Pathways from Developmental Screening to Services:
Ensuring Young Children Identified At-Risk for Developmental, Behavioral and Social Delays Receive Best Match Services

May 17th 2018

Presentation to the State Advisory Council for Special Education

Colleen Reuland, MS Director – Oregon Pediatric Improvement Partnership
Dorothy Spence, Director – Northwest Early Learning Hubs

Ensuring Follow-up to Developmental Screening: Community-Based Approaches With Primary Care, Early Intervention, and Early Learning

Agenda

- **Part 1: Setting the Landscape for the Community-Based Improvement Effort**
- **Part 2: Data Identifying Where Children Fall out of Pathways, Community Asset Mapping, Improvement Priorities**

Community-Based Improvement Effort

- **Part 3: Improving Follow-Up in Primary Care**
- **Part 4: Improving Follow-Up in Early Intervention**
- **Part 5: Improving Follow-Up to Home Visiting & Parenting Education**

Setting the Landscape for the Community-Based Improvement Project: Fertile Ground in Oregon for an Effort Focused on Early Childhood

Transformation within Health Care in Oregon that Created a Fertile Landscape for This Project

1. Development of Coordinated Care Organizations
   – Incentive Metrics

2. Focus on Patient-Centered Primary Care Homes (PCPCH)

Coordinated Care Model

- Coordinated Care Organizations (CCOs)
  - Network of all types of health care providers (physical health care, addictions, mental health care, dental care) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).
  - 16 CCOs operating in communities around Oregon
  - 93% of children in Oregon Health Plan are enrolled in a CCO
- Key Levers within Coordinated Care Model
  - Global budget
  - Performance Improvement Projects
  - **Performance Metrics – Incentive Metrics**

Incentive Metrics for Oregon's Coordinated Care Organizations (CCO)

2017 Incentive Metrics

1. Adolescent well-care visits
2. Ambulatory care: Emergency department utilization
3. CAHPS Composite: Access to care
4. CAHPS Composite: Satisfaction with care
5. Childhood immunization status
6. Colorectal cancer screening
7. Controlling high blood pressure
8. Dental sealants on permanent molars for children
9. Depression screening and follow-up plan
10. **Developmental screening in the first 36 months of life**
11. Diabetes: HbA1c Poor Control
12. Effective contraceptive use among women at risk of unintended pregnancy
13. EHR Adoption
14. Follow-up after hospitalization for mental illness
15. Mental, physical and dental health assessments within 60 days for children in DHS Custody
16. **Patient Centered Primary Care Home (PCPHC) Enrollment**
17. Prenatal and postpartum care: Timeliness of prenatal care

Oregon's Patient-Centered Primary Care Home (PCPCH) Program

- State-specific definition and accreditation
  - General definition, not specific to certain populations
  - Scoring used to identify practices within "Tiers", with Tier 5 being the highest
    - 11 "must-pass" criteria that every clinic must meet in order to be recognized
      - **Developmental screening is included in a global "Must Pass Measure"**
        - » Measure: 3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources
    - Other criteria worth varying amounts of points. Harder concepts = Higher # of points
    - Total points determines clinic's overall tier on the PCPCH recognition.
- Incentives related to PCPCH
  - CCOs get incentive monies based on number of members who go to a PCPCH
    - High variability within CCO on use of PCPCH tiers for alternative payment reform to clinics
  - Some incentive to privately insured OHA members who go to a PCPCH, reduction in co-pays

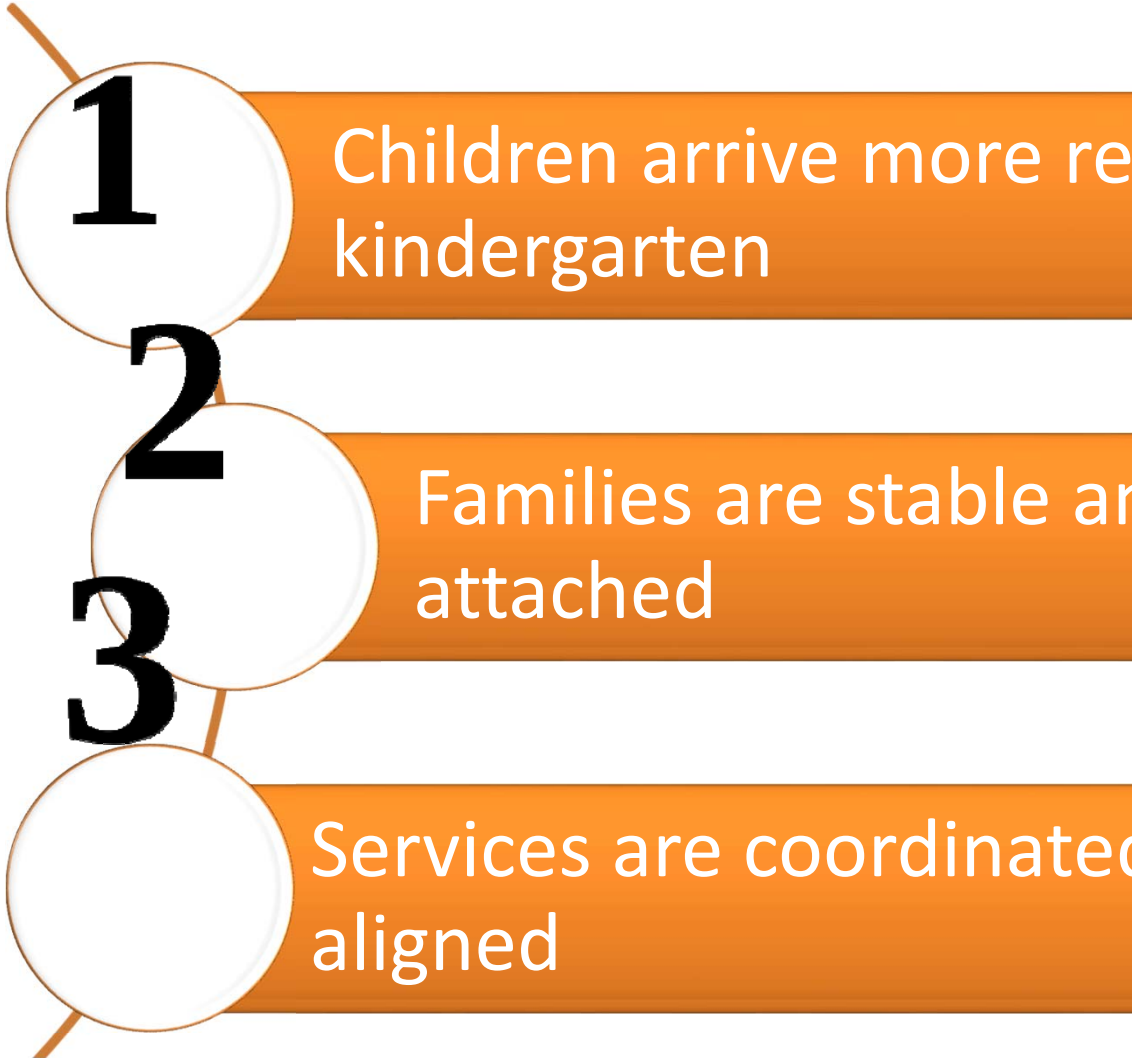
Transformation within Early Learning in Oregon

*Within **Early Learning**:*

- Development of Early Learning Division
- Development of Early Learning Hubs
- High Quality Child Care

Early Learning System & Early Learning Hubs

- In 2011, legislature established the Oregon Education Investment Board (OEIB) and Early Learning Council (ELC).
- Established 16 Early Learning Hubs to bring together Human Services, Health, Early Learning, K-12 Education and Business Sectors.
- First Hub started in 2014.
- Collective Impact philosophy.



What is an Early Learning Hub?

- Early Learning Hubs support underserved children and families in their region to learn and thrive by making resources and supports more available, more accessible and more effective.
- Hub functions:
  1. **Identify the populations** of children most at-risk of arriving at kindergarten unprepared for school.
  2. **Identify the needs** of these children and their families.
  3. **Work across sectors** to connect children and families to services and support that will meet their needs.
  4. **Account for outcomes** collectively across the system.
- Hubs are not direct providers of services.
- Currently there are 16 Hubs across the Oregon - not necessarily aligned with regions of the CCOs

Marion & Polk Early Learning Hub

Connection with Coordinated Care Organization:

- Connecting clinics with early learning system work:
- Developmental Screening work – desire to share Ages & Stages Questionnaires with Medical providers
- Reach Out and Read
- Parent Education
- Immunization book project

Yamhill CCO & Early Learning Hub

- Yamhill CCO received contract for ELH in May 2014
- Two Early Learning Council members (including the ELC founding chair) sit on CCO Board
- CCO goal = better care for more people at a lower cost
- Shared strategy
  - Prevent Adverse Childhood Experiences (ACEs)
  - Address social determinants of health
  - Invest in upstream prevention/early intervention

hub inc.
MARION & POLK EARLY LEARNING HUB

Yamhill Community Care Organization

Opportunity to NOW Focus on Follow-Up to Developmental Screening that is the Best Match for the Child & Family

- Oregon one of the highest states for developmental screening.

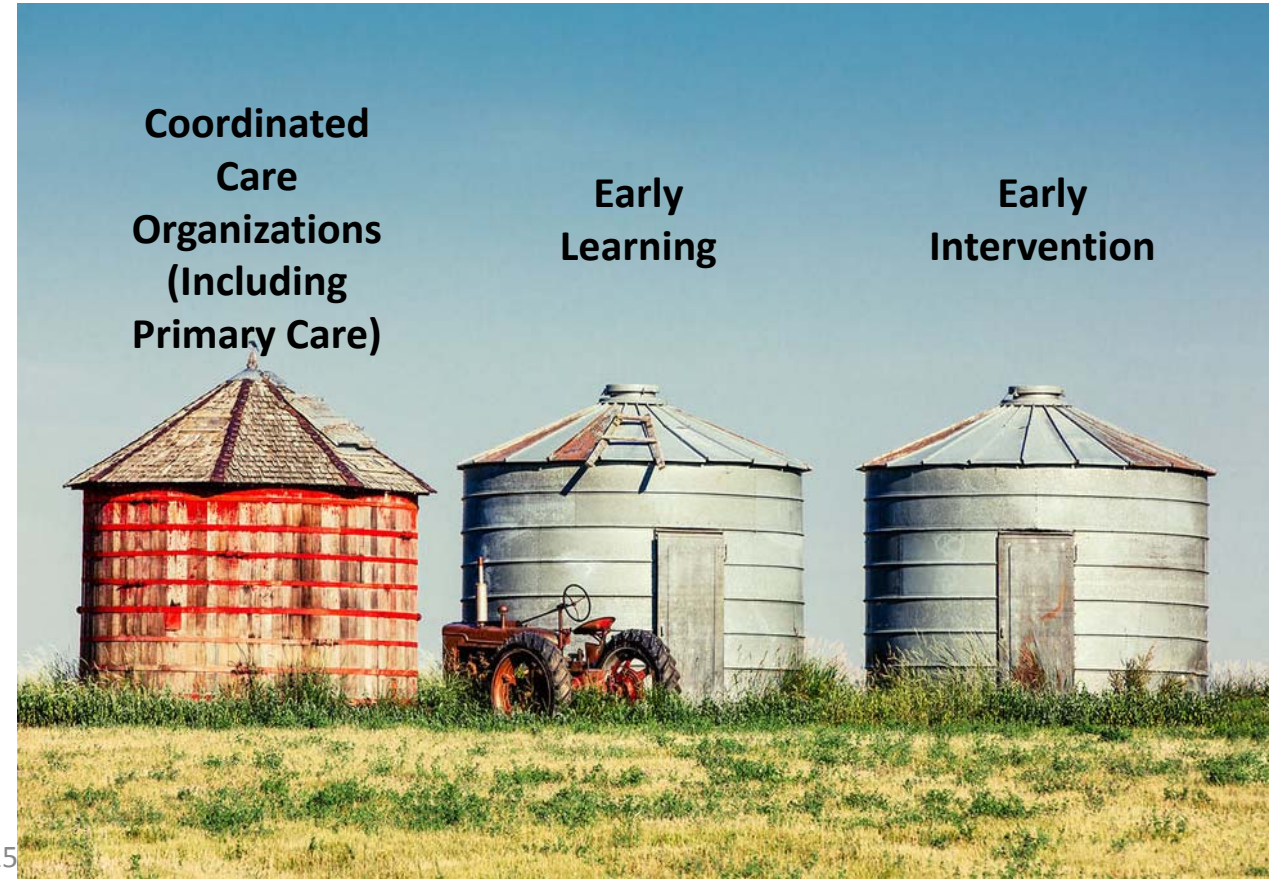
Goals of screening:

- –Identify children **at-risk** for developmental, social and/or behavioral delays
- –For those children identified, **provide developmental promotion, refer to services** that can further evaluate and address delays
  - Follow-up services live within a variety of settings. For example:
    - Health Care

Children Identified "At-Risk" on Developmental Screening *are identified "at-risk" for developmental, behavioral or social delays on standardized developmental screening tools. In the communities of focus for this work, a majority of providers are using the Ages and Stages Questionnaire (ASQ)[3]. Therefore the children of focus are those identified "at-risk" for delays based on the ASQ domain level findings.*

OPIP

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



Key Components of Community-Based Improvement Efforts

1. Community-level Stakeholder **Engagement** Across Seven Sectors & with Parent Advisors:
   - **Understand** current pathways,
   - Identify **existing community assets**
   - Prioritize **where** to focus pilots of improved follow-up

2. **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:

   A. Primary Care Practices
   B. Early Intervention
   C. Early Learning

Spotlight on Two OPIP Projects

http://oregon-pip.org/focus/FollowUpDS.html

1. **Oregon Health Authority** contracted with OPIP to provide consulting and technical assistance to **Yamhill Early Learning Hub** and **Yamhill CCO** on a community pilot focused on ensuring children identified at-risk for developmental, behavioral, and social delays receive follow-up services. (January-December '16)
   - *Supported by Funding Opportunity Number CMS-1G1-12-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services*

2. **Willamette Education Service District** contracted with OPIP to lead efforts in Marion, Polk and Yamhill County (May '16-June '17)
   - In 2015 the Oregon Legislature directed Oregon Department of Education (ODE) to identify pathways from developmental screening to appropriate early learning services

Three Communities, Two CCOs, Two Early Learning Hubs and One Early Intervention Contractor

Three Communities: Marion, Polk and Yamhill Counties

Stakeholders Engaged in Community-Based Efforts

1. Identified over 60 stakeholders across the 3 communities that had a role in a) conducting developmental screening and/or b) providing follow-up to developmental screening
   - Engaged people across seven sectors

2. Parent advisors
   - Recruited four parent advisors whose children had experienced an early learning system(s)
   - Engaged the Early Learning Hub parent advisory group

Stakeholder Engagement in Marion, Polk, and Yamhill Counties to Inform Community Asset Mapping

1) CCOs (WVCH, YCCO)

- Medical Director
- Metrics Staff
- Practice Support Staff
- Mental Health Director
- Staff that oversee services for children
- Liaison to Early Learning Hubs
- OHA Innovator Agent

2) Primary Care

- Practices that see large number of children and are doing developmental screening
- Practice staff engaged included:
  - ✓ Physician
  - ✓ Care Coordinator
  - ✓ Referral Coordinator
  - ✓ Practice Manager

3) EI & Education

- EI/ECSE Program Coordinator
- EI Referral Intake Coordinator
- School District Representative

4) Early Learning Hub (Yamhill Early Learning Hub, Marion and Polk Early Learning Hub)

- Director or Executive Director
- Community Engagement Staff
- Staff involved in efforts around developmental screening

5) Home Visiting and Head Start/Early Head Start

- Centralized home visiting referral programs
- Public Health/ CaCoon/ BabiesFirst
- Healthy Families
- Other community services that provide home visiting
- Early Head Start and Head Start

6) Child Care and Parenting Supports

- Childcare Resource and Referral Center
- Childcare Centers conducting screening
- Oregon Parenting Education Collaborative entities

7) Infant and Early Childhood Mental Health

- Clinic director
- Staff who conduct child and parent psychotherapy
- If available, Parent and Child Interaction Therapy

Stakeholders We Have Here Today

Let's learn about who we have here to today to help us tailor the rest of the session

Raise Your Hand If You Are From:

1. Health system
2. Primary care
3. Early Intervention
4. Early learning – which for now will include Home Visiting, Early Head Start, Head Start
5. Childcare
6. Infant and early childhood mental health
7. Parent advocate
8. What group did we miss?

Momentum Around Follow-Up to Developmental Screening:
What Levers Do You Have In Your Own State?

In Oregon, these levers create fertile ground:

*Within **Health Care**:*

- CCO Incentive Metric – Developmental Screening
- Oregon PCPCH Standards

*Within **Early Learning**:*

- Early Learning Hub Metrics
  - 1st wave included CCO Developmental Screening Incentive Metric
- High quality child care – part of highest level designation

Self Reflection:

- What levers do you have your own state to focus on follow-up to developmental screening?
- Did your state Title V Agency pick Developmental Screening as a priority area?

OPIP

Stakeholders Important to Engage in Your Communities

- **Self Reflection – As you focus on follow-up to developmental screening, who are the stakeholders across the seven sectors that you will engage?**

1. Health System
2. Primary Care
3. Early Intervention
4. Early Learning – which for now will include Home Visiting, Early Head Start, Head Start
5. Childcare
6. Infant and early childhood mental health
7. Parent advocate
8. What group did we miss?

