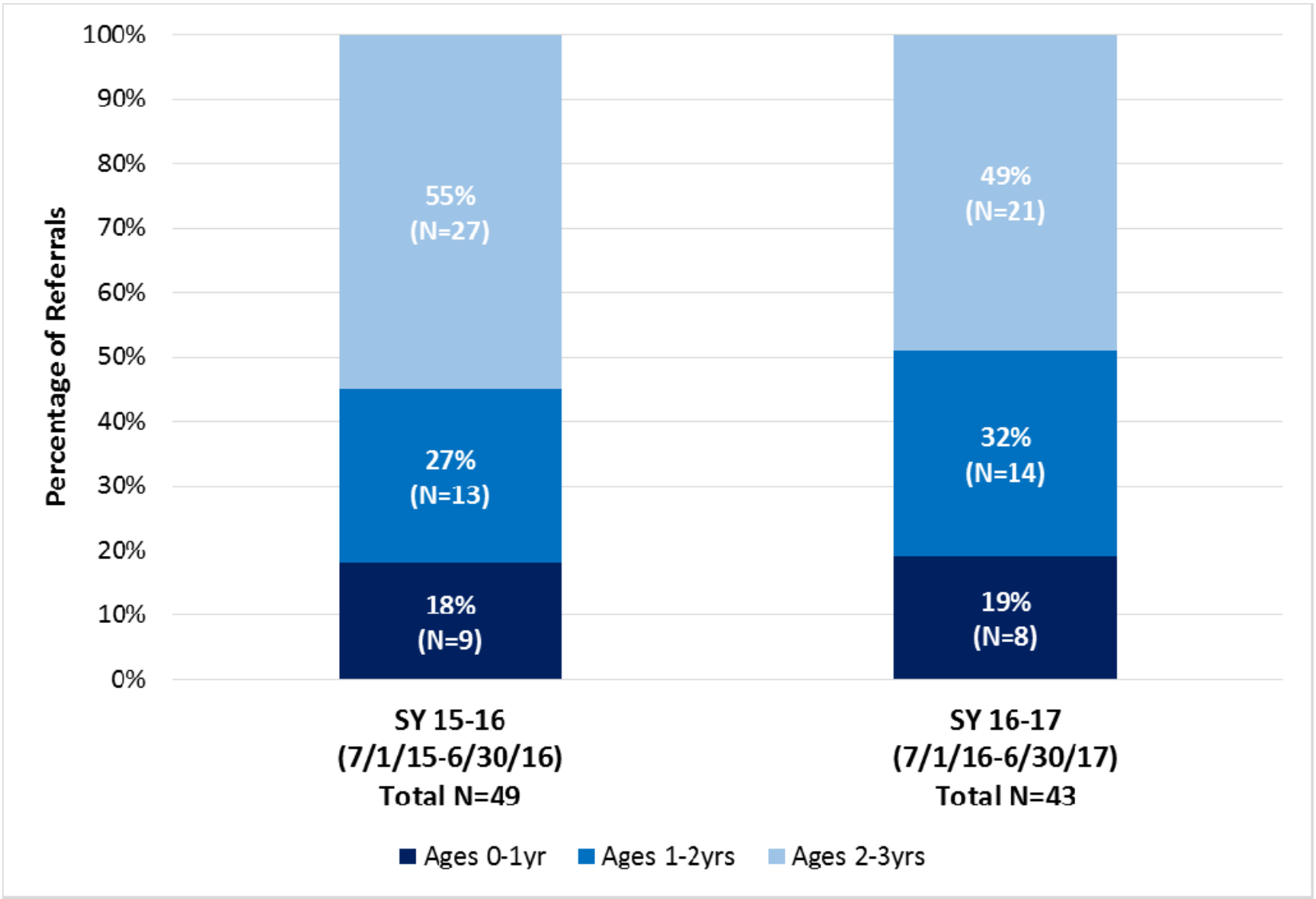
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Number of Early Intervention Referrals in Tillamook vs Number of CHILDREN Referred in Tillamook



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

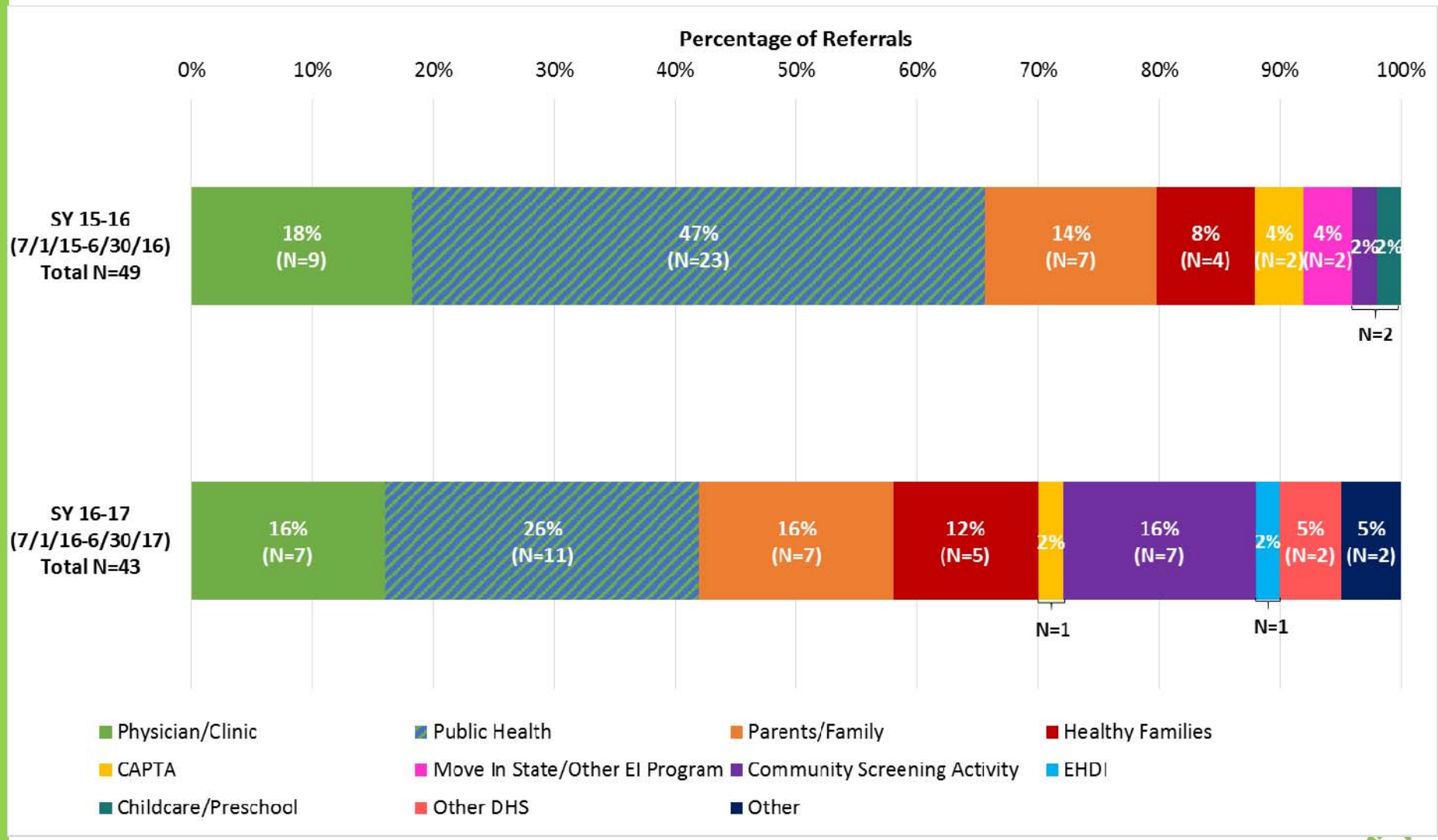
Tillamook Early Intervention (EI) Referrals by Age of Child