Agenda

- Part 1: Setting the Landscape for the Community-Based Improvement Project. Overview of Improvement Strategies Developed
- **Part 2: Data Identifying Where Children Fall out of Pathways from Screening to Services, Community Asset Mapping, Improvement Priorities**

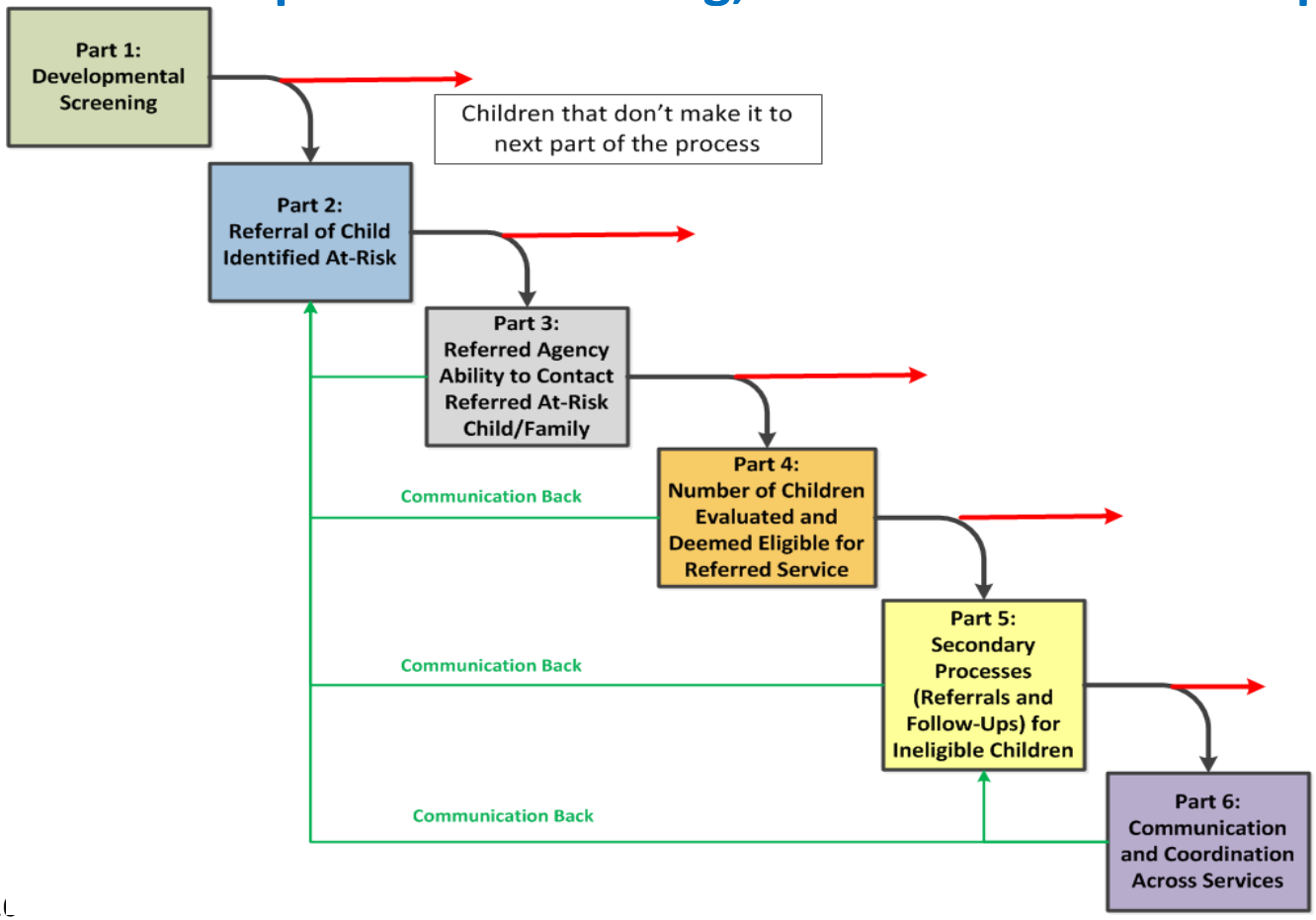
Community-Based Improvement Effort

- Part 3: Improving Follow-Up in Primary Care
- Part 4: Improving Follow-Up in Early Intervention
- Part 5: Improving Follow-Up in Home Visiting & Parenting Education Supports

Qualitative & Quantitative Data Gathered to Inform Priority Pathways to Focus Community-Based Improvement Efforts

- Baseline **qualitative and quantitative** data collected in order to:
  1. **Understand the current pathways** from developmental screening to services in each of the three counties, and the community-level assets and resources that exist to support follow-up services.
  2. **Understand where and how children are falling out** of these pathways and not receiving services to address the identified risks, including where there is a lack of capacity to serve children identified.
- Convene stakeholders in **group-level meetings** to share the baseline qualitative and quantitative findings:
  1. To **understand current pathways**
  2. **Confirm priority areas** to pilot improvements

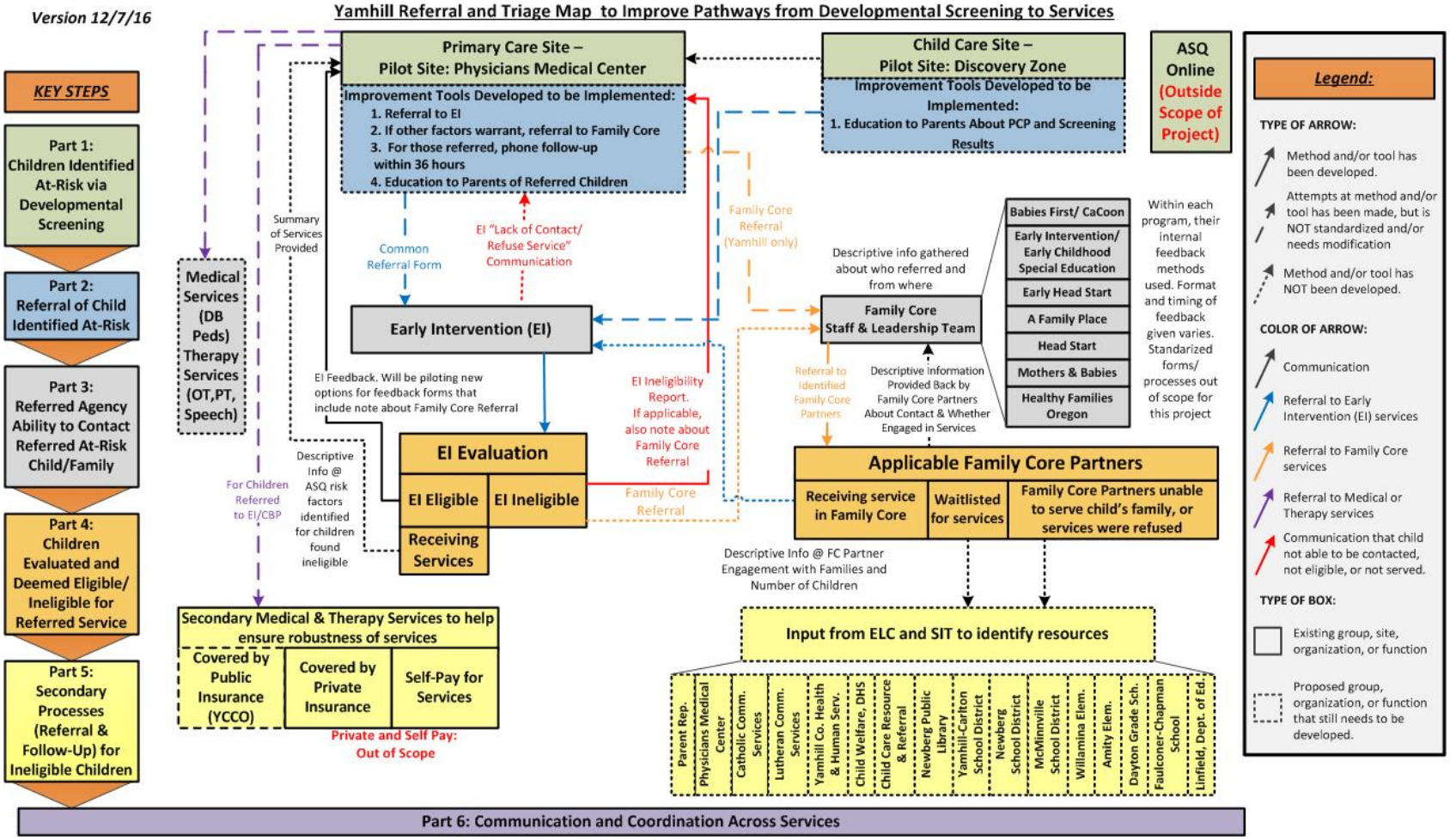
Key Building Blocks of the Pathways for Developmental Screening, Referral and Follow-Up



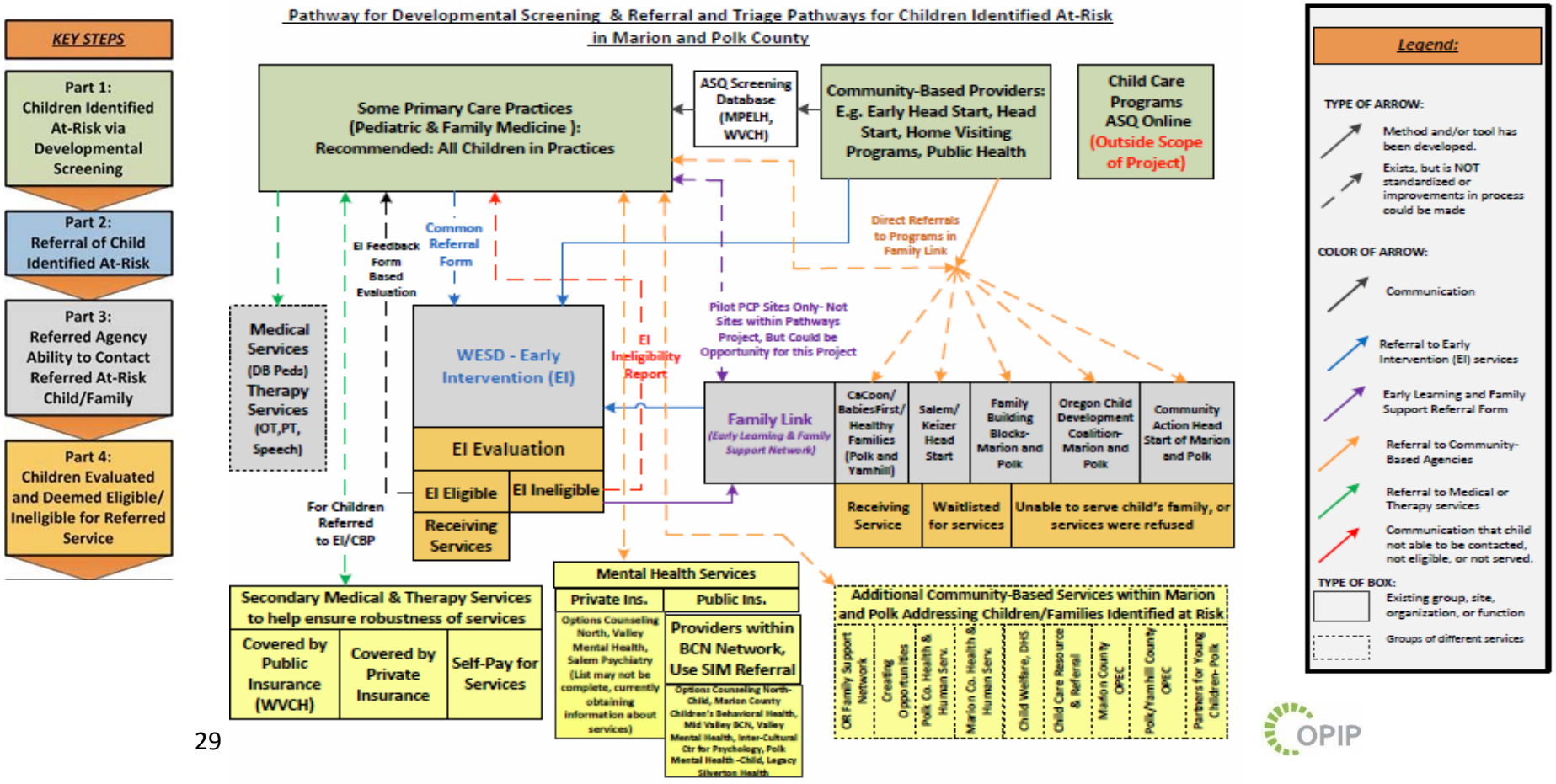
Qualitative Data: Stakeholder Interviews

- Interviewed people from organizations that either:
  - Conduct developmental screening and are responsible for follow-up AND/OR
  - Provide follow-up for children 0-3 identified on developmental screening
- Purpose of Interview
  1. Current follow-up process
     - When refer
     - How refer – what form, how tracked
     - Feedback loops – child able to be contacted, eligible, services received
  2. Current services to inform the **Asset Map, which may include places where assets are needed but not yet present**
  3. Opportunities
  4. Barriers
  5. Capacity within the region

Community Asset Mapping and Pathway Identification in Yamhill County



Community Asset Mapping and Pathway Identification in Marion and Polk Counties



Key Qualitative Findings Related to Follow-Up to Developmental Screening for Young Children

Follow-up to Screening in Primary Care

- Confusion and lack of awareness within primary care about difference between recommendations for when to refer to EI vs EI Eligibility
  - Perception that many children who are referred will not be eligible impacts if and when they refer
- Need for referral criteria that take into account child and family factors, particularly for those children for whom the delay may be because of lack of exposure to the developmental tasks asked about in the ASQ
- Lack of awareness of resources within Early Learning and/or WHEN or HOW to refer to them
- Parent push-back on referrals, cultural variations

Early Intervention

- Value in communication back to referring provider
- Value in understanding who is eligible and what services receiving to inform secondary follow-up
- Follow-up steps for ineligible children

Need for Parent Supports

- Developmental promotion that could in occur in the home when referral not available
- Education about referrals when provided, parent support in navigation

Parent Advisor Input

#1: Need for Better Communication and Supports→ What does a Positive Developmental Screening Mean?

- Need printed and verbal information
- Information should include: Why screening was done, what the screening results mean, what they can expect moving forward, who they can call if they have questions
- Who will be calling them and why
- For EI, explanation that you are being referred for further evaluation → not for services
- How the information will be shared across the different providers
- Materials need to take into account different social contexts

#2 Multiple providers and multiple entities can be overwhelming and scary

- Understand the value and importance of each team
- That said, it can make a parent feel overwhelmed and scared about the "seriousness"

#3: Home visitors are extremely helpful in translating the different services and providing support

- Understand that some parents don't allow someone to come to the home
- Value of co-location at their PCP or partnership with Head Start

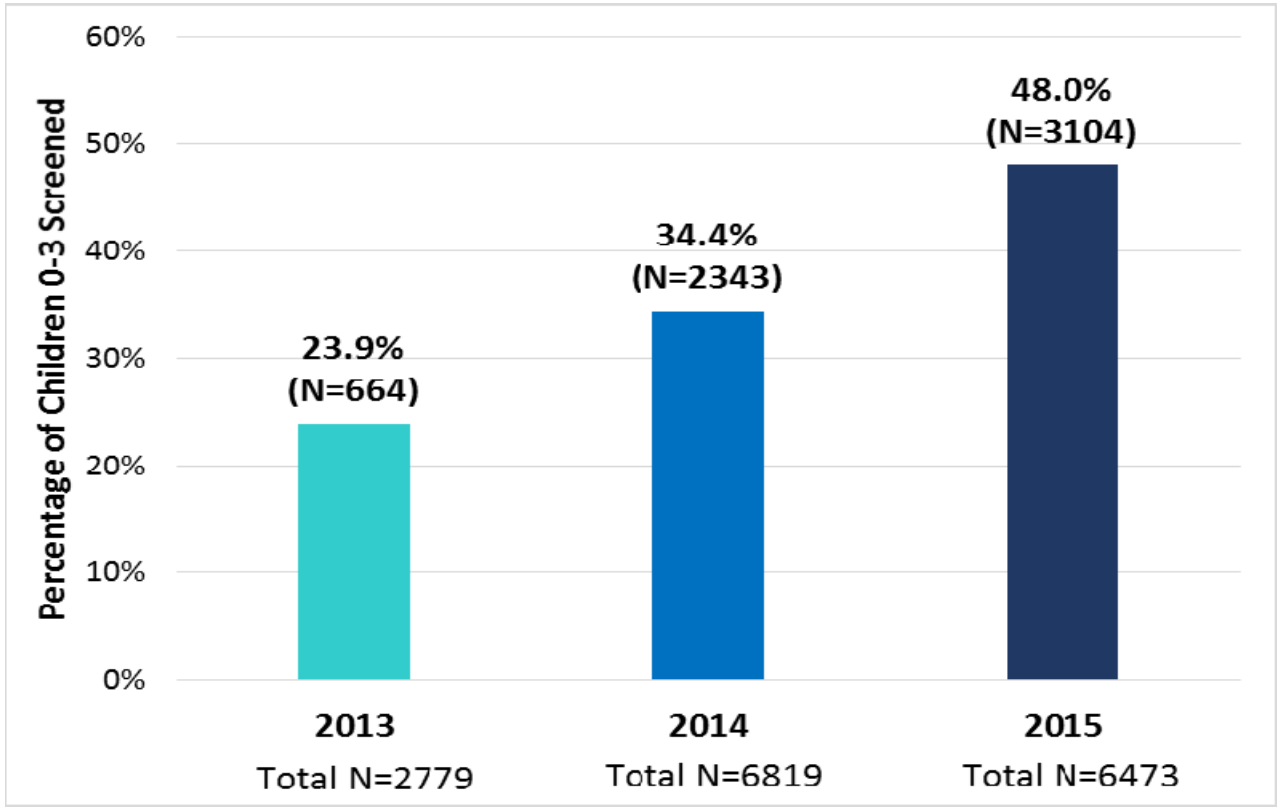
#4: Better communication between multiple entities working with the same family is necessary and appreciated

- Burden is on the parent to update the multiple providers their child sees, can be overwhelming

Quantitative Data Collected to Inform Baseline & Evaluation Data

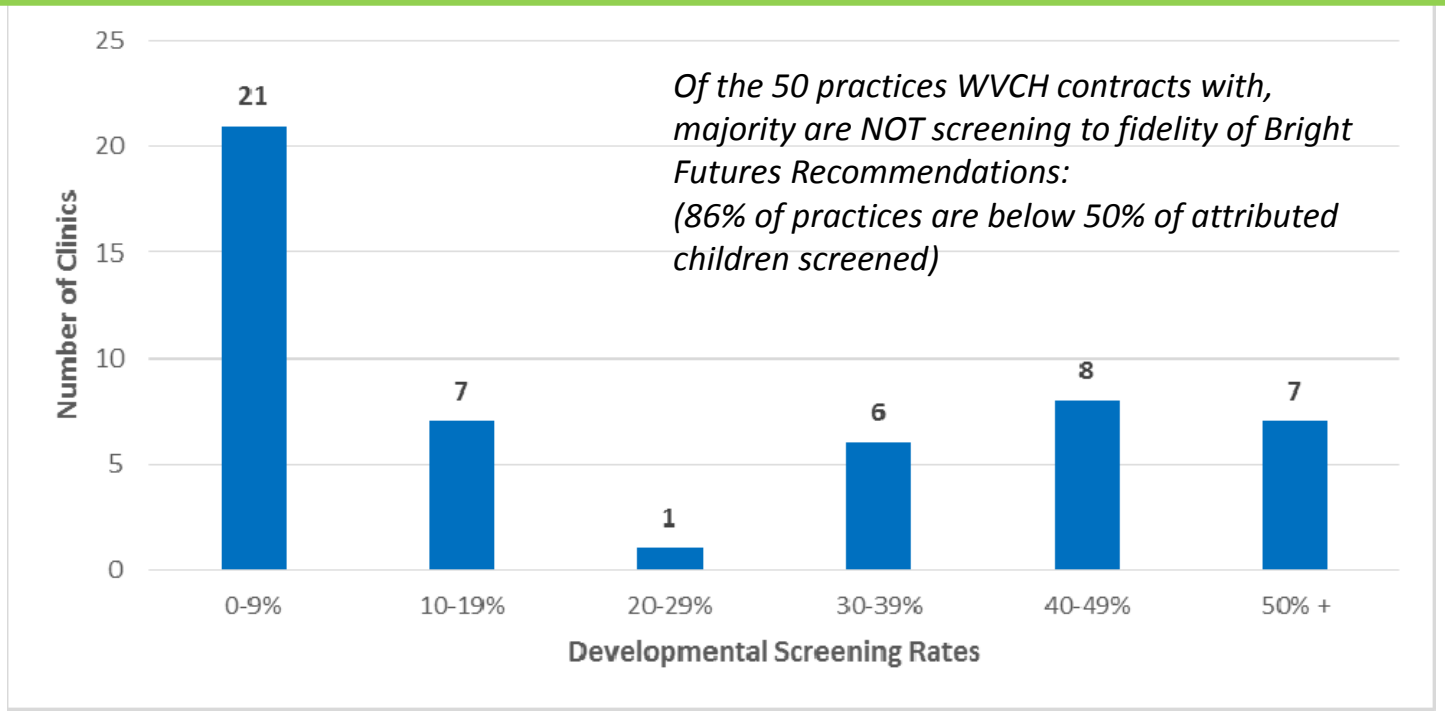
Focus of Metrics	CCO Data Based on Claims (Health System for Publicly Insured)	Primary Care Practice Data: Based on EMR	Early Intervention Data: Based on Data in ECWeb, Manual Review
Developmental Screening	X	X	
Of those screened in Primary Care:			
# at-risk , Types of Risk		X	
Referrals		X	X
Provision of other follow-up (i.e. rescreen, developmental promotion)		X	
Outcome of referral (i.e. Were they able to contact and evaluate?)			X
Outcome of evaluation/ assessment (i.e. Did child get a service?)			X
Follow-up steps of ineligible			X

Developmental Screening Rates in the First Three Years of Life for Publicly Insured Children in Willamette Valley Community Health (WVCH): As Tracked by 96110 Claims Submitted



Source: WVCH Developmental Screening Rates, Based on 96110 Claims Submitted for Children Continuously Enrolled for 12 Months

Variation in Developmental Screening Rates for Practices to Whom WVCH Children Are Attributed



Source: Based on 96110 Claims Submitted for Children Continuously Enrolled for 12 Months and Who WVCH Attributed to the Practice

OPIP

Primary Care Practice Data

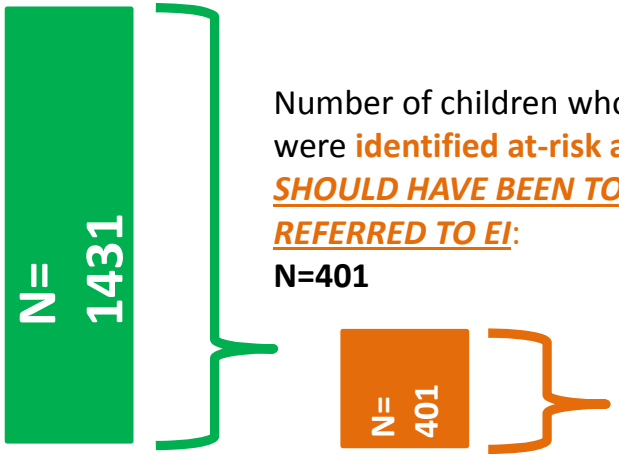
Highlight of Findings:

- Majority of children who come in were screened
  - Children who do not come in, not screened
  - Most likely for children 2-3 years old
- Across three practices, 19-28% of developmental screens conducted in the first three years of life identified a child at-risk for delays
- However, for those children identified at-risk for delays, referrals to EI ranged from 20-35%

An Applied Example from One of Our Primary Care Pilot Sites

Number of ALL Children in Clinic (Publicly and Privately Insured) ***WHO RECEIVED A DEVELOPMENTAL SCREEN IN ONE YEAR:***

N=1431



Number of children who were **identified at-risk and *SHOULD HAVE BEEN TO REFERRED TO EI***:

N=401

Of the children who received a developmental screen, **28% identified at-risk for delays** for which developmental promotion should occur

NUMBER REFERRED TO EI based on their developmental screen :

N= 76

81% NOT REFERRED

Data Source: Data provided by Childhood Health Associates of Salem, Aug. & Jan 2017

Baseline Data from Early Intervention Referral and Evaluation Outcomes

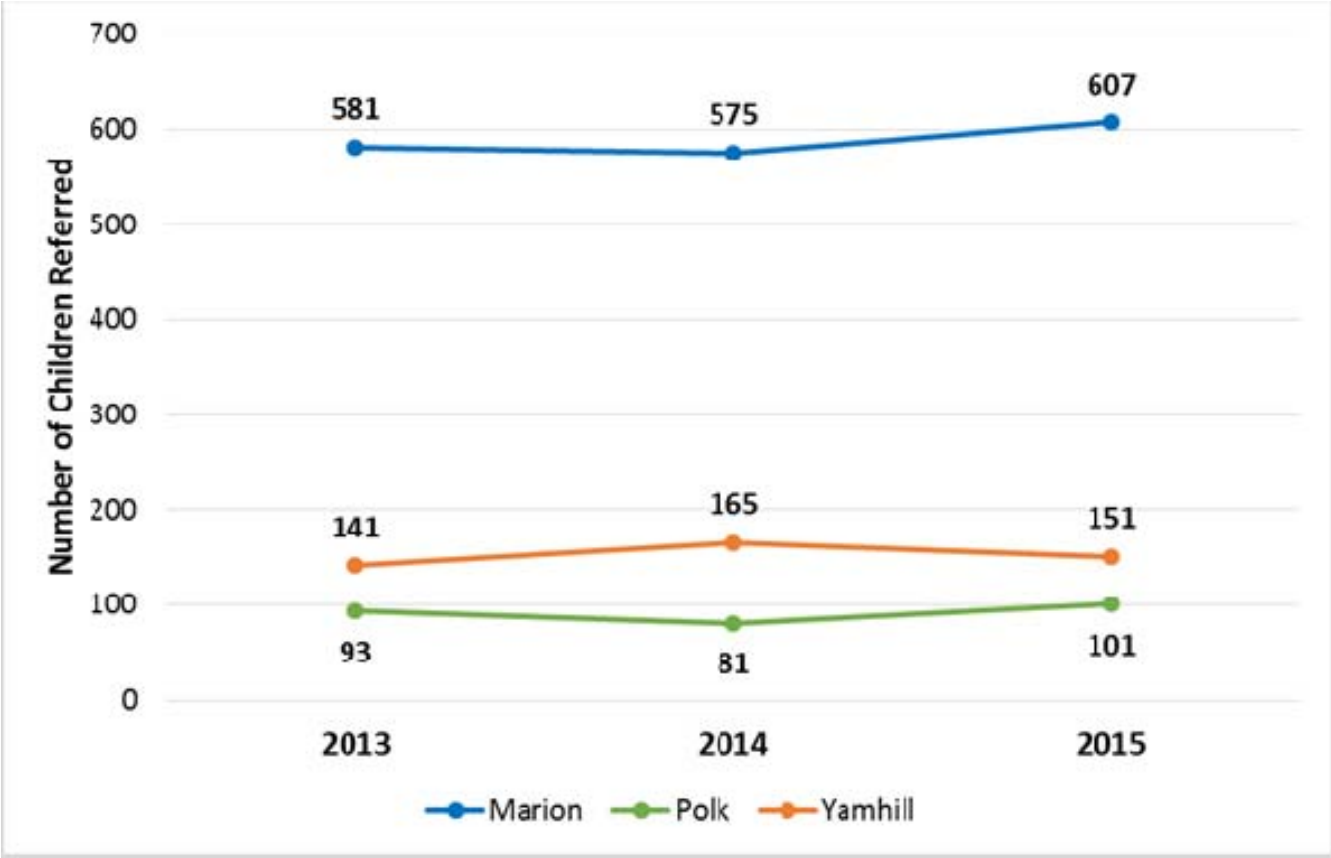
#1: Indication of Follow-Up to Developmental Screening

- 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

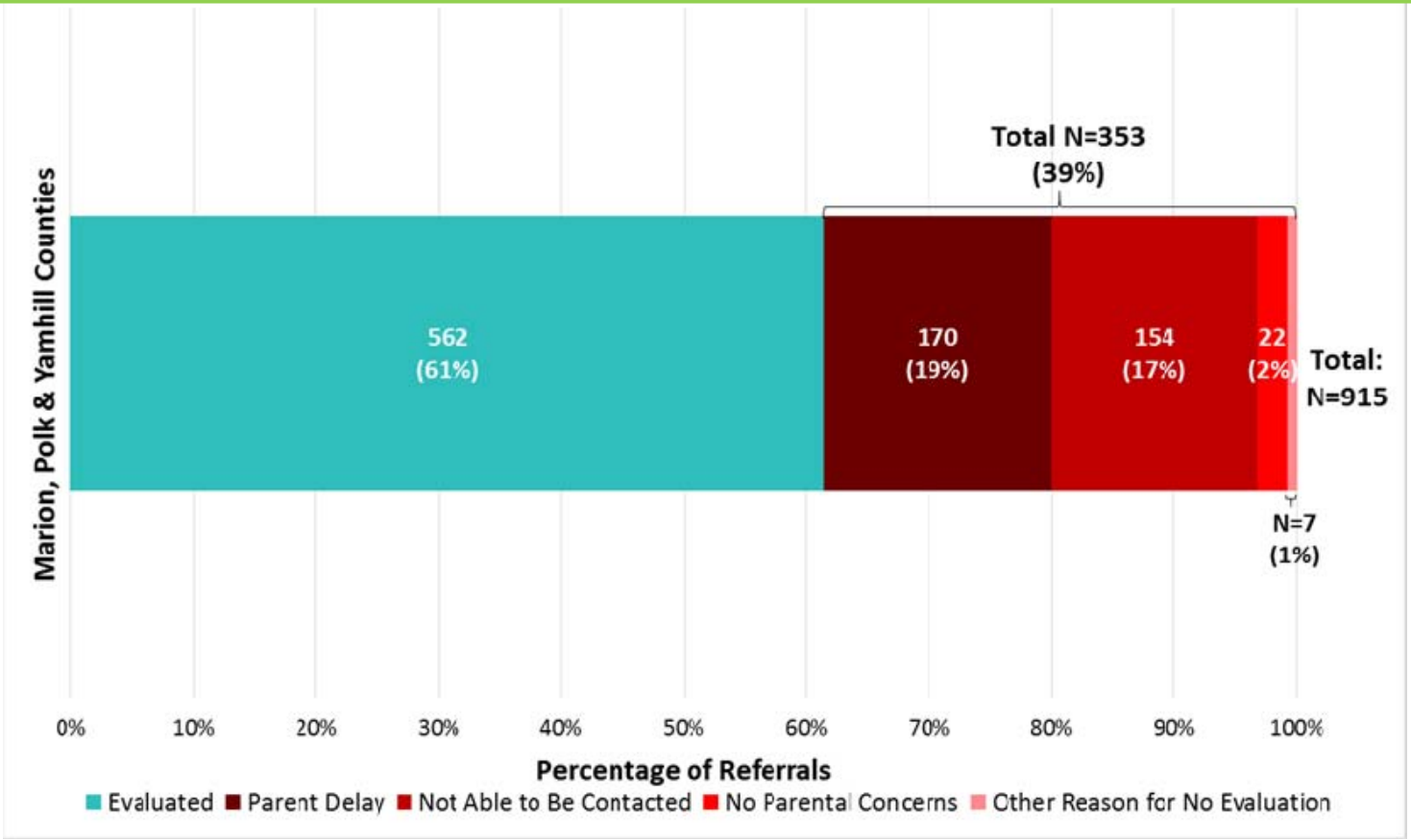
- Evaluation outcome results by referral and child characteristics

Number of CHILDREN referred to Early Intervention

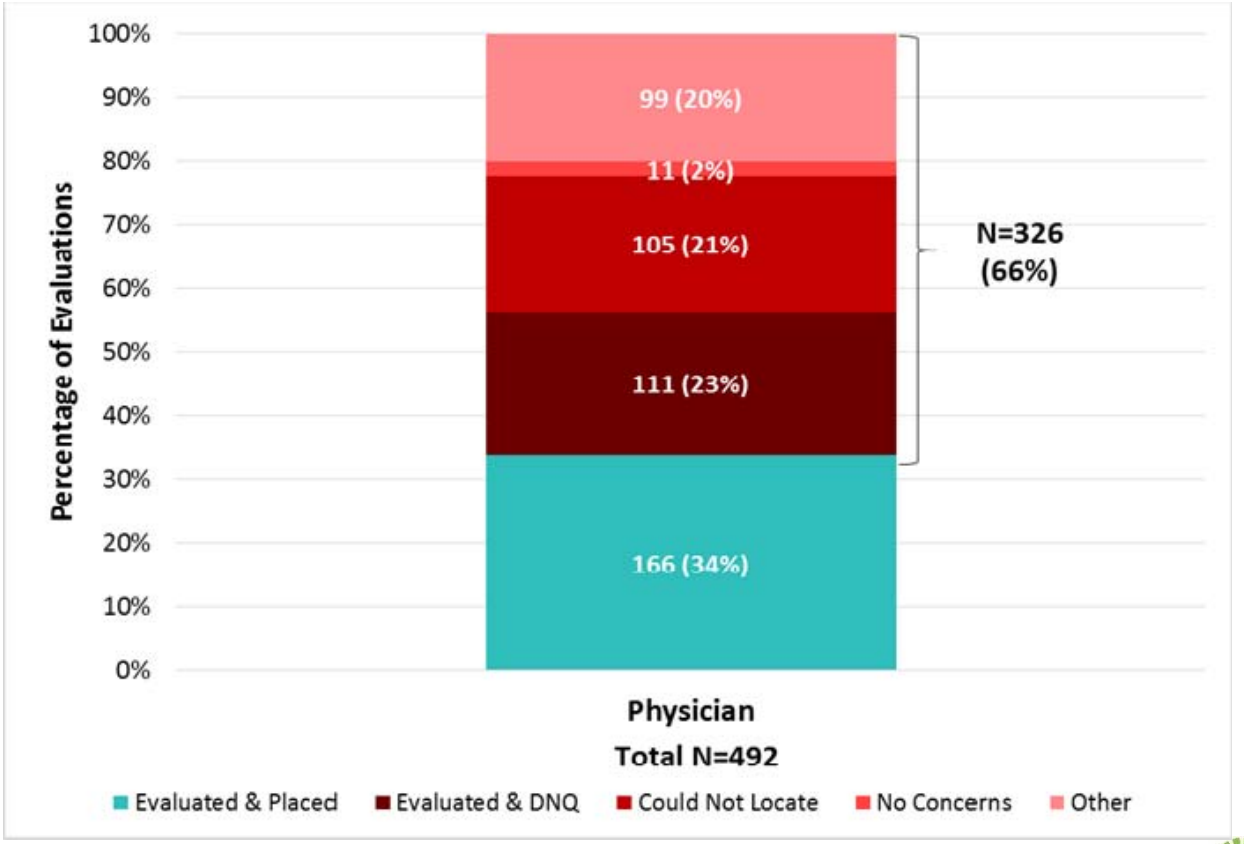


OPIP

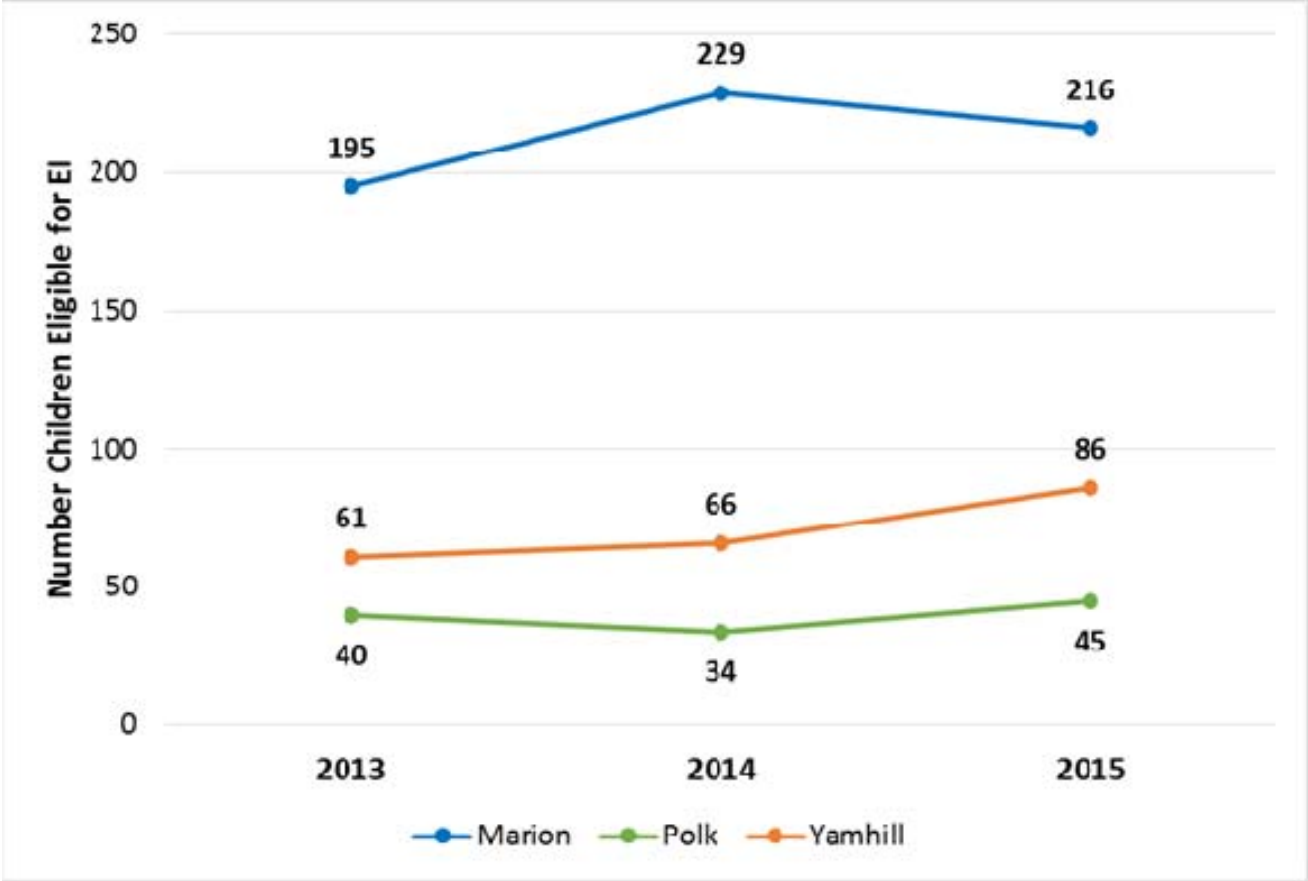
2015 WESD EI Referral Outcomes in Marion, Polk, & Yamhill Counties



Outcomes of Evaluation For WESD Referrals from Physicians: Marion, Polk, and Yamhill Counties (2015)



Number of CHILDREN Receiving EI Services

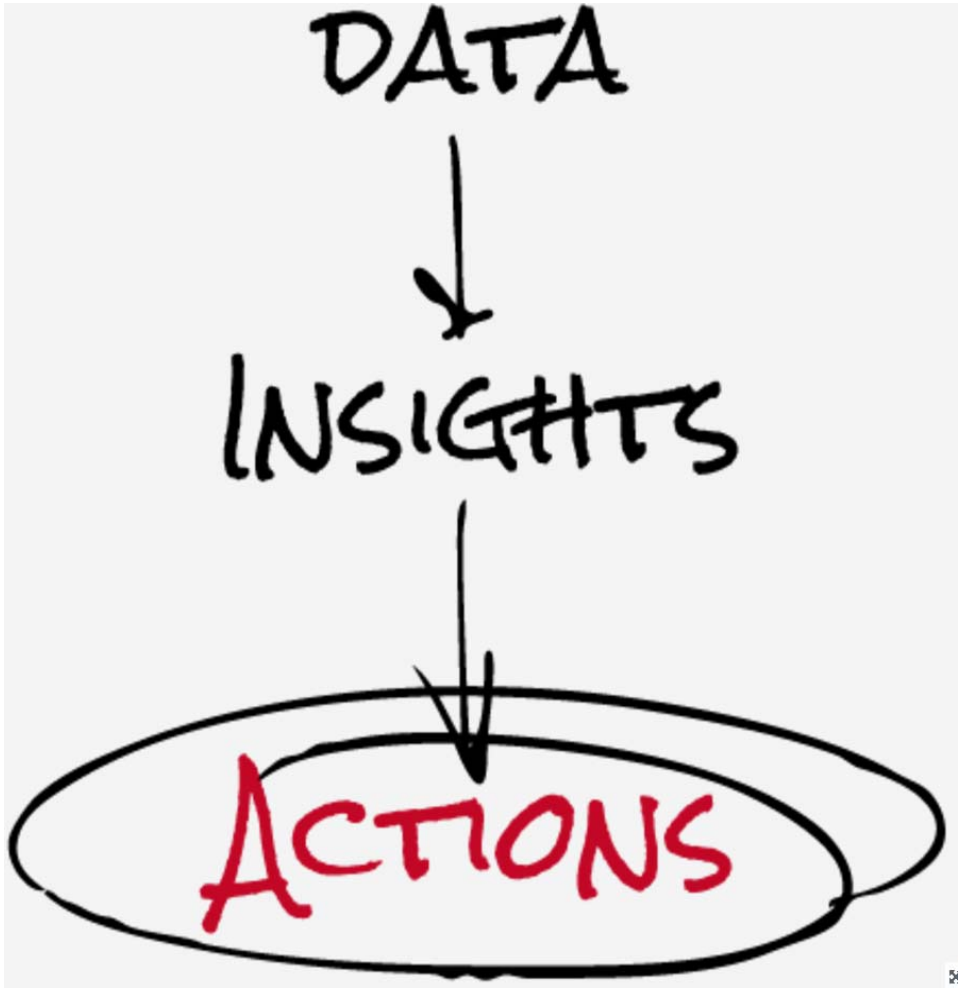


OPIP

The Punchline:
Opportunity and Need to Focus on Follow-Up to Developmental Screening that is the Best Match for the Child & Family

While there are increases in screening, most children identified at-risk are not receiving follow-up aligned with recommendations

- Primary care providers are not referring children identified at-risk
  - 60-80% of children identified at-risk for delays on the ASQ not referred for EI Services
- Referral rates to EI have not increased at a rate that is proportional to screening rates
- Number of children served by EI has not increased in a way aligned with early identification through screening
  - 2 in 5 children referred by PCP to EI not ever able to be evaluated, no communication back to referring entity
  - Of those evaluated, 62% were found to be eligible for services, meaning 38% were ineligible for services (Rates lower for PCP-based referrals)



Community-Level Stakeholder Meetings to Confirm Priority Areas for Improvement Pilot

- **Convened stakeholders who were interviewed for this project in a group-level meeting to review findings and confirm community-level priorities about areas of focus**
  - Leveraged shared table and relationships created within Early Learning Hubs (Yamhill Early Learning Hub & Marion and Polk Early Learning Hub)
  - Meeting within regions that shared Early Learning Hub and Coordinated Care Organizations
    - ✓Marion and Polk
    - ✓Yamhill
  - Review the asset maps and prioritized which "boxes" to focus on and which "arrows" to focus on

OPIP

Three Priorities Areas Identified for WHERE to Focus Improvement Pilots

1) **Enhance follow-up processes for children identified at primary care practices conducting developmental screening**
   - At a population-level, this is where the most "car seats" for children age 0-3 are parked
2) **For Early Intervention:**
   - Enhance coordination and communication with the entity that referred the child
   - Follow-up steps for EI ineligible
3) **Within** identified **early learning sites**, **pilots of referrals & connections**
   - Home visiting (Pilot of PCP to Centralized Home Visiting Referral)
   - Parenting classes (PCP Info about OPEC-supported

Questions about Qualitative & Quantitative Data

- Questions about data presented?
- Do the findings resonate with what you are finding in your own communities?