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

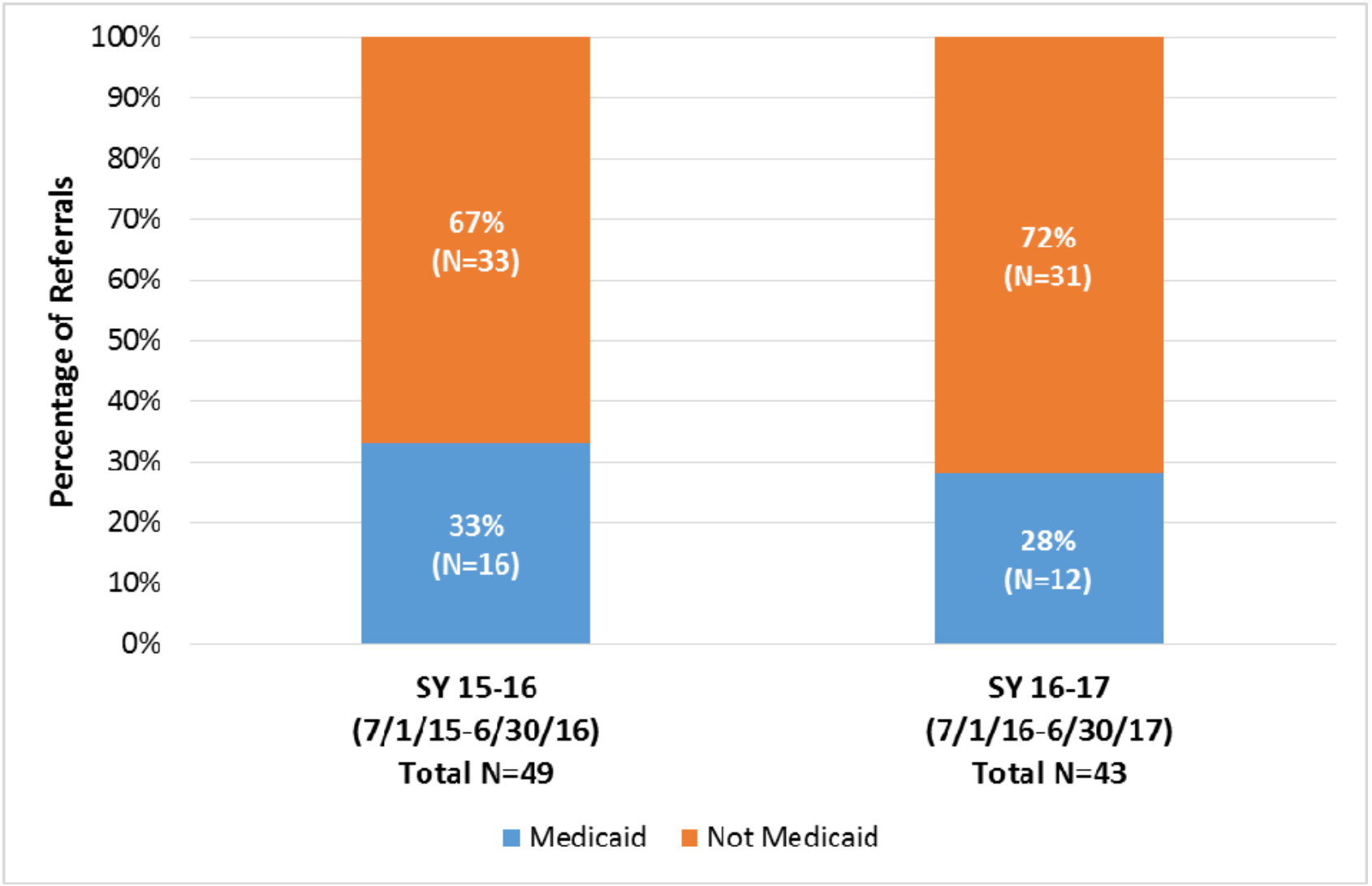
Tillamook EI Referrals by Referral Source As Documented in EC Web

Important NOTE:
The Public Health referral source contains all providers from TCCHC, which is a majority of the referrals.



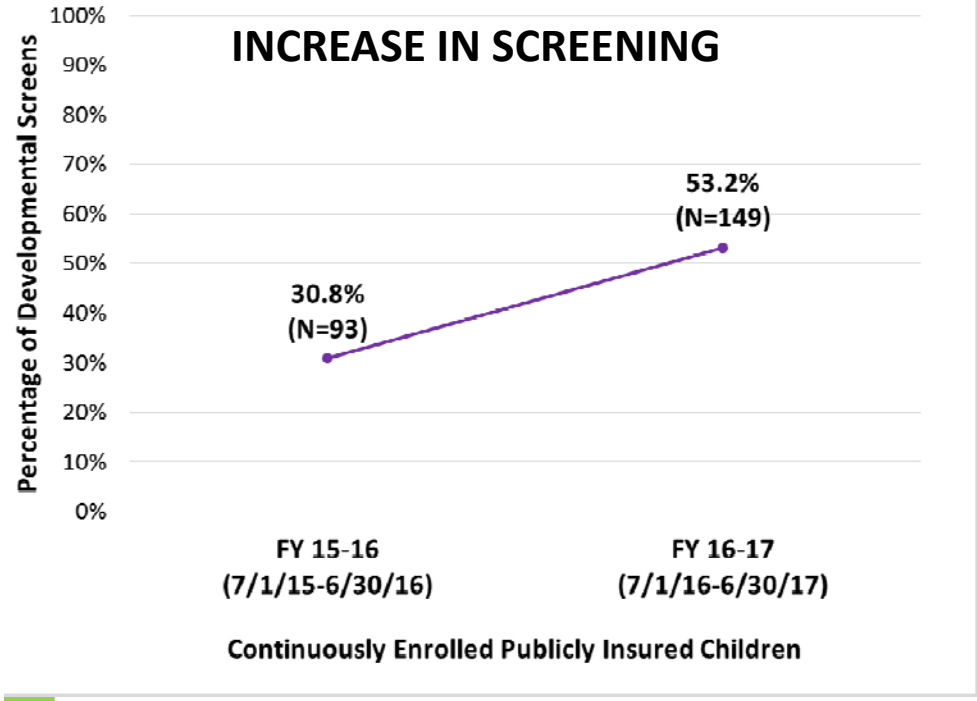
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

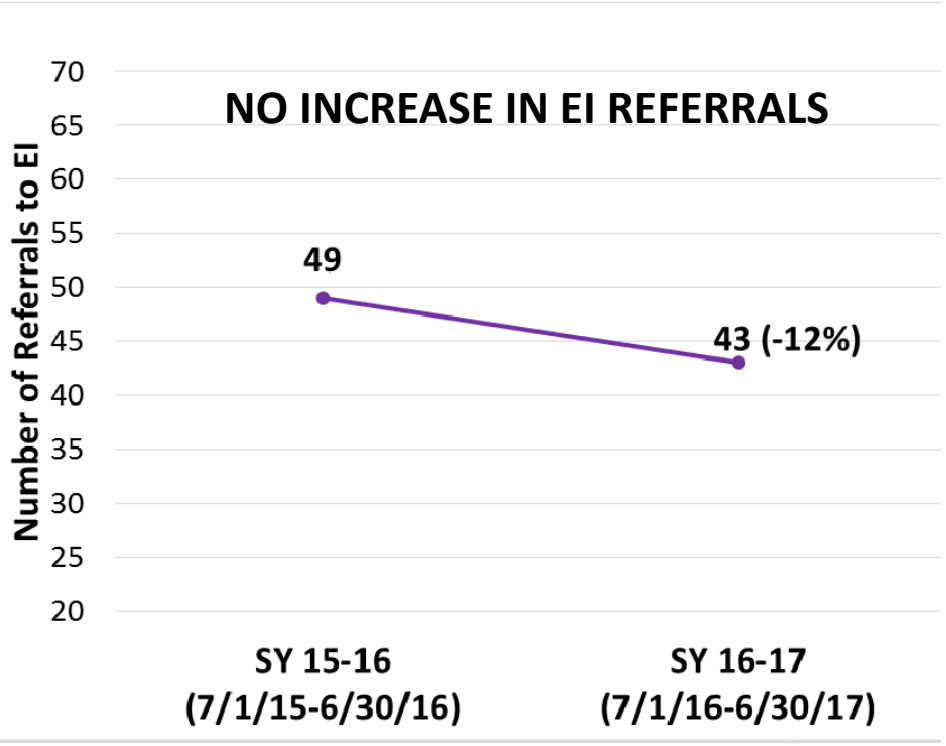
Tillamook EI Referrals by Whether Child Has Medicaid



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

Something to Ponder……..





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

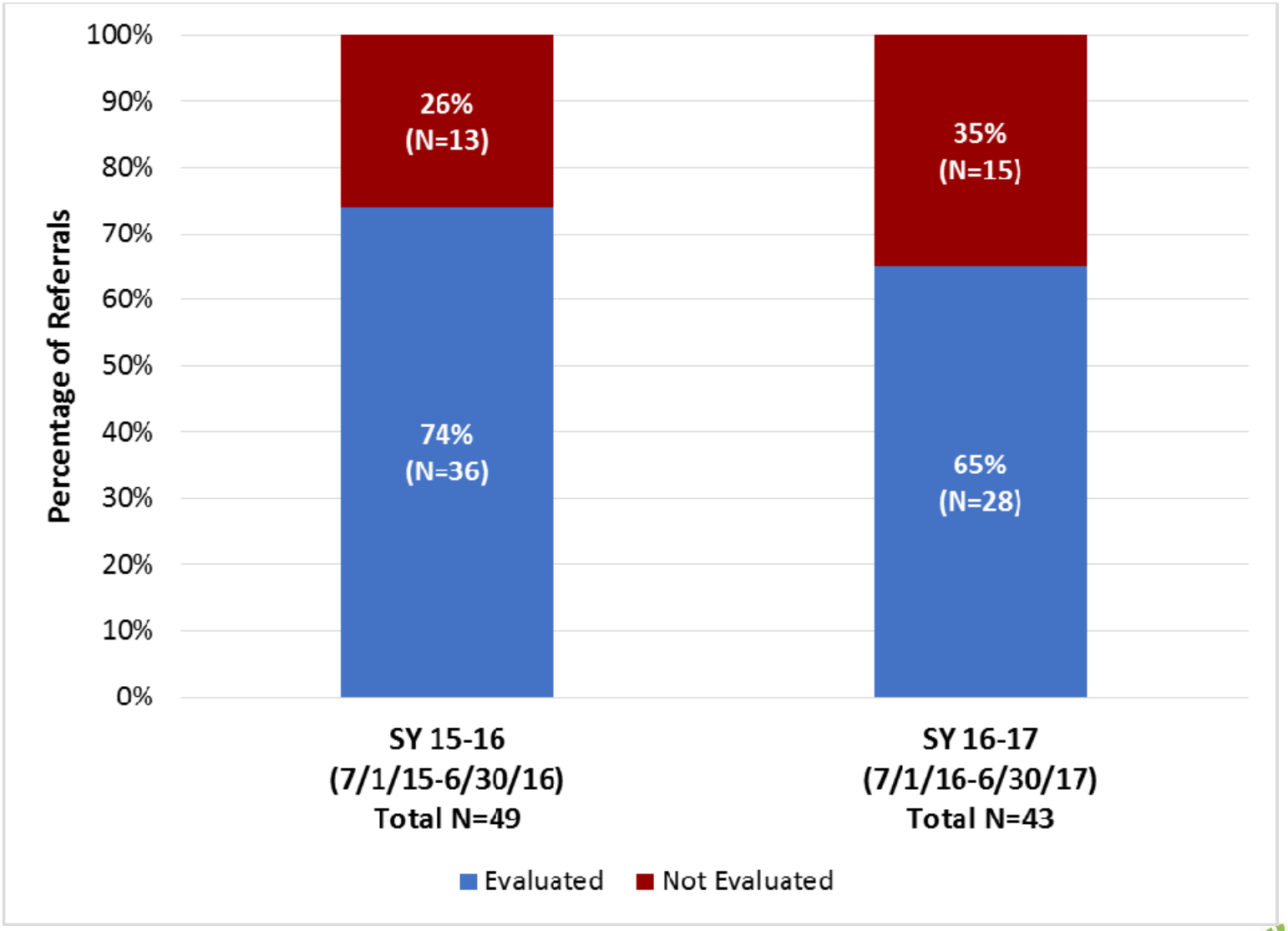
#1: Indication of Follow-Up to Developmental Screening

- 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

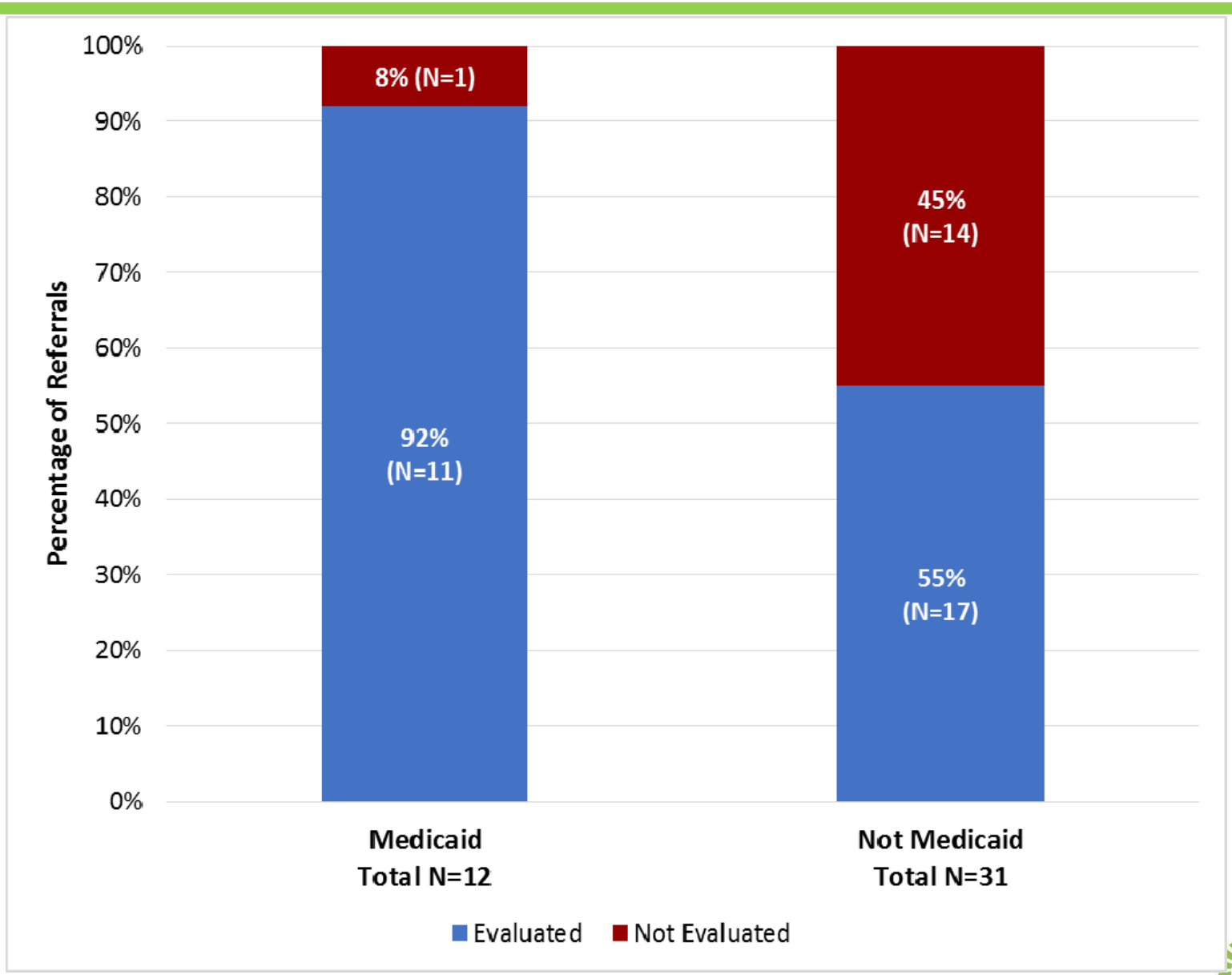
- Evaluation Outcome Results by Referral and Child Characteristics