Agenda

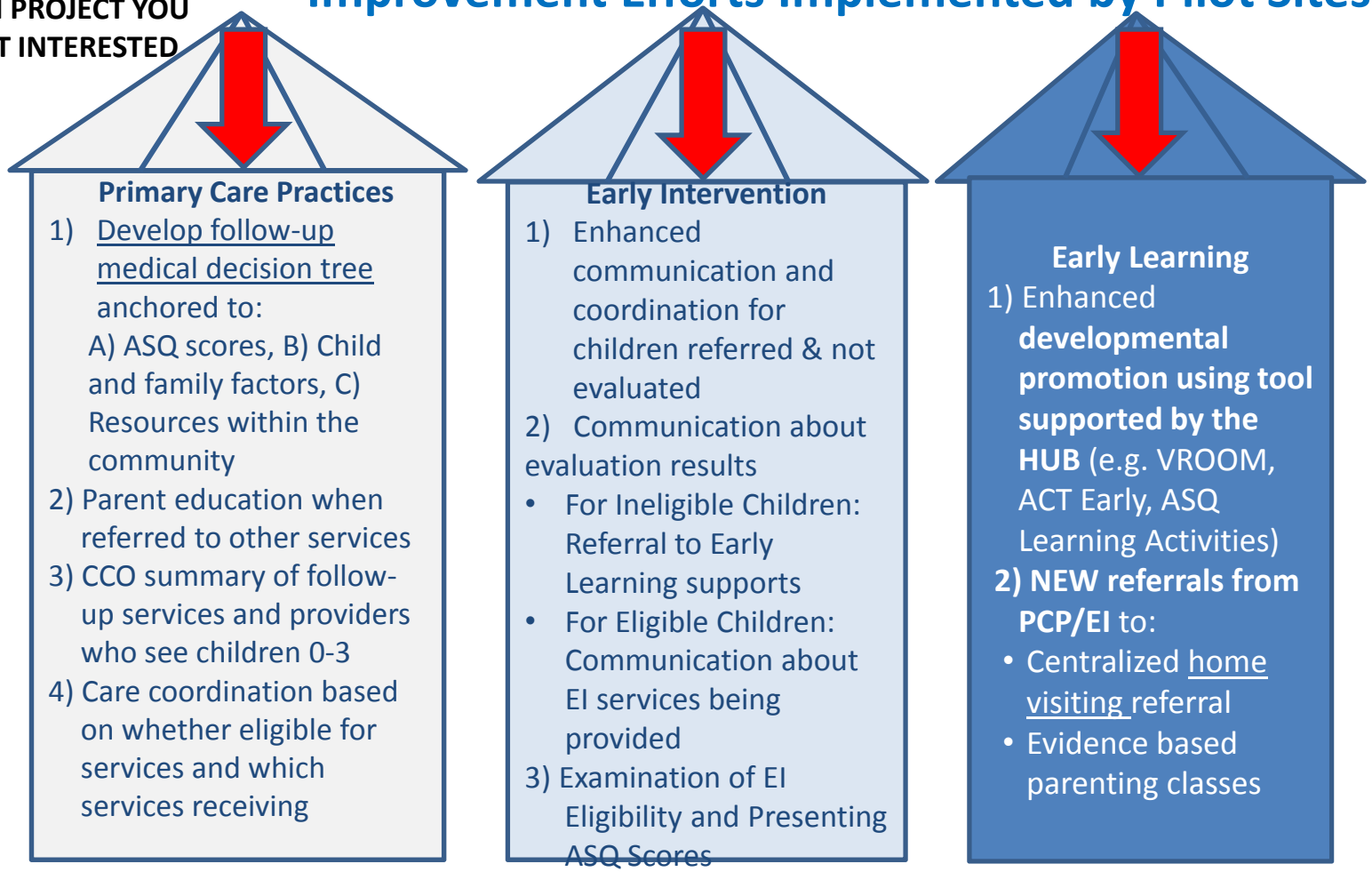
- Part 1: Setting the Landscape for the Community-Based Improvement Project.
- Part 2: Data Identifying Where Children Fall out of Pathways, Community Asset Mapping

Community-Based Improvement Effort

- Part 3: Improving Follow-Up in Primary Care
- Part 4: Improving Follow-Up in Early Intervention
- Part 5: Improving Follow-Up with Home Visiting & Parenting Education Supports

INPUT FROM THE AUDIENCE ABOUT PARTS OF THE QI PROJECT YOU ARE MOST INTERESTED

Community-Based Improvement Opportunity: Improvement Efforts Implemented by Pilot Sites



Primary Care Practices

1) Develop follow-up medical decision tree anchored to: A) ASQ scores, B) Child and family factors, C) Resources within the community
2) Parent education when referred to other services
3) CCO summary of follow-up services and providers who see children 0-3
4) Care coordination based on whether eligible for services and which services receiving

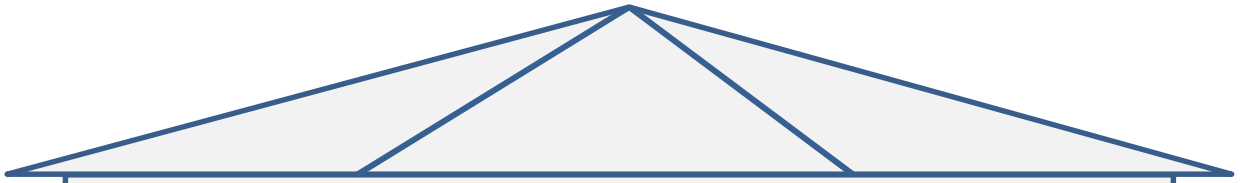
Early Intervention

1) Enhanced communication and coordination for children referred & not evaluated
2) Communication about evaluation results
   - For Ineligible Children: Referral to Early Learning supports
   - For Eligible Children: Communication about EI services being provided
3) Examination of EI Eligibility and Presenting ASQ Scores

Early Learning

1) Enhanced **developmental promotion using tool supported by the HUB** (e.g. VROOM, ACT Early, ASQ Learning Activities)
2) **NEW referrals from PCP/EI** to:
   - Centralized home visiting referral
   - Evidence based parenting classes

Community-Based Improvement Opportunity: Improvement Efforts Implemented by Pilot Sites



Primary Care Practices

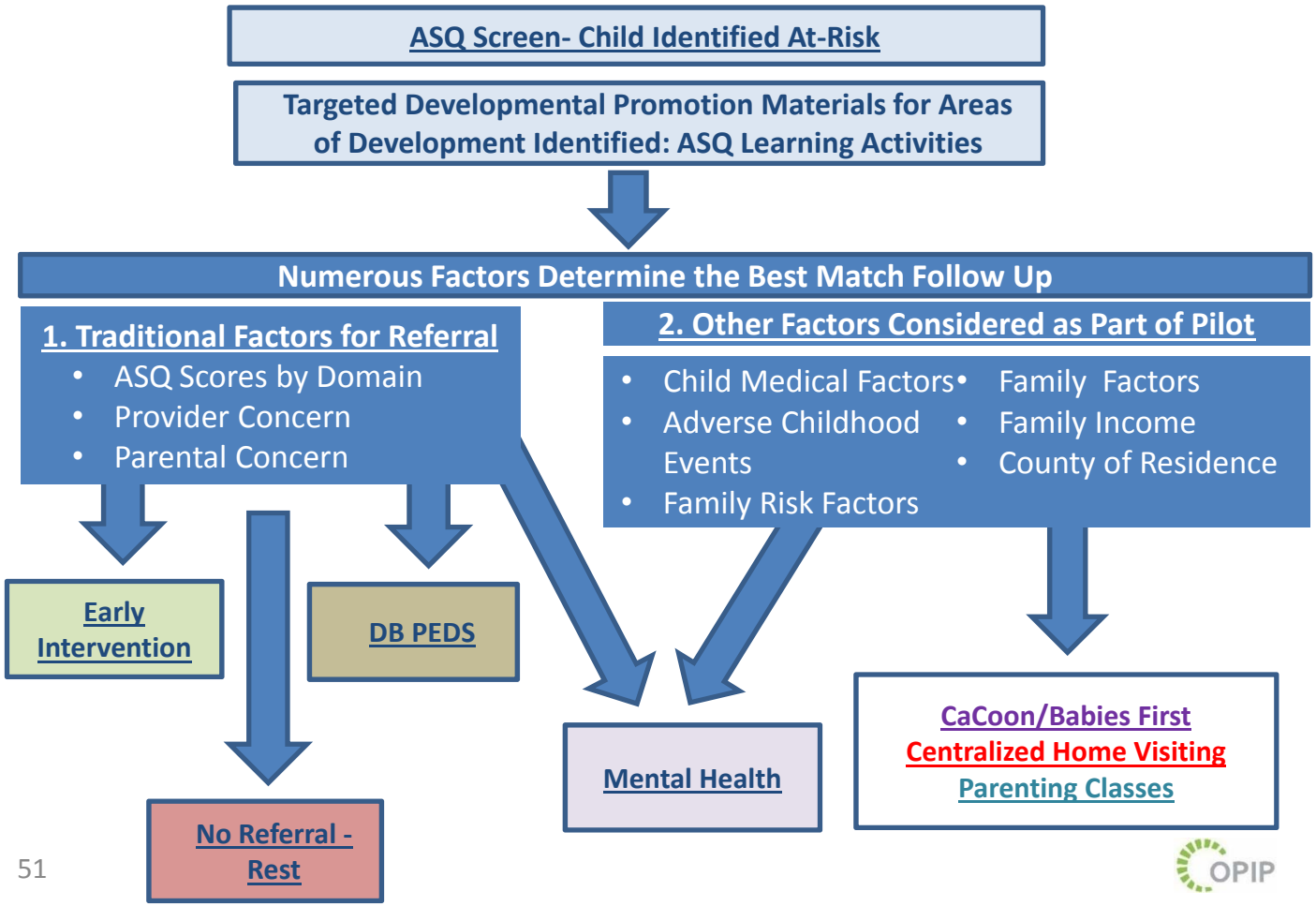
1) Develop follow-up medical decision tree anchored to:
   A) ASQ scores, B) Child and family factors, C) Resources within the community
2) Parent education when referred to other services
3) CCO summary of follow-up services and providers who see children 0-3
4) Care coordination based on whether eligible for services and which services receiving

Development of Decision Support Tools for Primary Care Providers to Identify Best Match Services in Community

- Based on data and community engagement, **six priority referrals** were identified and collaborative partnerships established.
- Created a medical decision tree for providers about WHICH kids to refer and WHERE:

1. Medical and Therapy Services (developmental evaluation and therapy services)
2. Early Intervention (EI)
3. CaCoon/Babies First
4. Centralized Home Visiting Referral (Includes Early Head Start and Head Start)
5. Parenting Classes
6. Mental Health

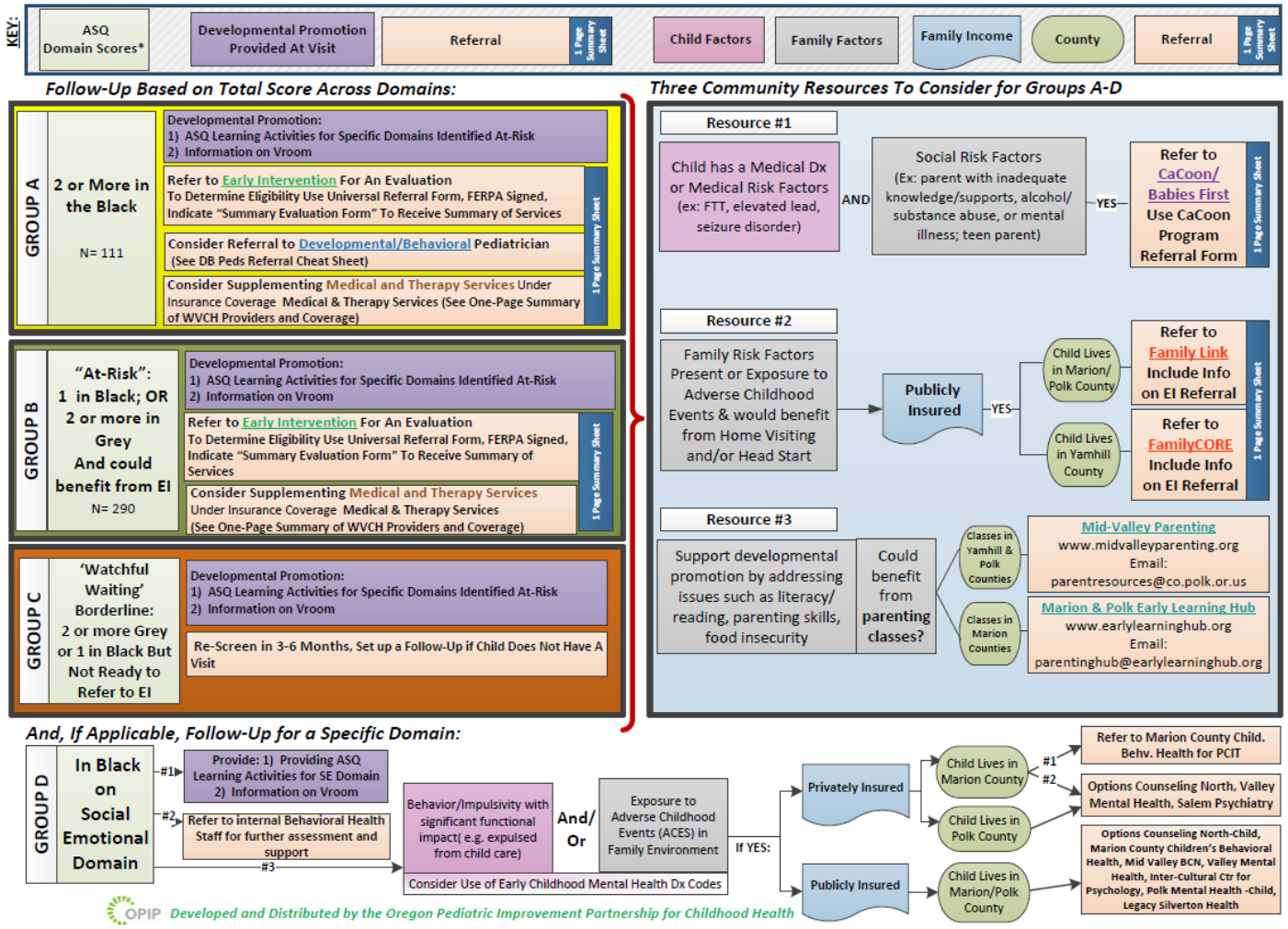
Determining the "Best Match" Follow Up for the Child and Family Which Included Promotion FIRST and Then, Where Applicable, Referral



Version 1.0 1/31

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

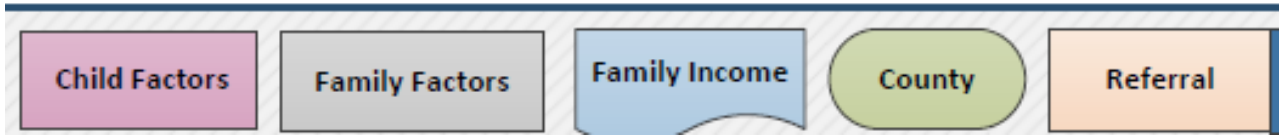
Figure 1.0: Decision Tree - Pilot to Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks



OPIP *Developed and Distributed by the Oregon Pediatric Improvement Partnership for Childhood Health*

Left Side:

- Anchored to ASQ Scores
- Promotion that should happen that day
- When and who to refer to Early Intervention (EI)
- When and who to refer to a Developmental Pediatrician for evaluation



Right Side

- Anchored to Child and Family Factors and Potential Needs
- Referral to early learning services to support child and family

Developmental Promotion

Developmental Promotion Opportunities Provided to Parent

ASQ Learning Activities for the Specific Domains

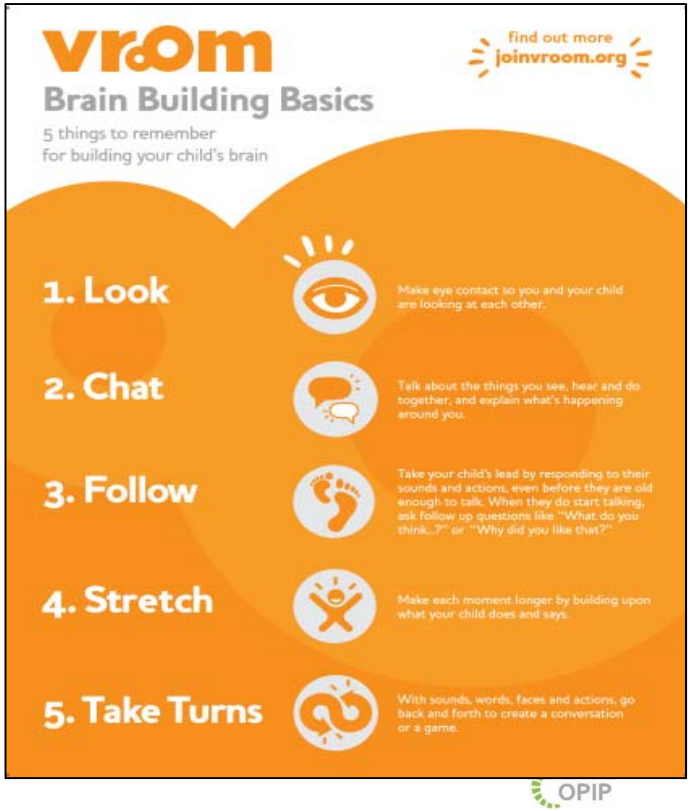
Vroom!

Fine Motor

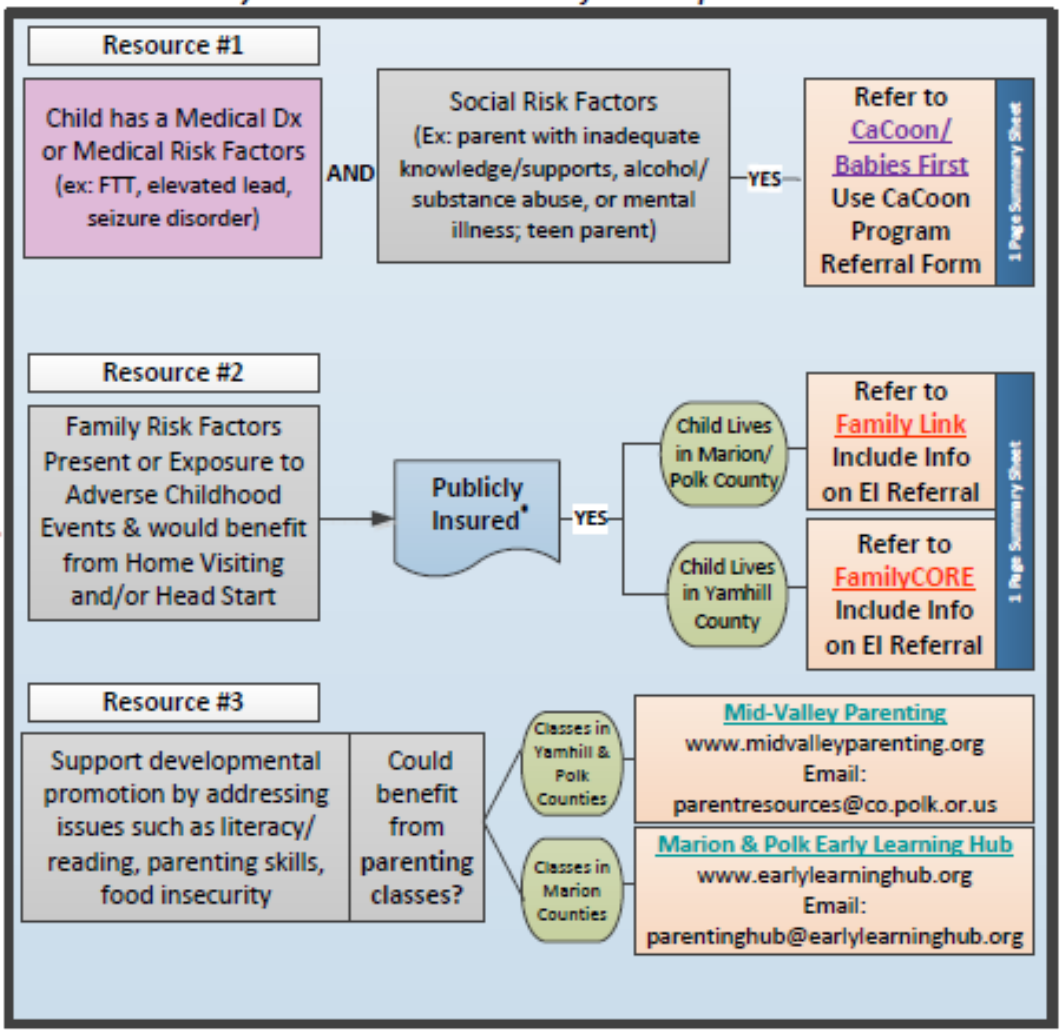
Activities to Help Your Toddler Grow and Learn

Your toddler's eyes and hands are working together well. He enjoys taking apart and putting together small things. He loves using any kind of writing or drawing tool. Provide scrap paper, washable crayons, or markers. You can also try puzzles, blocks, and other safe small toys. Talk and enjoy the time together. When writing or drawing, set up clear rules: "We draw *only on the paper, and only on the table.* I will help you remember."

Flipping Pancakes	Trim the corners from a simple sponge to form a "pancake." Give your child a small frying pan and a spatula. Show him how to flip the pancake.
Macaroni String	String a necklace out of dried pasta with big holes. Tube-shaped pasta, such as rigatoni, works really well. Your child can paint the pasta before or after stringing it. Make sure she has a string with a stiff tip, such as a shoelace. You can also tape the ends of a piece of yarn so that it is easy to string.
Homemade Orange Juice	Make orange juice or lemonade with your toddler. Have him help squeeze the fruit using a handheld juicer. Show him how to twist the fruit back and forth to get the juice out. To make lemonade, you will need to add some sugar and water. Let him help you stir it all up. Cheers!
Draw What I Draw	Have your child copy a line that you draw, up and down and side to side. You take a turn. Then your child takes a turn. Try zigzag patterns and spirals. Use a crayon and paper, a stick in the sand, markers on newspaper, or your fingers on a steamy bathroom mirror.
Bath-Time Fun	At bath time, let your toddler play with things to squeeze, such as a sponge, a washcloth, or a squeeze toy. Squeezing really helps strengthen the muscles in her hands and fingers. Plus it makes bath time more fun!
My Favorite Things	Your child can make a book about all of his favorite things. Clip or staple a few pieces of paper together for him. He can choose his favorite color. Let him show you what pictures to cut from magazines. He may even try cutting all by himself. Glue pictures on the pages. Your child can use markers or crayons to decorate pages. Stickers can be fun, too. You can write down what he says about each page. Let him "write" his own name. It may only be a mark, but that's a start!
Sorting Objects	Find an egg carton or muffin pan. Put some common objects such as nuts, shells, or cotton balls into a plastic bowl. Let your toddler use a little spoon or tongs to pick up the objects and put them in different sections of the egg carton. Give her a little hug when she has success!



Three Community Resources To Consider for Groups A-D



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

☐ 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

☐ 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

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**

Designed and distributed by Oregon Pediatric Improvement Partnership. Version 2.0 1/31

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)

- 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 (ph number).

Services Covered by WVCH

Version 1.0 2/14/2017

WVCH Coverage of Medical and Therapy Services for Children with Developmental, Behavioral or Social Delays

Type of Medical or Therapy Service Addressing Developmental Delays	Covered (Y/N)	Benefit Coverage, Any Requirements for Service to be Approved	Providers in WVCH Contract That are Able to Provide Services	Serve Children aged 1 month - 3 years old?
Occupational Therapy Services				
Occupational Therapy Services	Yes	Authorization required for therapy visits beyond the initial evaluation/ re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.	Creating Pathways	Yes
			Mighty Oaks Therapy Center (Albany)	Yes
			PT Northwest	No
			Salem Hospital Rehab	Yes
Physical Therapy Services				
Physical Therapy Services	Yes	Authorization required for therapy visits beyond the initial evaluation/ re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.	Capitol PT	No
			Keizer PT	No
			Pinnacle PT	No
			ProMotion PT	No
			PT Northwest	No
			Salem Hospital Rehab	Yes
			Therapeutic Associates	No
			Creating pathways	Yes
Speech Therapy Services				
Speech Therapy	Yes	Authorization required for therapy visits beyond the initial evaluation/re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.	Chatterboks	Yes
			Creating Pathways	Yes
			Mighty Oaks Therapy Center (Albany)	Yes
			PT Northwest	No
			Salem Hospital Rehab	Yes
			Sensible Speech	Yes
Pediatric Psychological Testing Services	Yes	Authorization required	Valley Mental Health	Yes - 18 months and up
			Willamette Family Medical Center	Yes - 18 months and up
			Intercultural Psychology Services	Yes - 18 months and up
Behavioral Health Services				
Social Skills Groups	Yes	Enrolled in services	Marion County Child Behavioral Health*	Yes
			Polk County Mental Health*	Yes
			Inter-Cultural Center for Psychology	Yes

*Bilingual provider

Key Findings from the Pilot: Successes

- **Improved primary care knowledge and awareness of follow-up pathways**
  - High value in the medical decision tree..but we to plan to revise it
  - High value in the ASQ Learning Activities
  - High value in the parent education sheets from provider perspective
- **Findings related to referrals for follow-up:**
  - Increase in the number of at-risk children receiving targeted **developmental promotion**
  - Increase in **referrals to early intervention** of the more delayed children
    - Across the three sites, referral to EI increased by 22%
    - In Marion and Polk, two pilot practices contributed to over 50% of the increased number of referrals in the community
  - Increase in referrals to **home visiting**

Findings from Primary Care Pilot Sites: Barriers

- **Increases in referrals didn't necessarily mean increase in services received**
- **Not all children received follow-up in alignment with the medical decision tree**
  - Lack of EI eligibility impacted their referral to EI, need to revise the medical decision tree
  - Provider lack of experience with talking about parenting classes and home visiting services, "clumsy referral"
  - Lack of knowledge about family risk factors to inform referrals to home visiting programs
  - No increase in mental health referrals for these young children.
  - Parent reluctance or push back on the follow-up steps
- **Cultural variations in expectations around child development, value of accessing services early to intervene**
- **Competing priorities for practices on where to focus, especially for multi-specialty practice**
  - Two pediatric practices implemented all components of the project to fidelity
  - Third practice was a multi-specialty practice and experienced barriers to robust participation
    - Lead physician-level champion, who also served as the primary liaison at community-level events, transitioned from the practice
    - Significant competing demands with adult-focused efforts
    - Given the lack of incentive metrics related to follow-up to developmental screening and because young children are a relatively small proportion of their total population, difficult to prioritize this topic area
- **Barriers to feasibility of meaningful and relevant evaluation data collection in the EMR**

Reflections from My Early Learning Hub Partners

- From your perspective, what part of the innovations piloted were most relevant and meaningful to you in your role as a HUB?

- What learnings did you gather about opportunities and needs to spread to other practices in your region?

Questions about
Primary Care Provider Improvement Efforts

- Questions ?
- What have you learned from your own efforts?

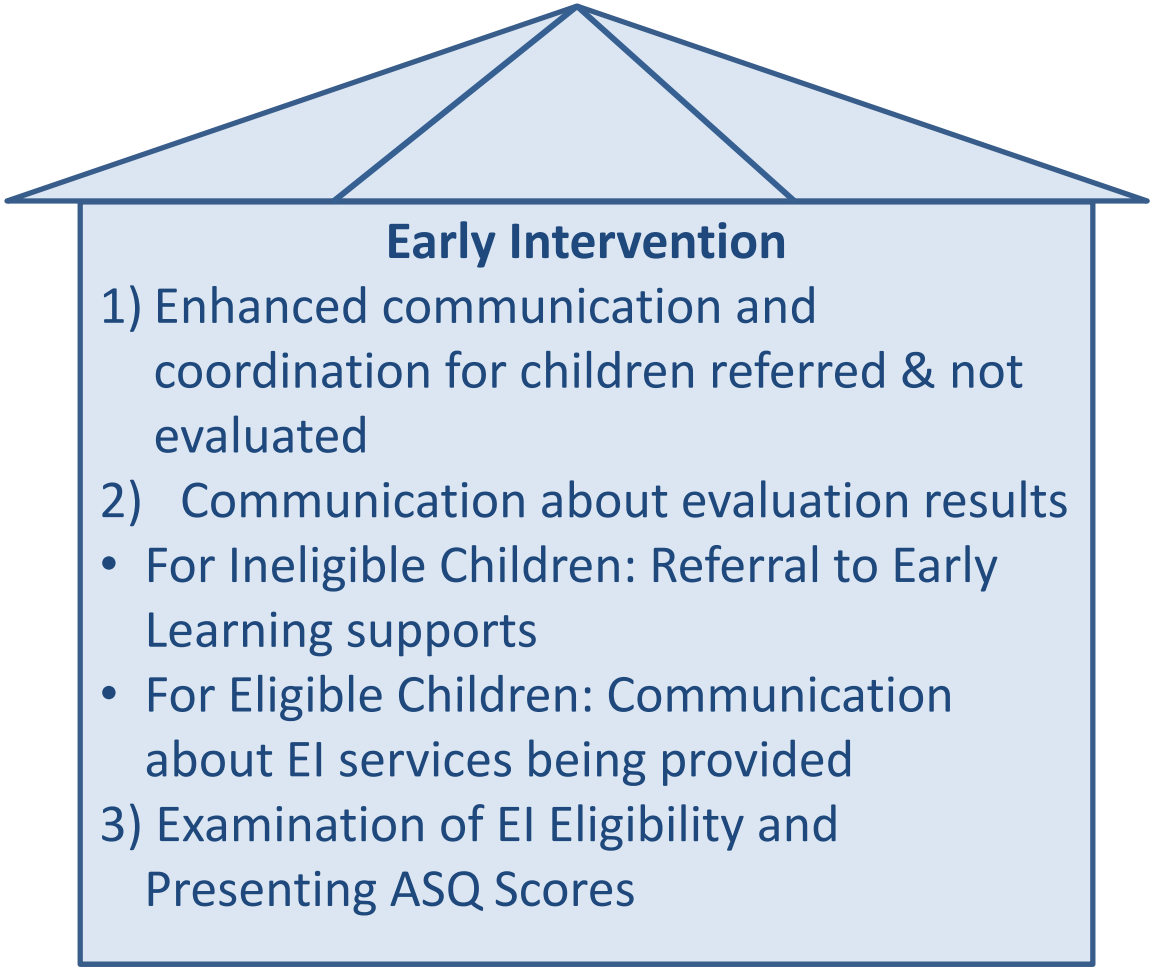
Agenda

- Part 1: Setting the Landscape for the Community-Based Improvement Project. Overview of Improvement Strategies Developed
- Part 2: Data Identifying Where Children Fall out of Pathways, Community Asset Mapping

Community-Based Improvement Effort

- Part 3: Improving Follow-Up in
- **Part 4: Improving Follow-Up in Early Intervention**
- Part 5: Improving Follow-Up with Home Visiting & Parenting Education Supports

Community-Based Improvement Opportunity: Improvement Efforts Implemented by Pilot Sites



Focus of Improvement Efforts
Within Willamette Education Service District (WESD)

Implement new processes focused on:

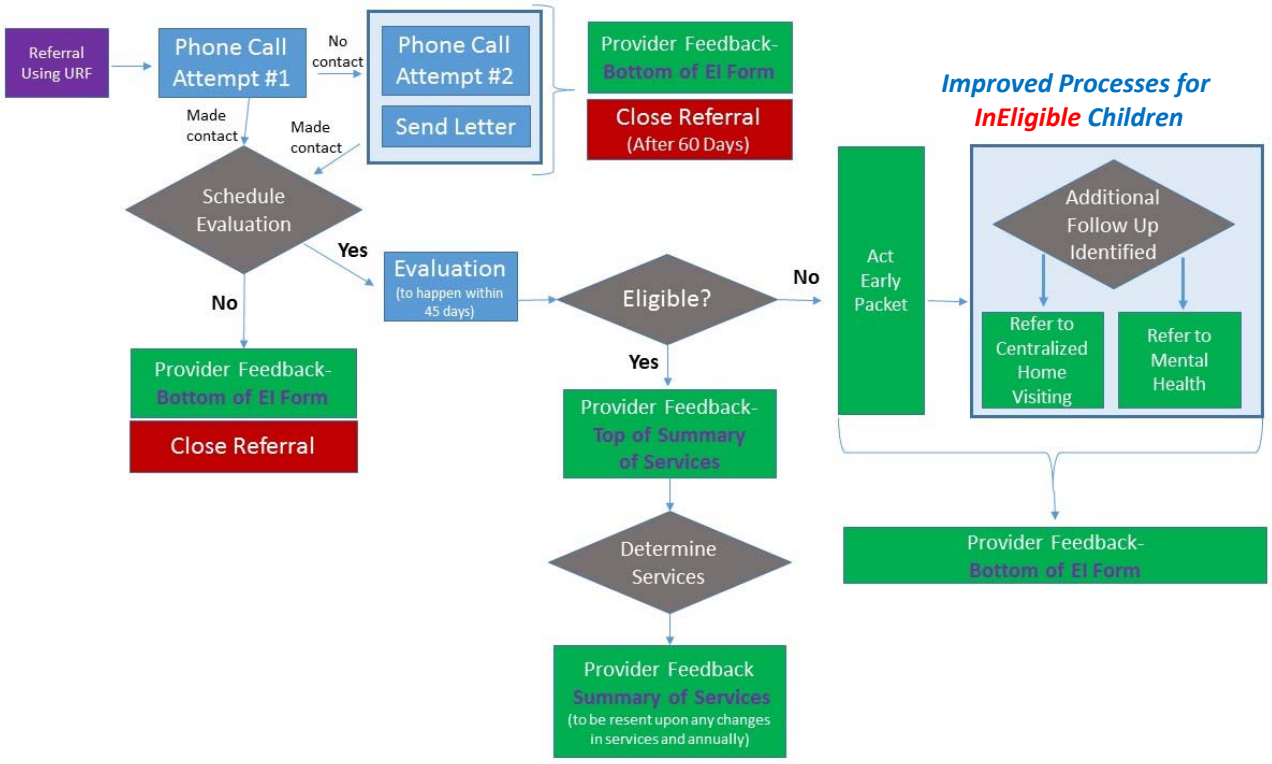
1. Improved communication and coordination
   A) For children not evaluated
   B) For children evaluated and found eligible
2. Follow-up steps for those found EI ineligible
   A) Provision of Act Early materials
   B) Referral of ineligible children to centralized home visiting

Willamette
EDUCATION SERVICE DISTRICT
Success, Achievement, Together...For All Students

Pilots of New Processes to Improve Communication and Coordination by WESD - Early Intervention

***GREEN**- new process implemented*

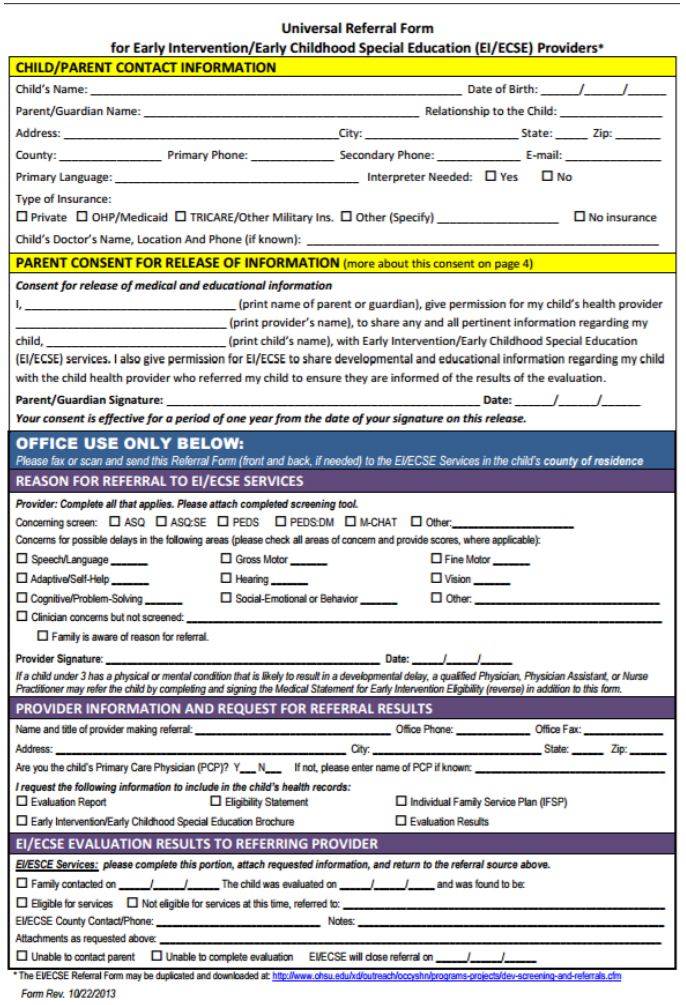
Improved Processes Related to Communication and Coordination



Early Intervention Universal Referral Form

Feedback to Referring Provider

- Not able to contact
- For those that were contacted and evaluated, general eligibility



Universal Referral Form
for Early Intervention/Early Childhood Special Education (EI/ECSE) Providers*

CHILD/PARENT CONTACT INFORMATION

Child's Name: _____ Date of Birth: _____/_____/_____
Parent/Guardian Name: _____ Relationship to the Child: _____
Address: _____ City: _____ State: _____ Zip: _____
County: _____ Primary Phone: _____ Secondary Phone: _____ E-mail: _____
Primary Language: _____ Interpreter Needed: ☐ Yes ☐ No
Type of Insurance:
☐ Private ☐ OHP/Medicaid ☐ TRICARE/Other Military Ins. ☐ Other (Specify) _____ ☐ No insurance
Child's Doctor's Name, Location And Phone (if known): _____

PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)

Consent for release of medical and educational information

I, _____ (print name of parent or guardian), give permission for my child's health provider _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with Early Intervention/Early Childhood Special Education (EI/ECSE) services. I also give permission for EI/ECSE to share developmental and educational information regarding my child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: _____ **Date:** _____/_____/_____

Your consent is effective for a period of one year from the date of your signature on this release.

OFFICE USE ONLY BELOW:

Please fax or scan and send this Referral Form (front and back, if needed) to the EI/ECSE Services in the child's county of residence

REASON FOR REFERRAL TO EI/ECSE SERVICES

Provider: Complete all that applies. Please attach completed screening tool.

Concerning screen: ☐ ASQ ☐ ASQ:SE ☐ PEDS ☐ PEDS:DM ☐ M-CHAT ☐ Other:_____
Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):
☐ Speech/Language _____ ☐ Gross Motor _____ ☐ Fine Motor _____
☐ Adaptive/Self-Help _____ ☐ Hearing _____ ☐ Vision _____
☐ Cognitive/Problem-Solving _____ ☐ Social-Emotional or Behavior _____ ☐ Other: _____
☐ Clinician concerns but not screened: _____
☐ Family is aware of reason for referral.