Percentage of Tillamook EI Referrals Able to Be Evaluated by EI



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

Tillamook EI Evaluations BY Medicaid Insurance



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

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

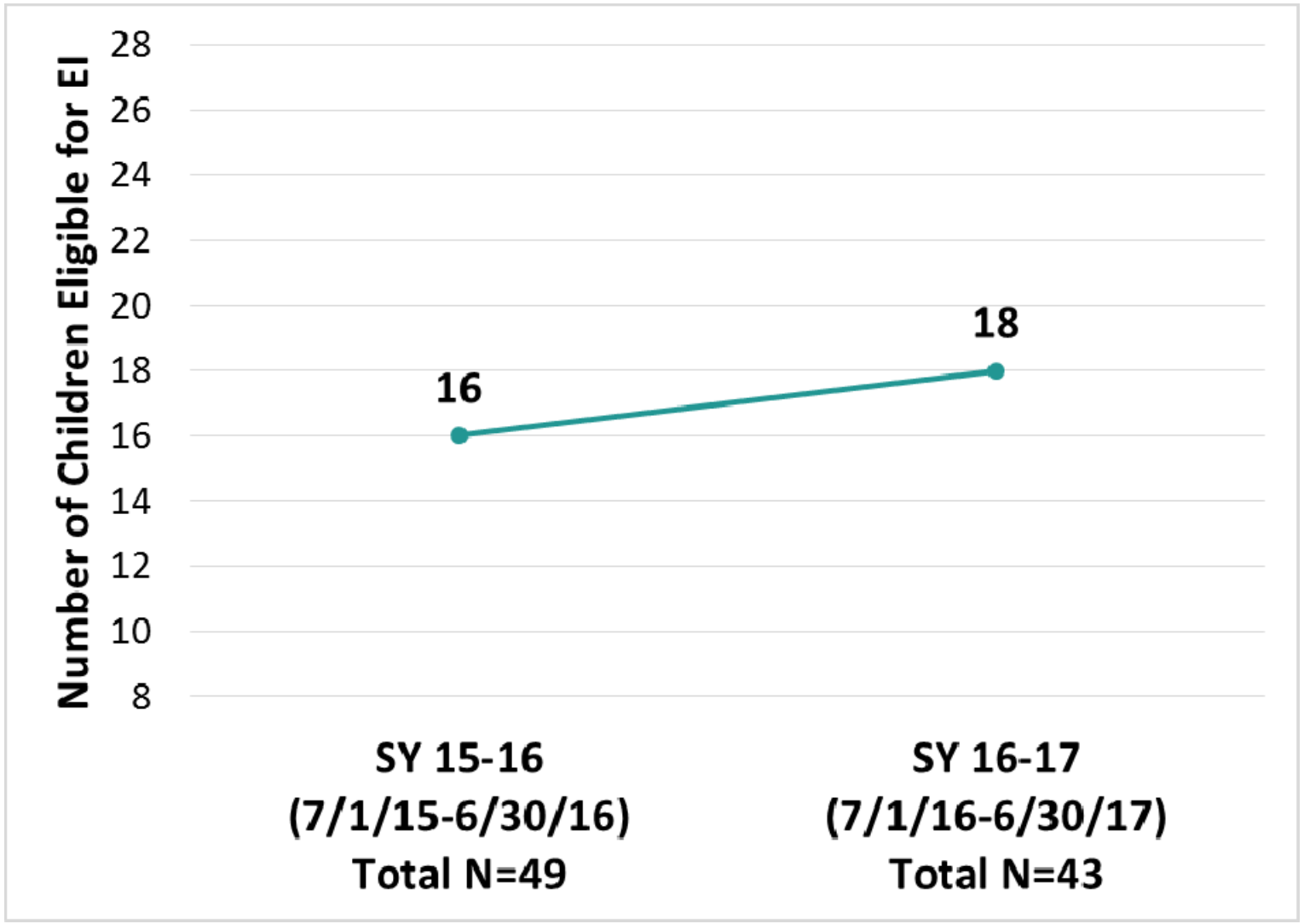
#1: Indication of Follow-Up to Developmental Screening

- 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

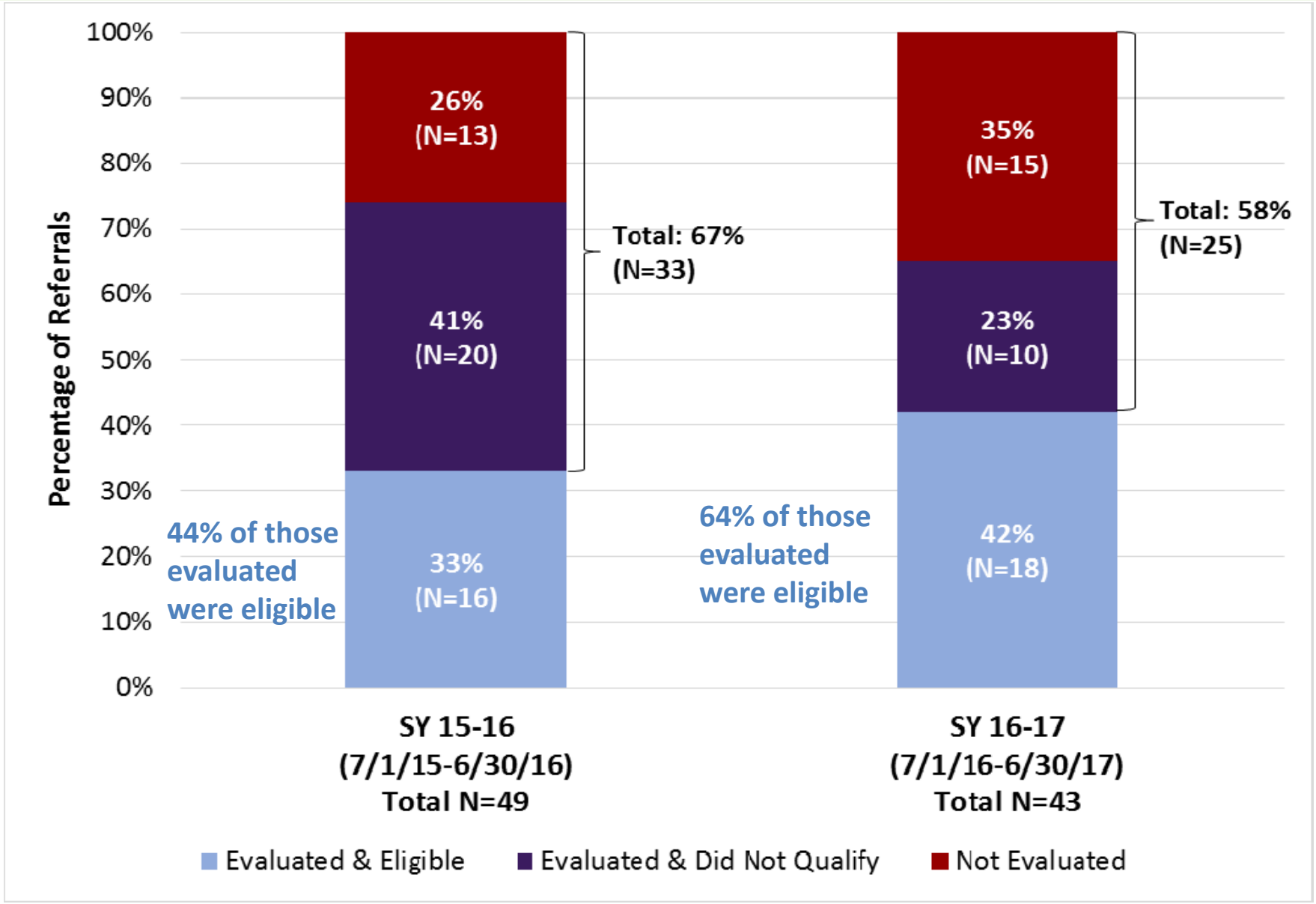
Number of Children Found Eligible in Tillamook



Percent Improvement from 2016 vs. 2017: 11% (N=2)