Provider Signature: _____ **Date:** _____/_____/_____

If a child under 3 has a physical or mental condition that is likely to result in a developmental delay, a qualified Physician, Physician Assistant, or Nurse Practitioner may refer the child by completing and signing the Medical Statement for Early Intervention Eligibility (reverse) in addition to this form.

PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS

Name and title of provider making referral: _____ Office Phone: _____ Office Fax: _____
Address: _____ City: _____ State: _____ Zip: _____
Are you the child's Primary Care Physician (PCP)? Y___ N___ If not, please enter name of PCP if known: _____

I request the following information to include in the child's health records:

☐ Evaluation Report ☐ Eligibility Statement ☐ Individual Family Service Plan (IFSP)
☐ Early Intervention/Early Childhood Special Education Brochure ☐ Evaluation Results

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

EI/ESCE Services: ***please complete this portion, attach requested information, and return to the referral source above.***

☐ Family contacted on _____/_____/_____ The child was evaluated on _____/_____/_____ and was found to be:
☐ Eligible for services ☐ Not eligible for services at this time, referred to: _____
EI/ECSE County Contact/Phone: _____ Notes: _____
Attachments as requested above: _____
☐ Unable to contact parent ☐ Unable to complete evaluation EI/ECSE will close referral on _____/_____/_____

* The EI/ECSE Referral Form may be duplicated and downloaded at: http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/dev-screening-and-referrals.cfm

Form Rev. 10/22/2013

Leveraging the EI Universal Referral Form to Communicate Whether Children Referred But NOT Evaluated

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

EI/ESCE Services: ***please complete this portion, attach requested information, and return to the referral source above.***

☐ Family contacted on _____/_____/_____ The child was evaluated on _____/_____/_____ and was found to be:

☐ Eligible for services ☐ Not eligible for services at this time, referred to: _____

EI/ECSE County Contact/Phone: _____ Notes: _____

Attachments as requested above: _____

☐ Unable to contact parent ☐ Unable to complete evaluation EI/ECSE will close referral on _____/_____/_____

* The EI/ECSE Referral Form may be duplicated and downloaded at: http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/dev-screening-and-referrals.cfm

Completed Example:

EI/ECSE EVALUATION RESTORATION TO REFERRING PROVIDER

EI/ESCE Services: ***please complete this portion, attach requested information, and return to the referral source above.***

☒ Family contacted on 8/12/16 The child was evaluated on _____/_____/_____ and was found to be:

☐ Eligible for services ☐ Not eligible for services at this time, referred to: _____

EI/ECSE County Contact/Phone: _____ Notes: contact attempts: 8/12/16, 8/20/16, 9/1/16

Attachments as requested above: _____ Closure letter mailed 9/1/16

☒ Unable to contact parent ☐ Unable to complete evaluation EI/ECSE will close referral on 9/1/16 due to NO CONTACT

* The EI/ECSE Referral Form may be duplicated and downloaded at: http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/dev-screening-and-referrals.cfm

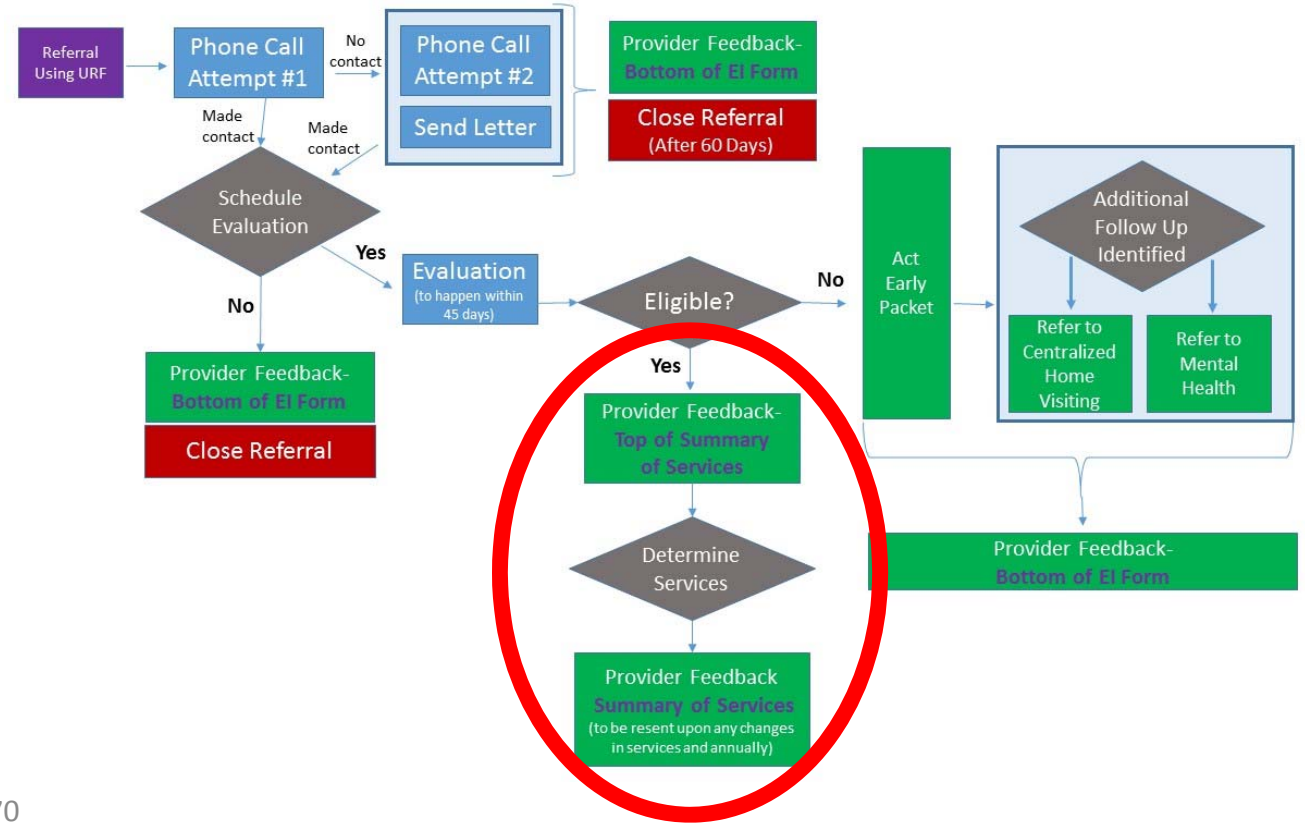
Form Rev. 10/22/2013

RECEIVED
OCT 11 2016
BY: AM

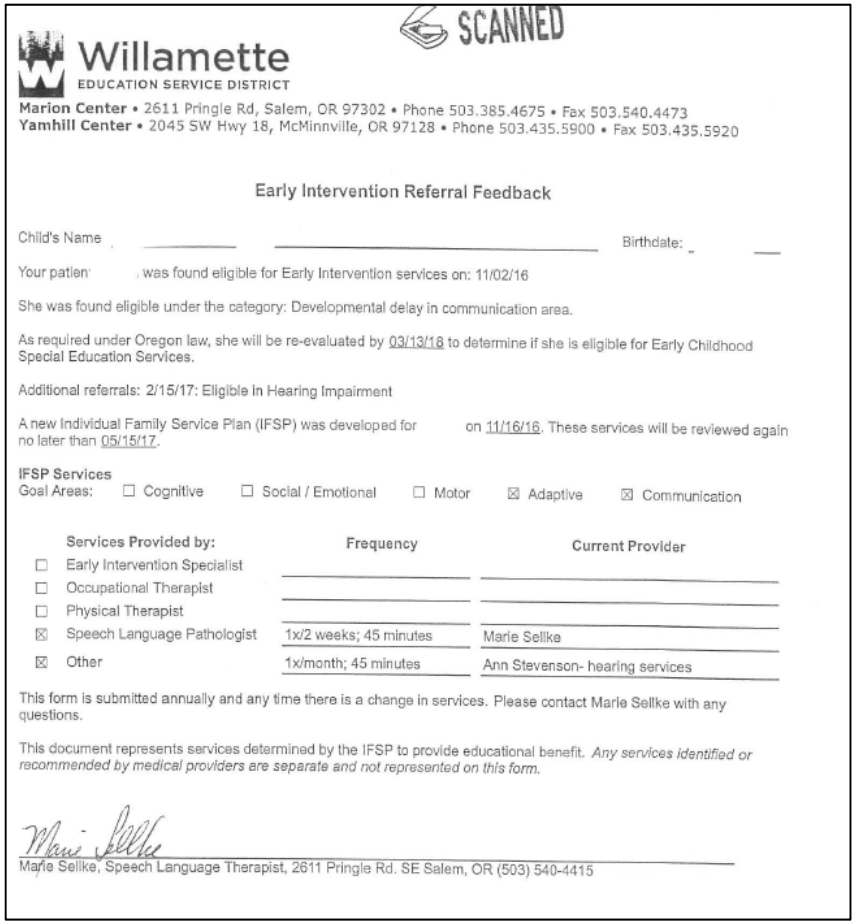
8/12 vm 8/20 vm 9/1 Letter W13

Pilots of New Processes to Improve Communication and Coordination by WESD - Early Intervention

***GREEN**- new process implemented*



One-Page Summary of Services



SCANNED

Willamette
EDUCATION SERVICE DISTRICT

Marion Center • 2611 Pringle Rd, Salem, OR 97302 • Phone 503.385.4675 • Fax 503.540.4473
Yamhill Center • 2045 SW Hwy 18, McMinnville, OR 97128 • Phone 503.435.5900 • Fax 503.435.5920

Early Intervention Referral Feedback

Child's Name _____ Birthdate: _____

Your patien was found eligible for Early Intervention services on: 11/02/16

She was found eligible under the category: Developmental delay in communication area.

As required under Oregon law, she will be re-evaluated by 03/13/18 to determine if she is eligible for Early Childhood Special Education Services.

Additional referrals: 2/15/17: Eligible in Hearing Impairment

A new Individual Family Service Plan (IFSP) was developed for on 11/16/16. These services will be reviewed again no later than 05/15/17.

IFSP Services
Goal Areas: ☐ Cognitive ☐ Social / Emotional ☐ Motor ☒ Adaptive ☒ Communication

Services Provided by:	Frequency	Current Provider
☐ Early Intervention Specialist		
☐ Occupational Therapist		
☐ Physical Therapist		
☒ Speech Language Pathologist	1x/2 weeks; 45 minutes	Marie Selke
☒ Other	1x/month; 45 minutes	Ann Stevenson- hearing services

This form is submitted annually and any time there is a change in services. Please contact Marie Selke with any questions.

This document represents services determined by the IFSP to provide educational benefit. *Any services identified or recommended by medical providers are separate and not represented on this form.*

Marie Selke

Marie Selke, Speech Language Therapist, 2611 Pringle Rd. SE Salem, OR (503) 540-4415

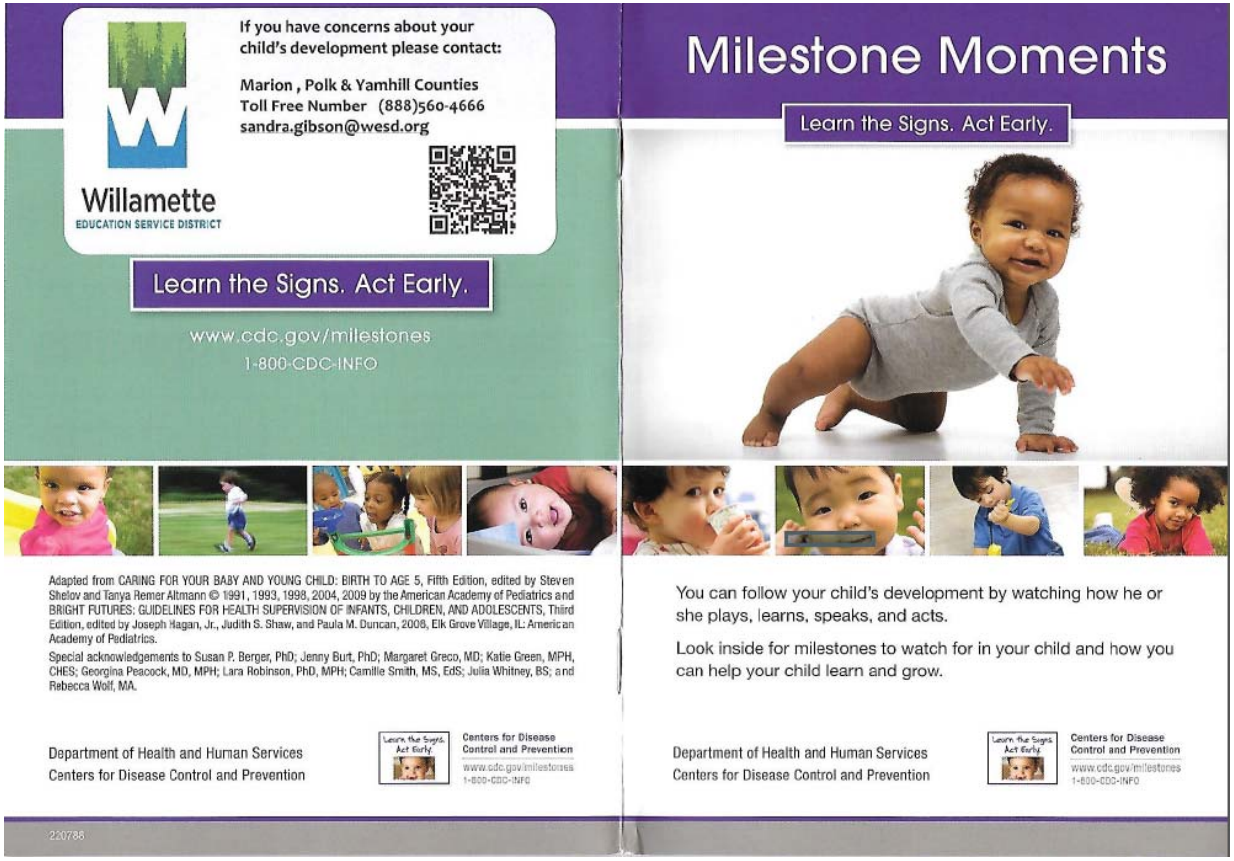
Focus of Improvement Effort Within
Willamette Education Service District (WESD)

Implement new processes focused on:

1. Improved communication and coordination
   - A) For children not evaluated
   - B) For children evaluated and found eligible
2. Follow-up steps for those found EI Ineligible
   - A) Provision of Act Early materials
   - B) Referral of ineligible children to centralized home visiting

Willamette
EDUCATION SERVICE DISTRICT
Success, Achievement, Together...For All Students

CDC Act Early Materials



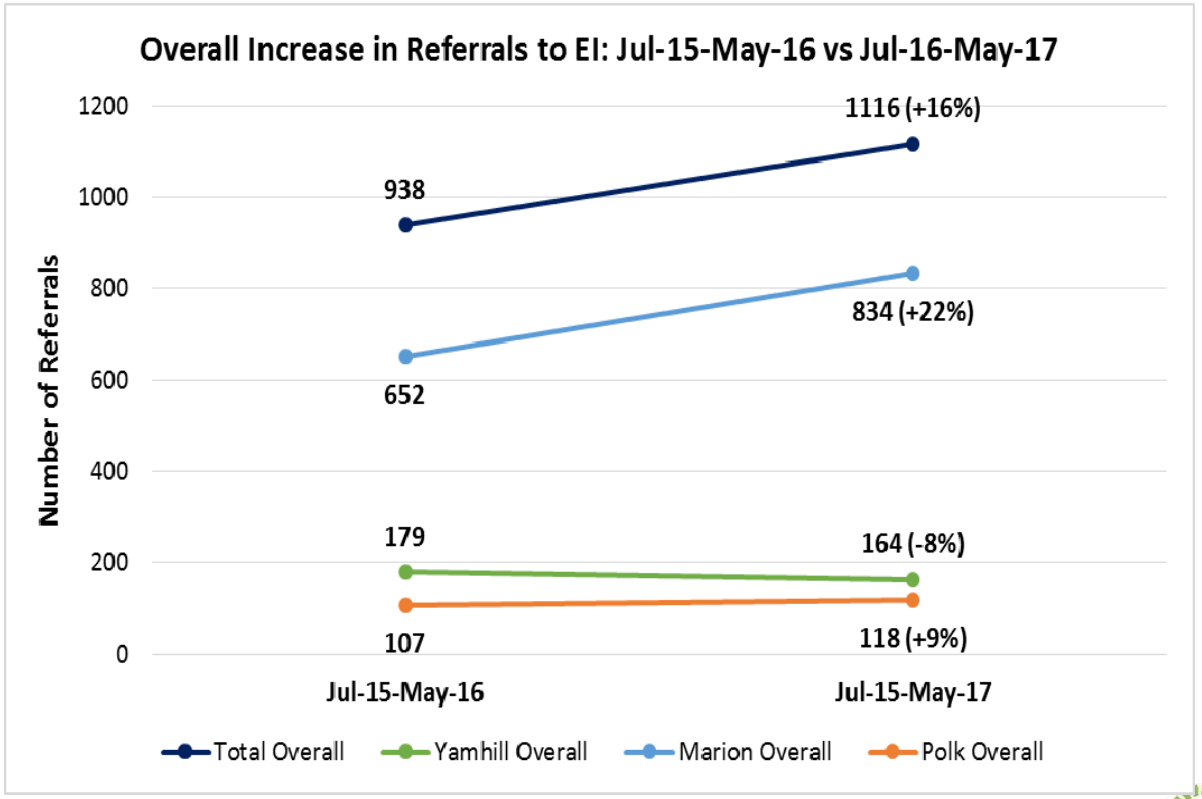
Successes in WESD Efforts

- Review of EI data internally and sharing of EI data helpful to inform community conversations, identify the priority pathways
- Refined internal data collection processes, development of standardization of processes
- In October 2017, Statewide EI adopted
  - Use of the Bottom of the Universal Referral Form to Communicate for children referred by not evaluated
  - One page Summary of Services for children eligible

From Our Perspective: Barriers to Our Efforts

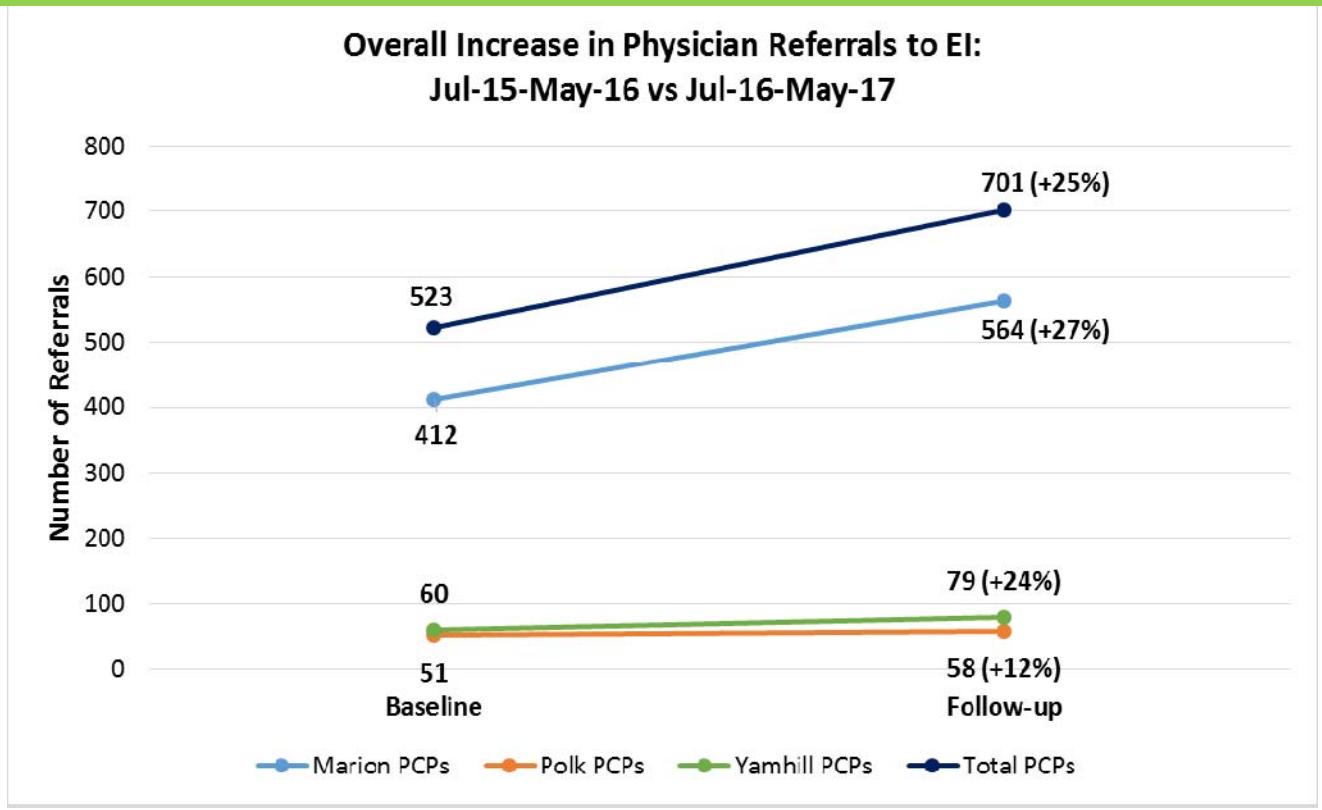
- **Staffing bandwidth to ensure these communications are sent in a timely manner**
- **Ensuring all practices use the Universal Referral Form & complete FERPA release**
  - Without proper use and inclusion of signatures, communication between entities is difficult and time consuming
- **Ability of programs to serve EI Ineligible children**
  - EI referrals have less context about family risk factors given they don't have an established relationship with the child/family; May impact the number of priority risk factors that are listed on referral form
  - Large number of EI Ineligible are privately insured and/or may not have risk factors that prioritize them

Over Course of Project:
Increase in Referrals to Early Intervention

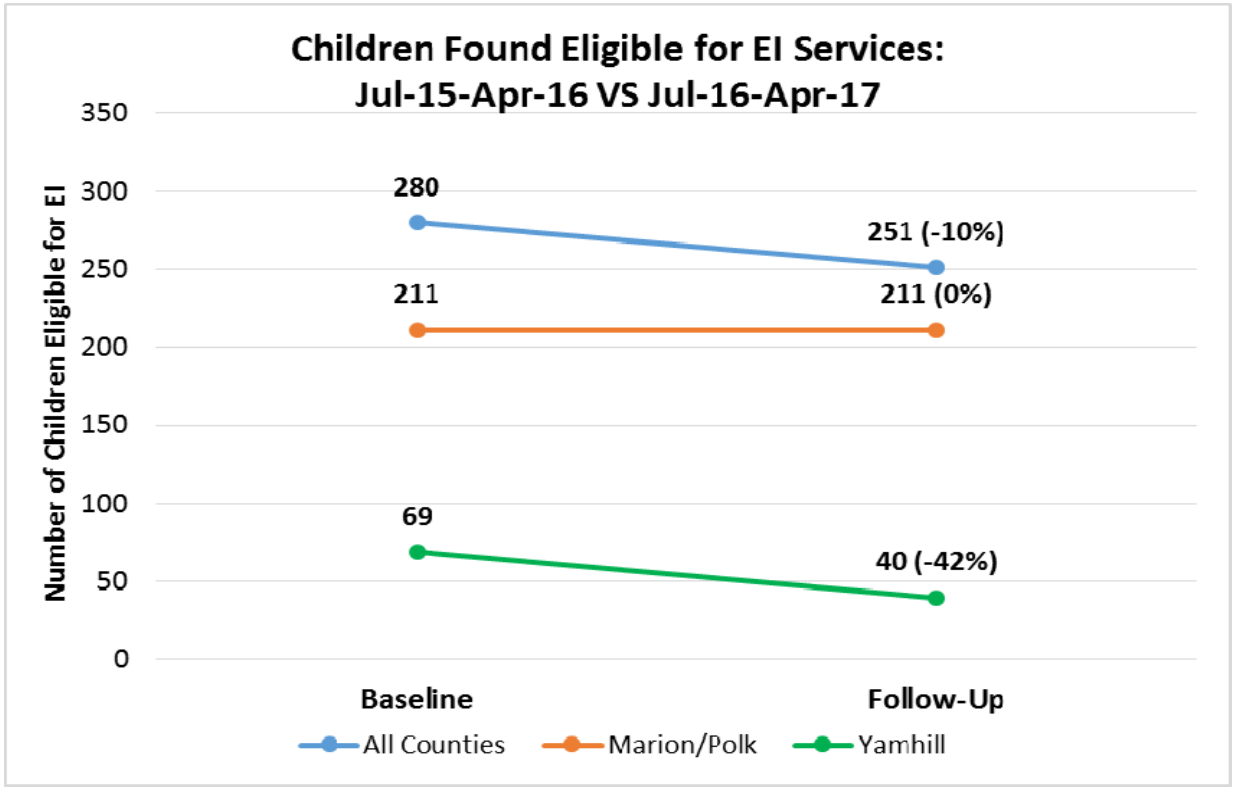


OPIP

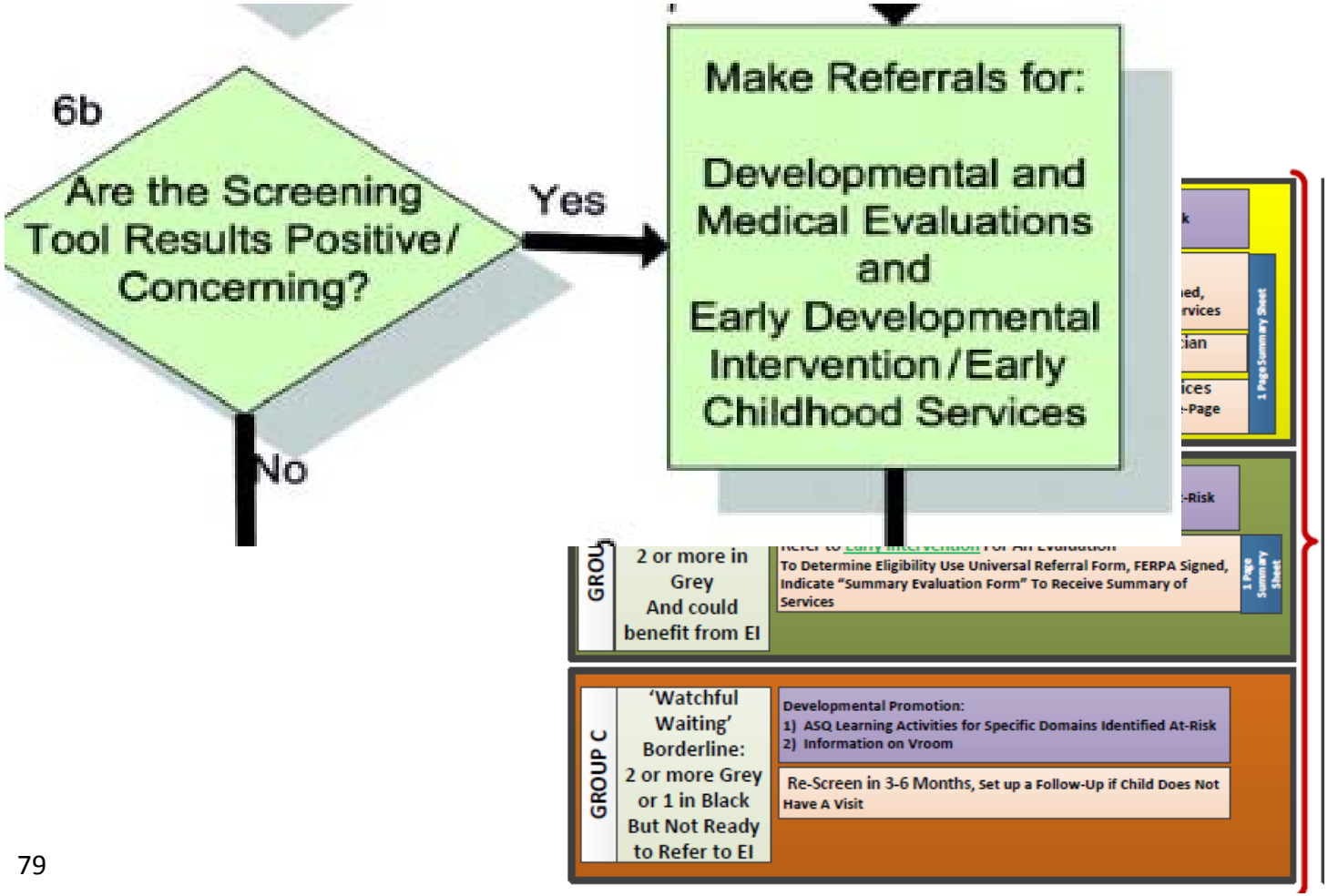
Over Course of Project:
Increase in Physician Referrals to EI Largely Driven by Pilot Sites



Over Course of Project:
No Increase in Number of Children Eligible for EI



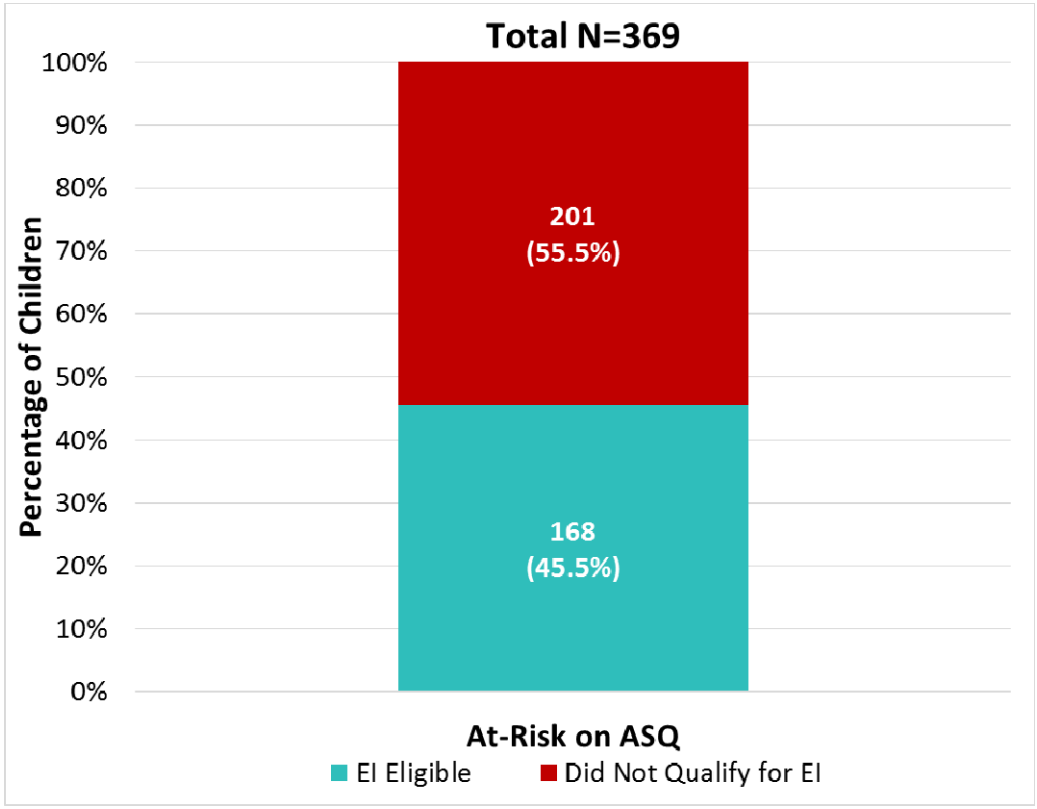
Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. Council on Children with Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children with Special Health Needs Project Advisory Committee. *Pediatrics. 2006: 118;405*



Examining Presenting ASQ Domain-Level Scores Provided by Referral and EI Eligibility

- **Identified children who were referred to EI and domain-level ASQ scores were provided**
  - Only 26% of referrals across nearly 3 school years had domain-level scores for ASQ
- **This required WESD to complete manual chart review and data entry**
- **WESD provided OPIP with blinded database that included:**
  - ASQ scores
  - EI eligibility and for which domains
  - Other descriptive factors to inform analysis. For example: Age of child, Medicaid insurance, referral source, medical eligibility
- **Primary care pilot sites also provided data on children referred to EI and their information about the child's domain-level score**
- **OPIP conducted analyses to identify any trends to inform better referrals from primary care to EI**

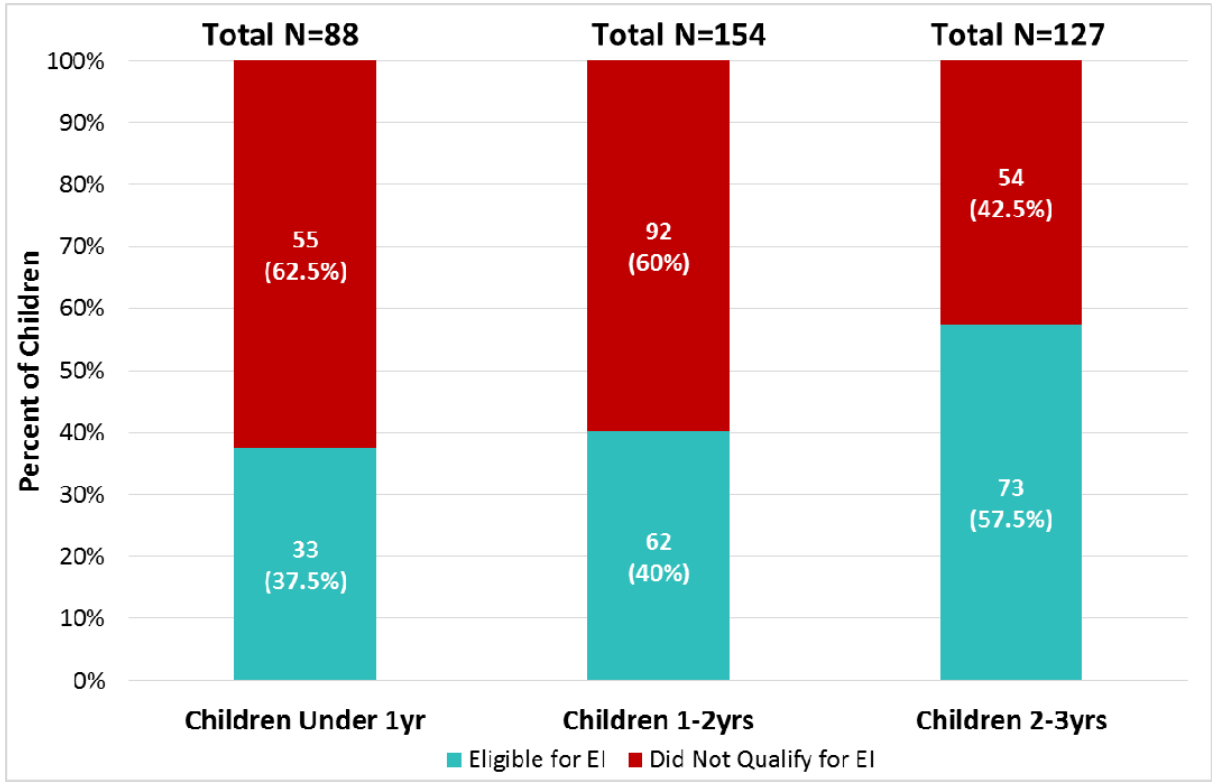
Children Identified as At-Risk on ASQ by Referring Provider & EI Eligibility



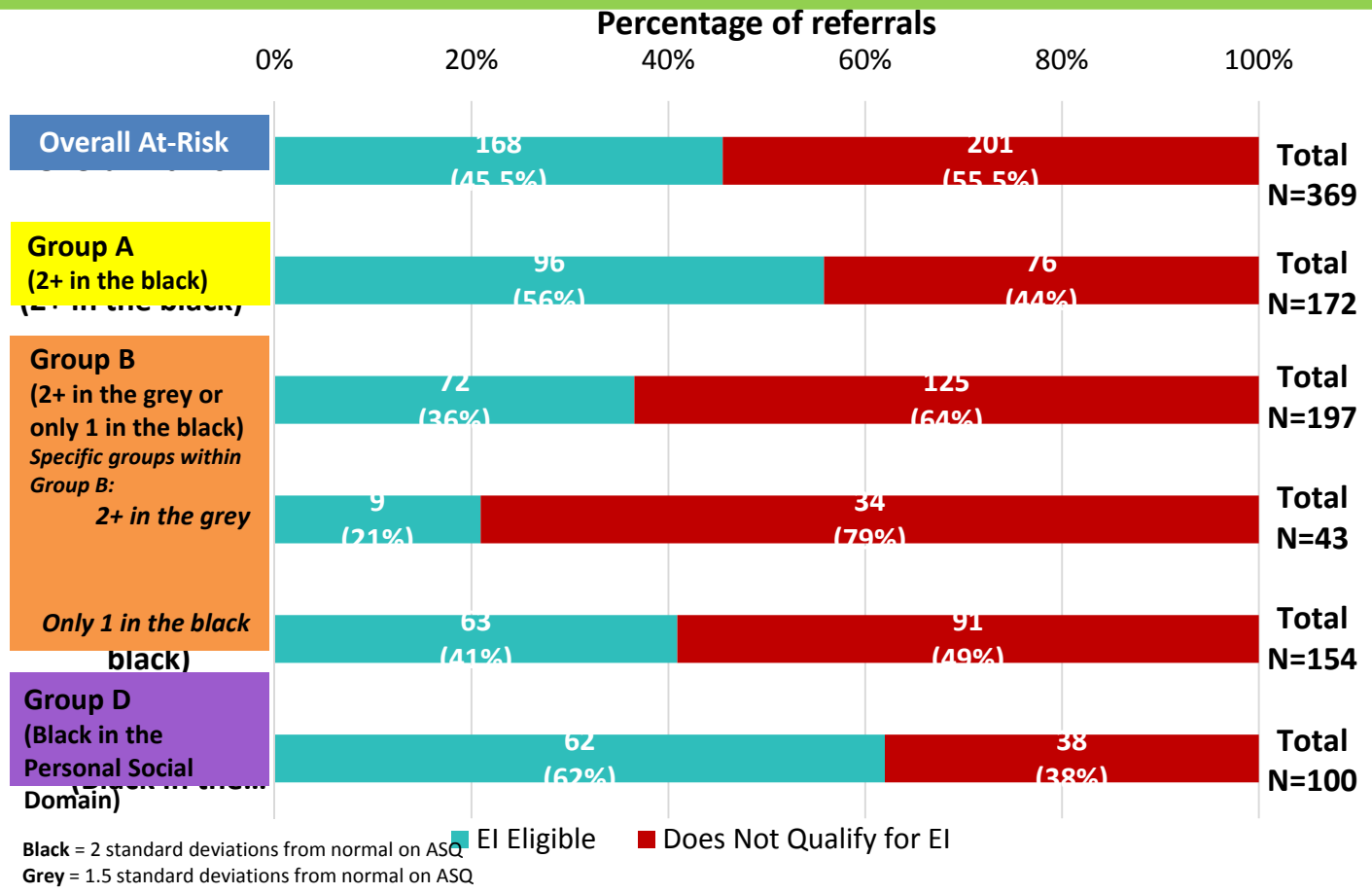
At-Risk on ASQ, Across Five Domains:

- **2 STDs from Normal on One Domain (Black)**
  or
- **1.5 STD from Normal on Two Domains (Grey)**

Children Identified as At-Risk on ASQ by Referring Provider and EI Eligibility: By Age



EI Eligibility by ASQ Scores: by Medical Decision Tree Groups



Black = 2 standard deviations from normal on ASQ
Grey = 1.5 standard deviations from normal on ASQ

Implications to Inform Future Efforts

- **Current recommendations are for all children identified "at-risk" to be referred to EI**
- **That said, given Oregon's eligibility requirement for EI, we know that many of the children identified "at-risk" on ASQ will not be eligible within EI**
  - If all children referred, more children will be evaluated and not eligible
  - Eligibility rates impact referral
    - ✓Providers stop referring
    - ✓Parents may not go back to referral if not found eligible at one point in time
- **Modifications to the medical decision tree**
  - Changing the referral guidance to EI based on data and collaborative conversations with PCPs and Local EI contractors
  - Will Vary by
    - ✓Level of parental concern
    - ✓Age of child
    - ✓

Reflections from My Early Learning Hub Partners

- From your perspective, what part of the Early Intervention engagement and QI work most relevant and meaningful to you in your role as a HUB?