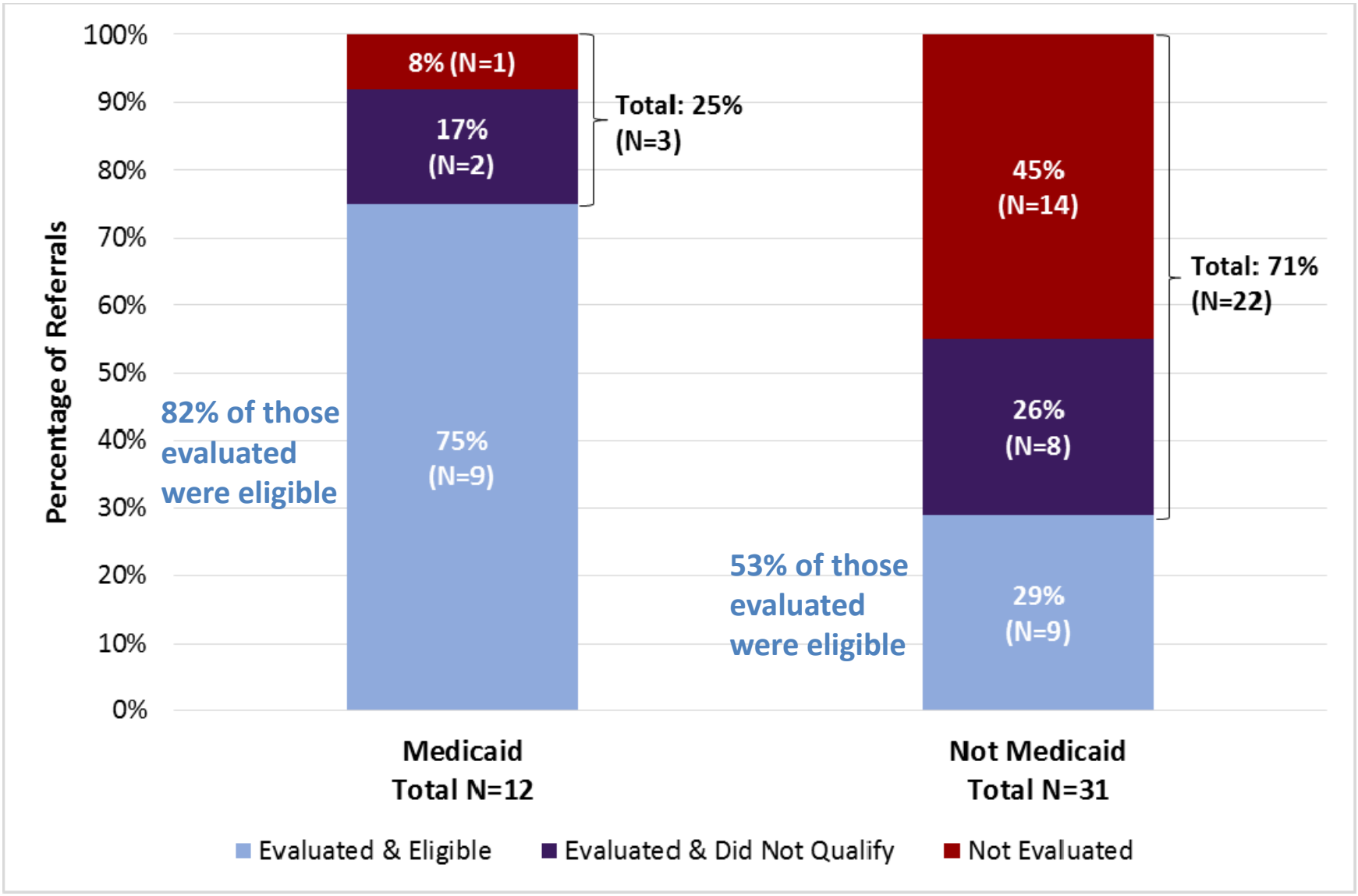
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

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



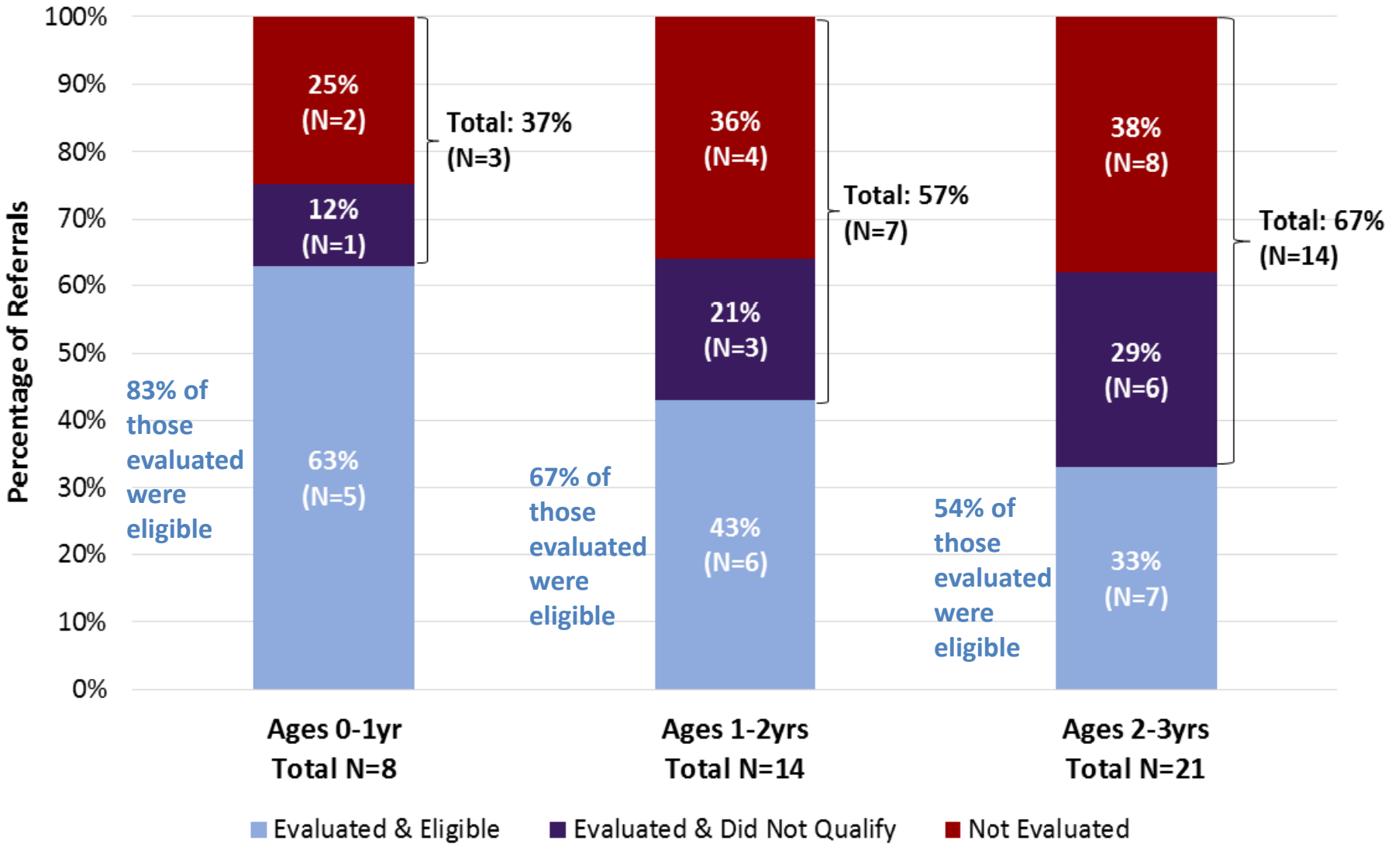
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Tillamook EI Referral Outcomes by Medicaid Eligibility



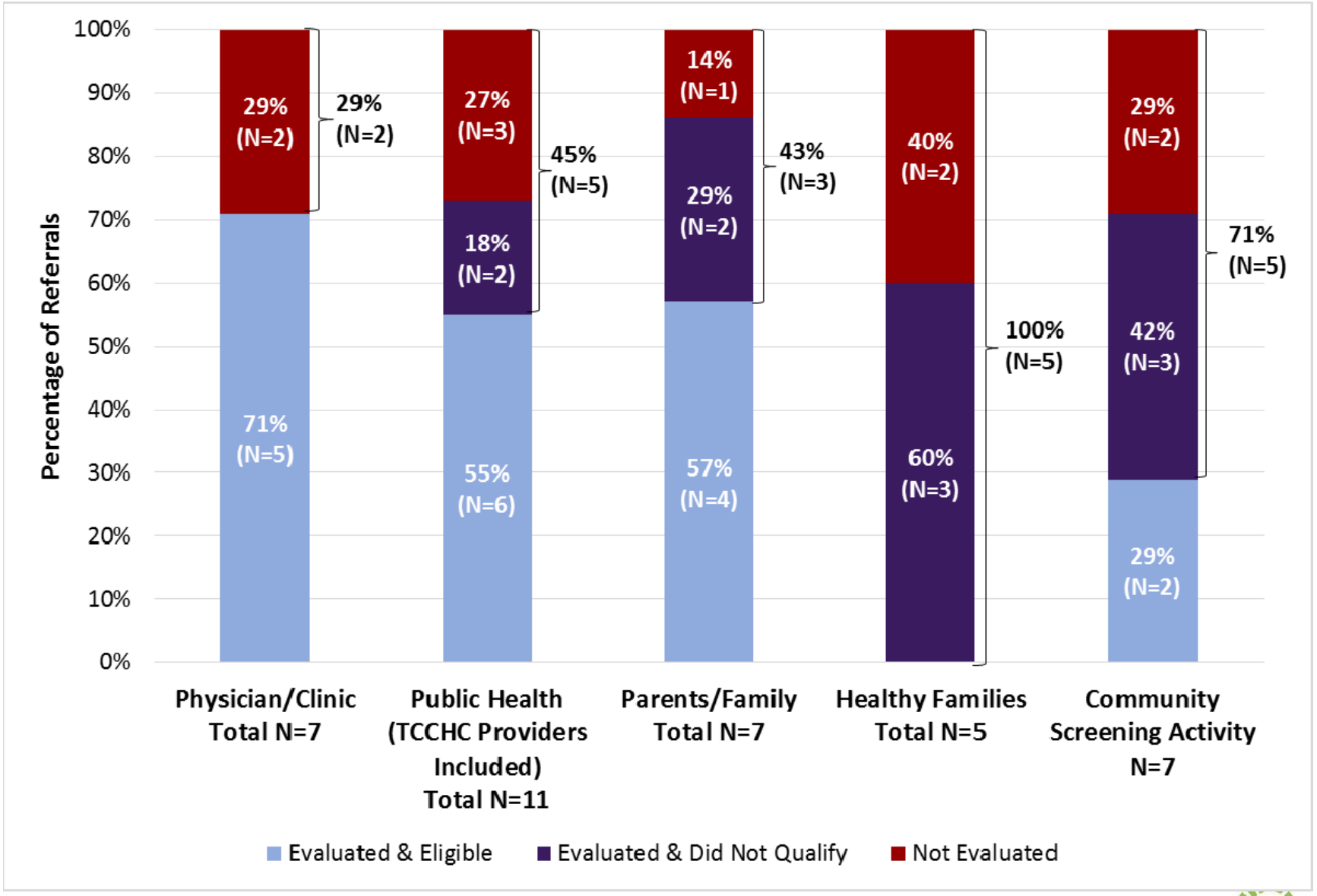
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

Tillamook EI Referral Outcomes by Age of Child

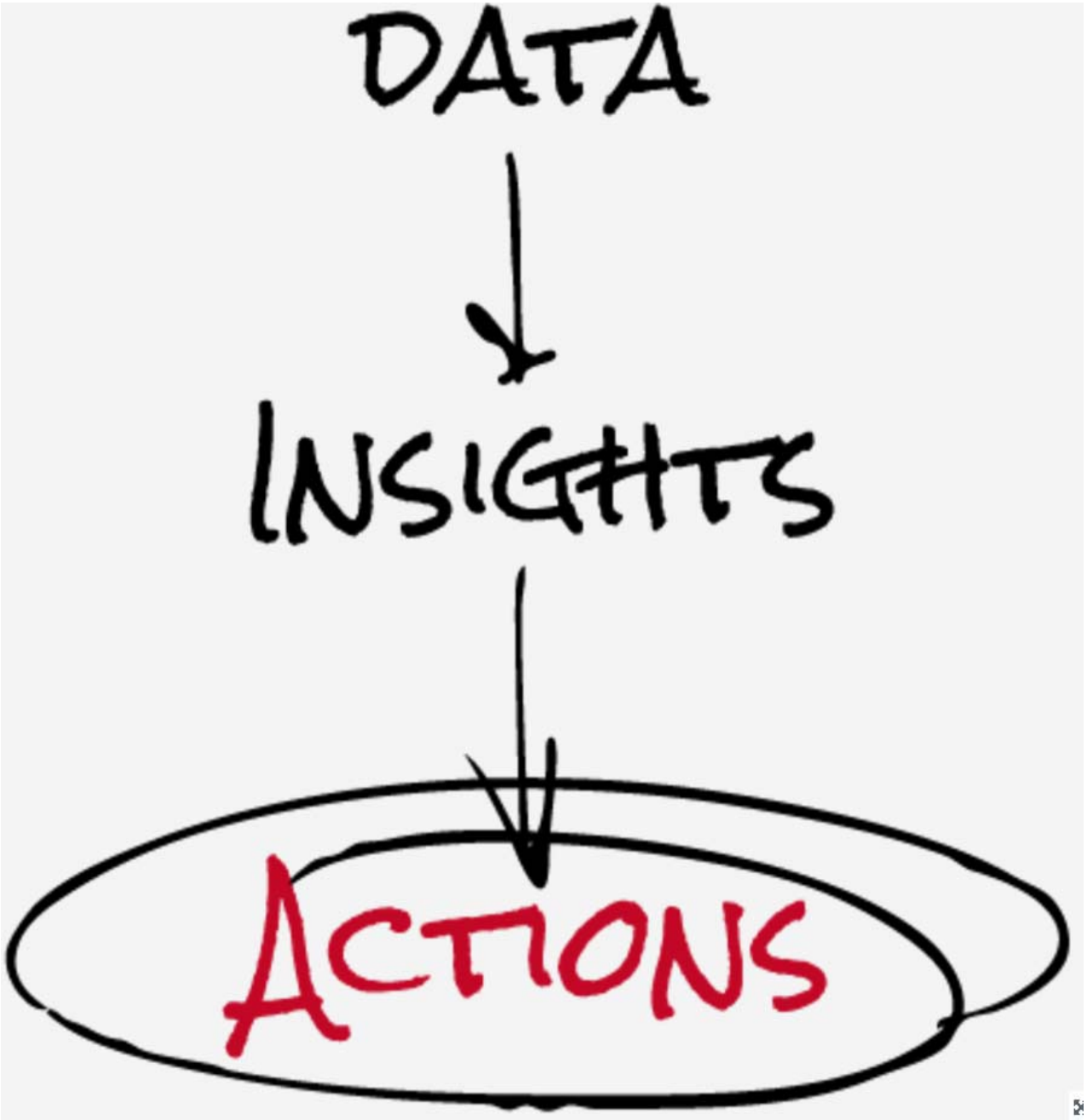


Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

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



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



Phase 2: Improvement Pilots

- In original grant, we were funded to **pilot the improvement processes** with:
  1. **One primary care practice** serving a large number of publicly insured children who demonstrated developmental screening was being done (based on billing) residing in this county: **Tillamook County Community Health Center (TCCHC)**
  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 to 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.

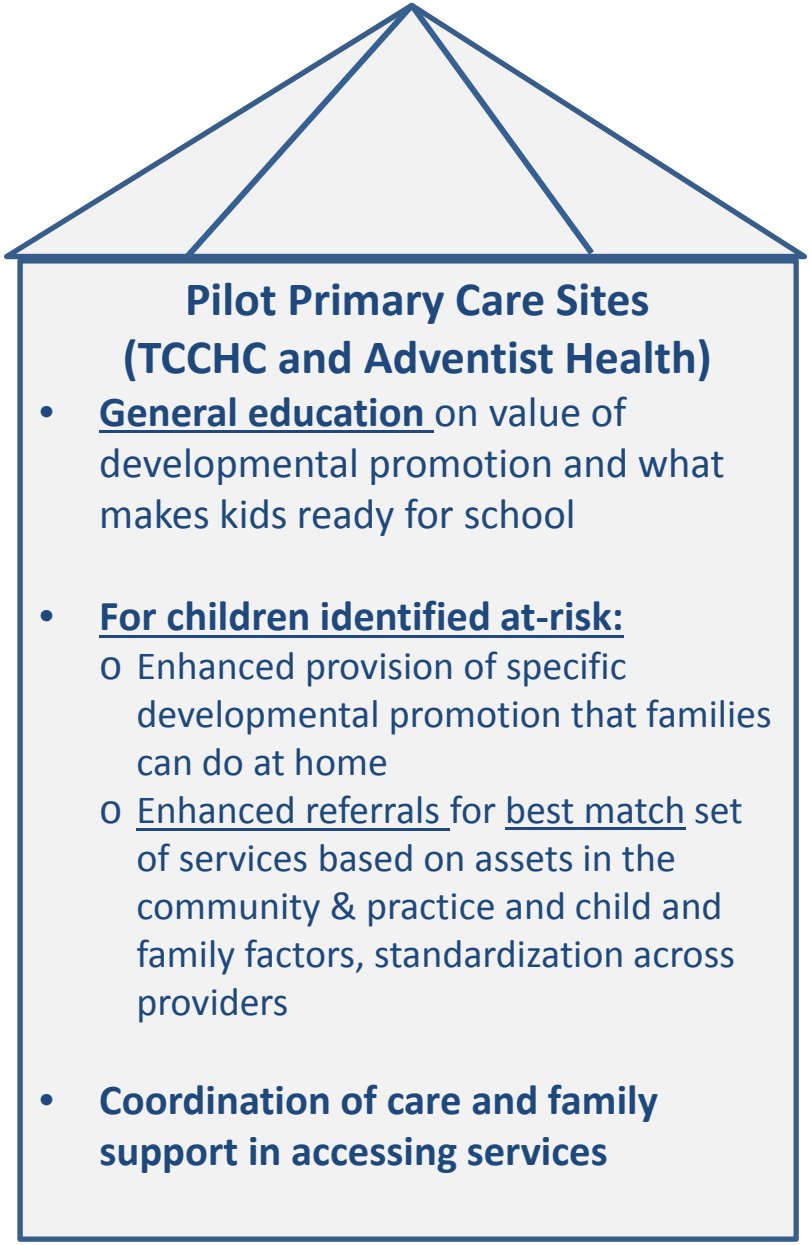
Improvement Pilot: Breadth and Depth, Components of a Pathway

- ***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 who are most vulnerable of needing a referral for follow-up, get to the various resources in the community
    - Decision support for primary care that identifies specific children who should be referred to specific community-level early learning providers
  - EI Ineligible
- ***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

Proposal to go for Breadth with Primary Care

- Given the early learning data, there appears to be under-use of early learning resources across all of primary care
- Stakeholders repeatedly noted the value of focusing on the primary part of the pathway, **from primary care** (where the most children are screened) **to follow-up services**
- Stakeholders repeatedly noted the value of engaging the two sites who provide primary care to the majority of children under three: TCCHC and Adventist
- **Proposal: To expand the breadth of the primary care** strategy beyond what was originally funded and work with two primary care sites to which 90% of CPCCO children are attributed to for primary care
  - Second Primary Care Pilot Site: Tillamook Regional Medical Center - Adventist Women's and Family Health office
    - They will pilot improved methods and outreach
    - Then will spread these follow-up tools and resources to the other Adventist sites
  - Adventist will also be engaged as a follow-up provider for OT/PT and Speech Therapy
- Refines the focus in Tillamook to how primary care – at large – can enhance best match referrals to the early learning providers in the community

Proposal for Focus of Improvement Pilots in Tillamook County



Pilot Primary Care Sites (TCCHC and Adventist Health)

- **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**

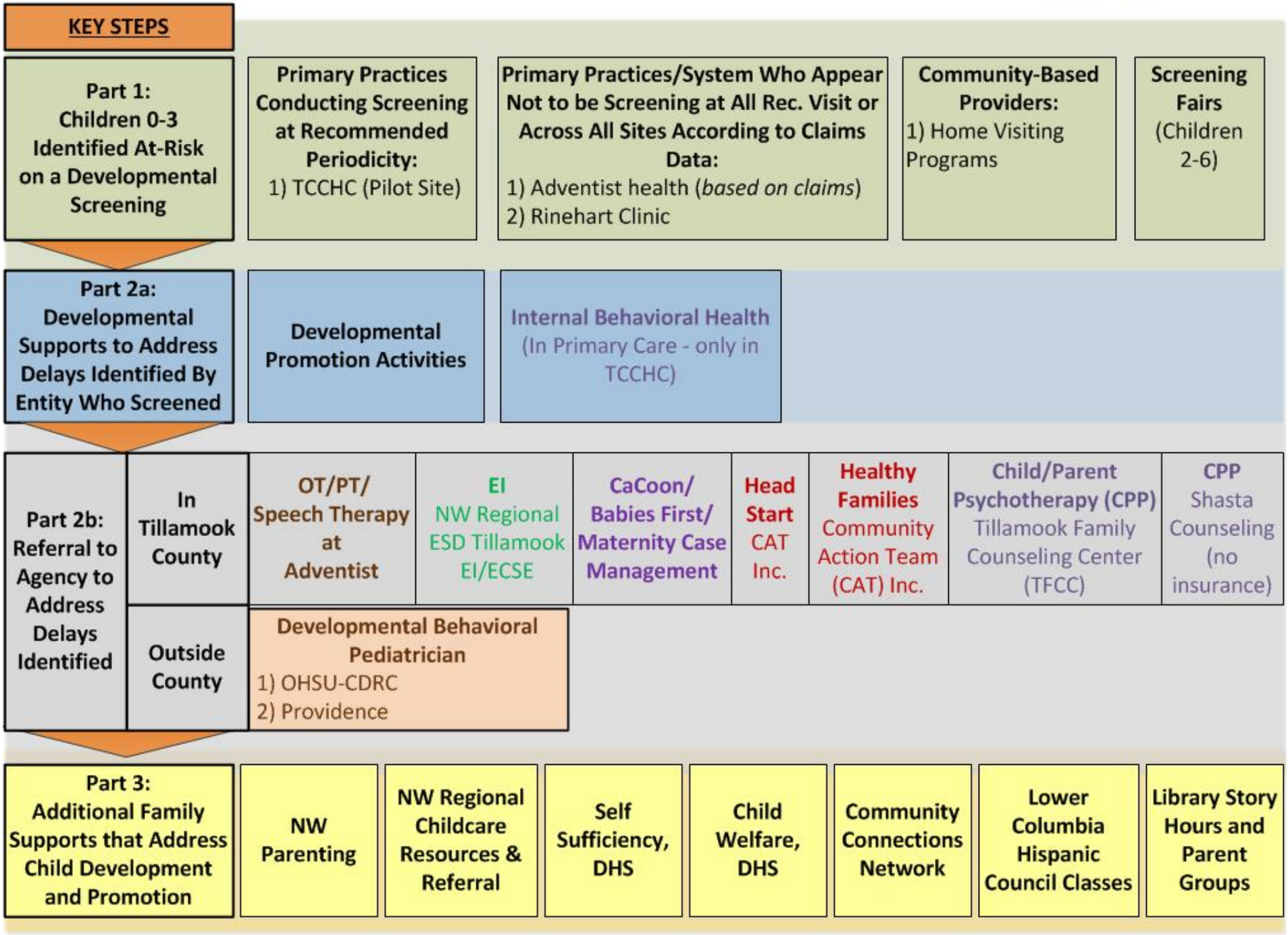
Early Intervention (NWESD-Tillamook)

- **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

- **For Eligible Children**: Communication about Services Provided to Inform Applicable Secondary Supports

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



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?

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 sites improvement efforts
  - EI pilot improvement efforts
  - Asset mapping with community-based providers

- **Next Stakeholder Meeting- June 6, 2018**

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

- **June, 2018**
  - Review pilot tools and strategies, get your 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:

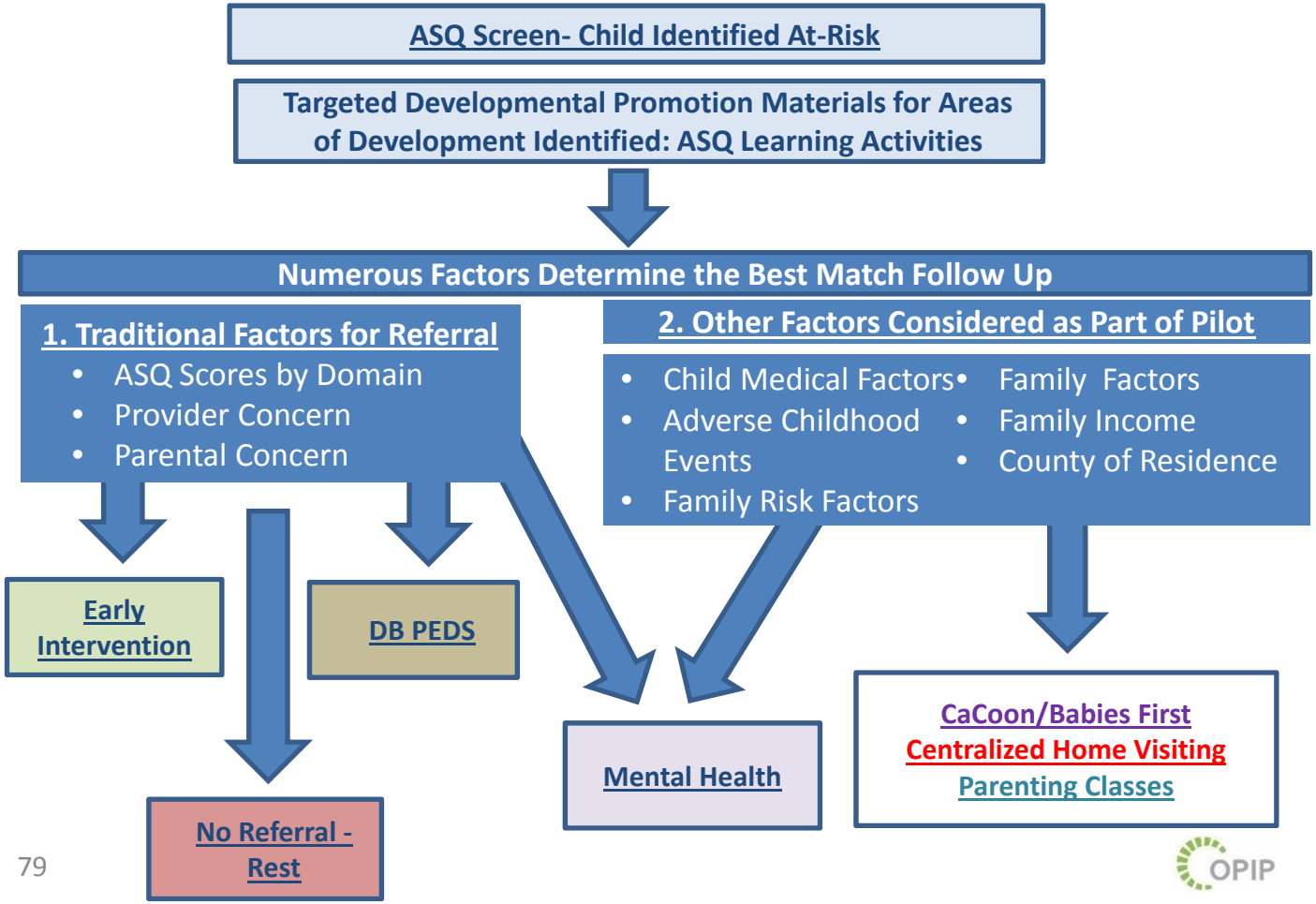
We Will Prioritize Group Discussion Over Reviewing these Details

Support to Primary Care Pilot: TCCHC and Adventist Health

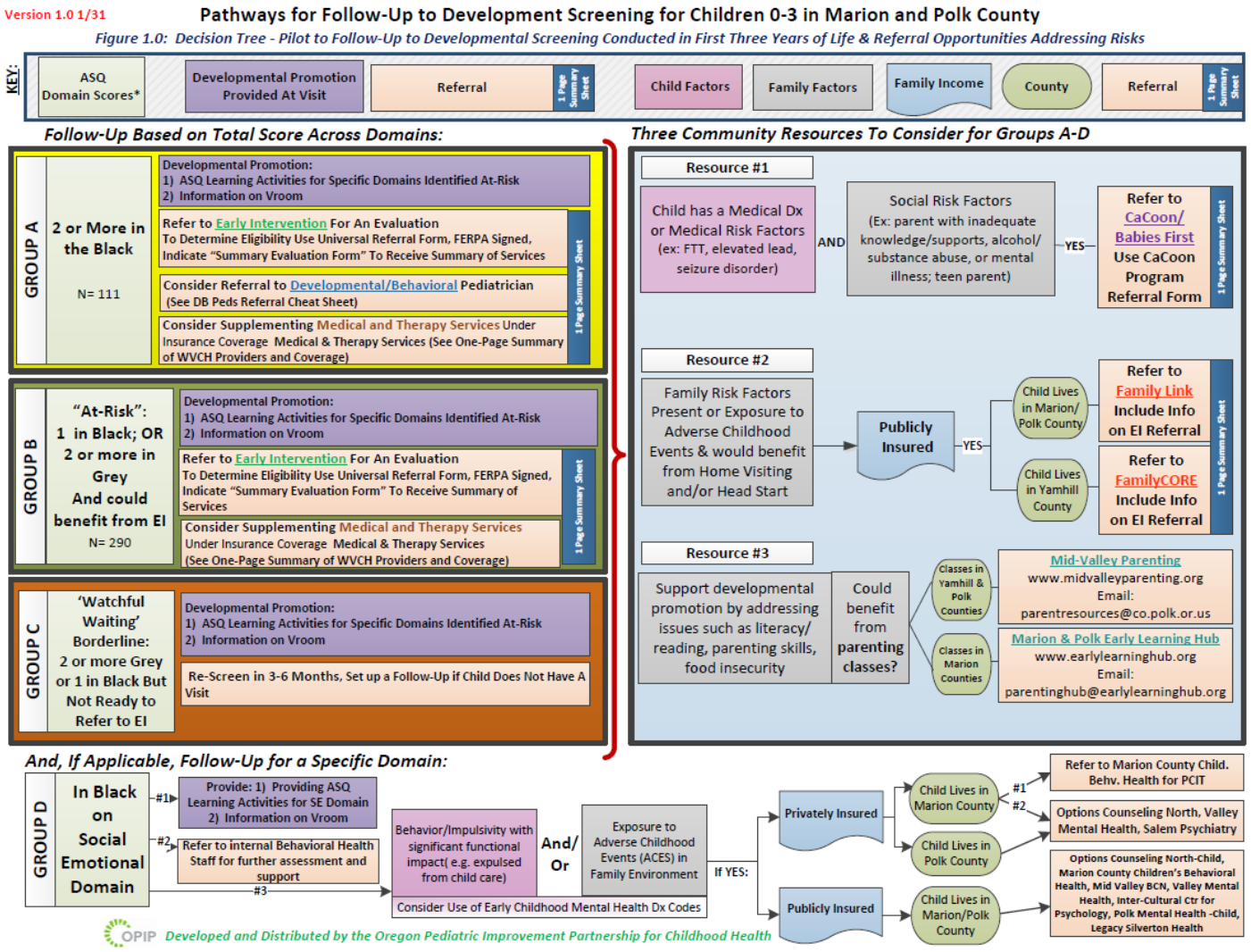
- **OPIP will develop new tools to enhance promotion and follow-up for all children identified at risk:**
  - Improved **developmental promotion activities** at the time of the visit,
  - Education tools about concept of "kinder readiness"
  - **Referral/Getting to Referral**- Improve workflows and processes for referral, including:
    - Develop a medical decision tree anchored to score and child and family risk factors and mapped to resources in the community
    - **Develop Parent education materials** to provide at the time of referral
    - Standardized methods and processes to **support families** in the referral process, Care Coordination
    - 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

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



Example of Medical Decision Tree from Past Projects



Family Supports in Navigating Referrals

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

☐ 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

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

☐ 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

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**

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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

OPIP

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)

- 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)
- ***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).

Early Intervention Support from NWELH and OPIP

- **General Quality Improvement**
  - **Support in sharing and use of EI data** for tracking, and community level conversations (This Meeting), Quarterly tracking to assess impact of the project
  - **EI Participation in development** of updated medical decision tree for providers
  - **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:
  - **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
  - 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
  - Pilot enhanced processes and follow up steps for children found to be ineligible for EI services, particularly to CCMH.