- What learnings did you gather about opportunities and needs based on the pilots within EI?

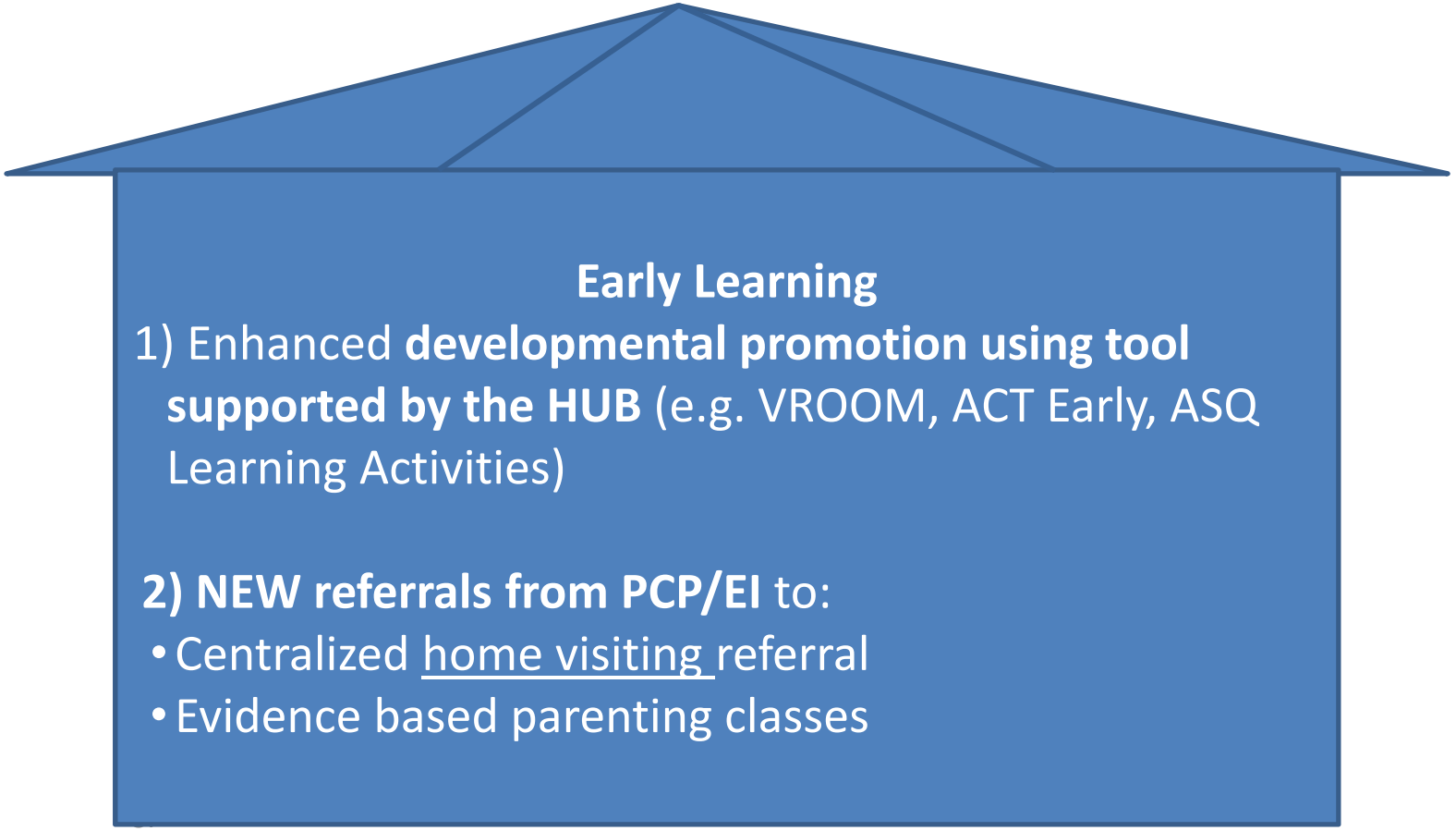
Agenda

- Part 1: Setting the Landscape for the Community-Based Improvement Project. Overview of Improvement Strategies Developed
- Part 2: Data Identifying Where Children Fall out of Pathways, Community Asset Mapping

Community-Based Improvement Effort

- Part 3: Improving Follow-Up in Primary Care
- Part 4: Improving Follow-Up in Early Intervention
- **Part 5: Improving Follow-Up in Home Visiting & Parenting Education Supports**

Community-Based Improvement Opportunity: Improvement Efforts Implemented by Pilot Sites



Referrals to Centralized Home Visiting

- Two different regions (Yamhill, Marion and Polk) created a centralized referral form for home-visiting programs
- Allows for providers to have one place to refer to
- Programs meet periodically to review the referral and identify the "best match" for the referral
  - Feedback loops
  - No wrong door

Examples of the Centralized Home Visiting Referral Forms in these Communities

In Yamhill:

Family CORE

Coordinated 0-5 years Referral Exchange

Referral form for prenatal, infant and young children home visitation programs

Those with chronic medical conditions are eligible up to age 21 years
Clients with or without insurance are eligible for programs

Please fax this form to 503-857-0767.

The person or family being referred will be contacted.
We will provide a follow-up letter to you regarding the outcome of the referral.
For questions or mailed submissions please call 503-376-7426.
807 NE 3rd St., McMinnville, OR 97128

Date: _____

Child OR pregnant women being referred:
_____ Date of Birth: _____
Due Date (if applicable) _____
Parent or Guardian names (if a child):
_____ Relationship:_____ Date of Birth: _____
_____ Relationship:_____ Date of Birth: _____

Phone number _____
Home address _____

Primary Language_____
Race/Ethnicity White O Hispanic/Latino O Black/African American O Native American O Other O

Please check all that apply

- O Medical condition Please specify_____
- O Teen parent
- O Parent with developmental delays
- O Child with or at risk for developmental delays
- O Infant feeding/weight gain problems
- O Risk of maternal depression
- O Isolation/lack of support
- O Challenging child behaviors
- O Newly pregnant needing assistance
- O Limited income/resources (i.e. lack of transportation, food, housing)
- O Lack of adequate parenting skills
- O Domestic violence (present or history of)
- O Lack of client/patient follow through
- O Substance abuse-*please describe below*
- O Tobacco Use
- O DHS involvement
- O Other- *please describe below*

Additional Information:
_____
_____
_____

Referring Source Information:
Person (provider) to receive referral follow-up information: _____
Agency/Organization:_____
Phone Number: _____ Fax Number: _____

For Internal Family CORE use only

A Family Place Relief Nursery
Babies First
CaCoon
Early Head Start/Head Start
Early Intervention/Early Childhood Special Education
Healthy Families
Maternity Case Management
Mothers and Babies
Responsible Moms

In Marion and Polk Counties:

Family Link

Use this form to refer pregnant women or parenting families with children ages 0-5 to early learning and family support programs in Marion and Polk counties. Services are most often delivered through home visits and/or classroom-based programs and designed to improve child health and development, increase school readiness, improve maternal health, and increase positive parenting practices.

Child:	Sex: ☐ M ☐ F	DOB:
Child:	Sex: ☐ M ☐ F	DOB:
Parent/Guardian:	DOB:	Relationship to child:
Sex: ☐ M ☐ F	Pregnant? ☐ Y ☐ N	Due date:
Parent/Guardian:	DOB:	Relationship to child:
Sex: ☐ M ☐ F		
Address:	City:	Zip:
Cell Phone: Texts? ☐ Y ☐ N	Home Phone:	Best Time to Call:
Preferred Language:		Email:

Reason for Referral: Check ALL that Apply

Child or Children

☐ Lack of Prenatal Care	☐ Has Disability	☐ Behavior concerns
☐ Support with Breastfeeding	☐ Born Premature	☐ Feeding concerns
☐ Support with Infant Care	☐ Home Environment concerns	☐ Health concerns
☐ Drug-Exposed Infant/Pregnancy	☐ Development concerns	☐ Weight concerns
☐ Support with Attachment/Bonding	☐ Social/Emotional concerns	

Parent or Guardian

☐ Feels Depressed or Overwhelmed	☐ Teen/Young Parent	☐ Lack of Food/Clothing/Housing
☐ Isolation/Lack of Support	☐ First Time Parent	☐ Incarceration/ Probation
☐ Support with Parenting	☐ Tobacco Use	☐ Low Income
☐ Has Disability	☐ Alcohol/Drug Use	☐ Other:

Additional Family Information:
☐ Migrant/Seasonal Work ☐ Unemployed ☐ Homeless ☐ Receives TANF/SSI ☐ Receives SNAP

Is there anything else we should know?

Referred by: Contact Person: Agency: Phone:

Parent Consent to Refer: By signing this form, I authorize **Yakima Valley Farm Workers Clinic** to disclose the information listed above, for the purpose of connecting my family to an early learning and family support program, to the following organizations:

☒ Family Building Blocks	☐ Oregon Child Development Coalition (OCDC)
☐ Mid-Willamette Valley Community Action Agency	☐ Marion County Public Health Department
☐ Polk County Public Health Department	☐ Willamette Education Service District (WESD)
☐ Salem-Keizer Head Start	☐ Other _____

Parent/Guardian Signature:_____ Date: _____

YCCO Support of Family CORE

- Family CORE originally housed at Yamhill County Public Health
- As CCO staff capacity increased, Family CORE moved to CCO – BAAs signed October 2016.
- Member Engagement Coordinator continued to support, but Family CORE Leadership Team desired increased focus on home visiting
- Grant & Project Coordinator now collecting/reporting data quarterly
- New hire in July 2017: Family Engagement Coordinator
  - Service Integration Team coordination
  - Family CORE support & expansion

Pilot of Referrals in Primary Care Pilots Sites as Part of ASQ Follow-Up

Follow-Up Based on Total Score Across Domains:

GROUP A — 2 or More in the Black — N= 111

- Developmental Promotion:
  1) ASQ Learning Activities for Specific Domains Identified At-Risk
  2) Information on Vroom
- Refer to Early Intervention For An Evaluation
  To Determine Eligibility Use Universal Referral Form, FERPA Signed, Indicate "Summary Evaluation Form" To Receive Summary of Services
- Consider Referral to Developmental/Behavioral Pediatrician
  (See DB Peds Referral Cheat Sheet)
- Consider Supplementing Medical and Therapy Services Under Insurance Coverage Medical & Therapy Services (See One-Page Summary of WVCH Providers and Coverage)

1 Page Summary Sheet

GROUP B — "At-Risk": 1 in Black; OR 2 or more in Grey And could benefit from EI — N= 290

- Developmental Promotion:
  1) ASQ Learning Activities for Specific Domains Identified At-Risk
  2) Information on Vroom
- Refer to Early Intervention For An Evaluation
  To Determine Eligibility Use Universal Referral Form, FERPA Signed, Indicate "Summary Evaluation Form" To Receive Summary of Services
- Consider Supplementing Medical and Therapy Services
  Under Insurance Coverage Medical & Therapy Services
  (See One-Page Summary of WVCH Providers and Coverage)

1 Page Summary Sheet

GROUP C — 'Watchful Waiting' Borderline: 2 or more Grey or 1 in Black But Not Ready to Refer to EI

- Developmental Promotion:
  1) ASQ Learning Activities for Specific Domains Identified At-Risk
  2) Information on Vroom
- Re-Screen in 3-6 Months, Set up a Follow-Up if Child Does Not Have A Visit

Three Community Resources To Consider for Groups A-D

Resource #1

Child has a Medical Dx or Medical Risk Factors (ex: FTT, elevated lead, seizure disorder) AND Social Risk Factors (Ex: parent with inadequate knowledge/supports, alcohol/ substance abuse, or mental illness; teen parent) — YES → Refer to CaCoon/ Babies First Use CaCoon Program Referral Form

1 Page Summary Sheet

Resource #2

Family Risk Factors Present or Exposure to Adverse Childhood Events & would benefit from Home Visiting and/or Head Start → Publicly Insured — YES →

- Child Lives in Marion/ Polk County → Refer to Family Link Include Info on EI Referral
- Child Lives in Yamhill County → Refer to FamilyCORE Include Info on EI Referral

1 Page Summary Sheet

Resource #3

Support developmental promotion by addressing issues such as literacy/ reading, parenting skills, food insecurity — Could benefit from parenting classes?

- Classes in Yamhill & Polk Counties → Mid-Valley Parenting
  www.midvalleyparenting.org
  Email: parentresources@co.polk.or.us
- Classes in Marion Counties → Marion & Polk Early Learning Hub
  www.earlylearninghub.org
  Email: parentinghub@earlylearninghub.org

Example of Pilot of Referrals as Part of Follow-up to Screening from PCP Sites to Centralized Home Visiting

- **Agreed upon criteria for referrals were as follows:**
  - Children identified **at-risk on the ASQ** who also have **Family Risk Factors, including those listed below:**

✓ Feels Depressed or Overwhelmed
✓ Isolation/Lack of Support
✓ Support with Parenting
✓ Has Disability
✓ Teen/Young Parent
✓ First Time Parent
✓ Tobacco Use
✓ Domestic Violence (present or history of)
✓ Alcohol/Drug Use
✓ Lack of Food/ Clothing/Housing
✓ Incarceration/Probation
✓ Low Income
✓ Migrant/Seasonal Worker
✓ Unemployed
✓ Homeless
✓ Receives TANF/SSI/SNAP

Successes and Barriers to Pilots of PCP Follow-up to Home Visiting

Successes:

- **Improved communication and understanding between both entities of each other and their services**
- **Increased referrals**

  Example from Marion and Polk Counties and Referral to Family Link

  - *Pilot primary care site referred 30 kids from February 2017-May 2017 to Family Link*
  - *Referral to Family Link spread to 2nd primary care pilot site*
  - *Early Intervention referred 70 EI Ineligible children to Family Link*

Barriers:

- **Not able to contact families referred by phone**
  - *Example from Family Link Pilot: Of the 30 kids referred in pilot primary care site, 30% unable to be reached and 7% declined conversation with Family Link when they were contacted.*
- **Many children who do get connected are still pending or put on waitlists**
  - Reality of the capacity across organizations to catch these children
  - *Example from Family Link Pilot: Of the 30 kids referred in pilot primary care site, 10% on waiting lists and 23% closed to lack of eligibility*
- **Stigma around home visiting**
- **Cultural variations and acceptance of home visiting services**

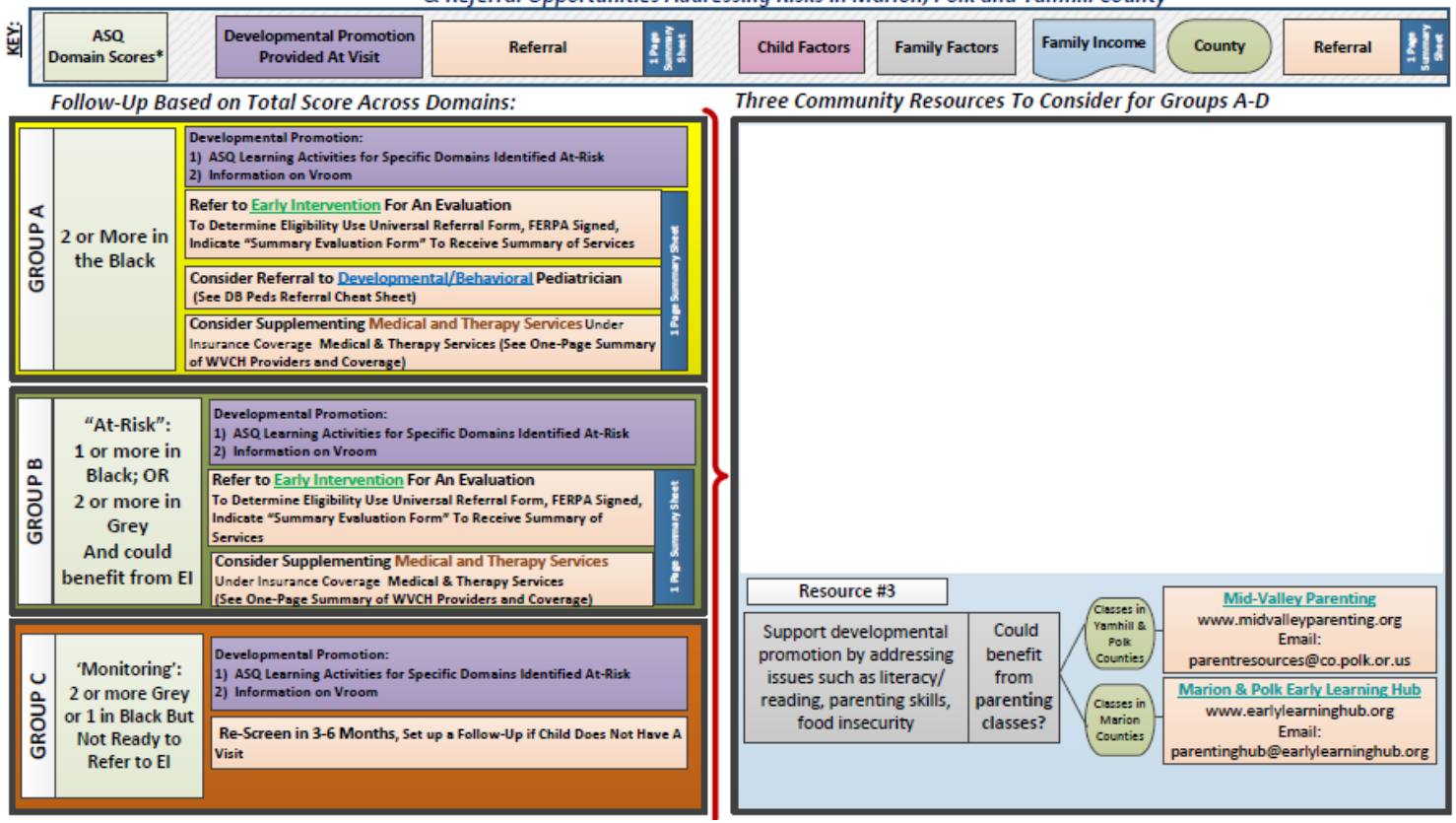
Pilot to Parenting Classes

hub inc.
MARION & POLK EARLY LEARNING HUB

Connection to Parenting Classes

2-23 DRAFT

Figure 1.0: Pilot Medical Decision Tree for Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks in Marion, Polk and Yamhill County



Parenting Classes Pilots

- Extend the number of parent education courses and locations
- Mind in the Making and other new curriculums for the community
- Hold course in locations where families gather
- Doctors recommending courses helpful
- Desire to “normalize” parent education
- Partner with area medical clinics to host classes
- Partner with other area organizations to host classes

hub inc.
MARION & POLK EARLY LEARNING HUB

Oregon Parenting Education Collaboratives: Example Classes

Make Parenting a Pleasure (in Spanish *Haga de la Paternidad un Placer*)

- This parenting curriculum has been in practice for more than 30 years. It is designed for parents who are highly stressed with children 0 to 8 years old.

Abriendo Puertas (in English *Opening Doors*)

- Nation's first evidence-based comprehensive training program developed by and for Latino parents with young children between the ages of 0 and 5 years old.

Nurturing Parenting

- Family-centered trauma-informed program designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices.

Collaborative Problem Solving: Parent workshop

- *CPS* is a strengths-based, neurobiologically-grounded approach that brings new ideas and new hope for helping kids with behavioral challenges.

Mothers and Babies

- This class is designed specifically to provide support and encouragement to mothers who are pregnant or have an infant 36 months or younger. Each mom learns ways to think about and interact with their young baby to create an emotionally and physically healthy reality. Topics include baby development, managing stress and mood changes. Mothers receive individual support from their instructor/coach as well as build support with other new moms.

Successes and Barriers to Referrals to Parenting Classes

Successes:

- Providers were excited to learn about parenting classes, as this was not a resource they utilized previously
- General sentiment is that this would be helpful for many families they care for

Barriers:

- Can be an awkward conversation
  - Value of general efforts to normalize efforts
- Negative stigma of 'parenting classes'
  - Impacting family engagement and follow through
- Since it is not a traditional referral, practices can't track referrals and "follow-up" on the "referral"

Looking Forward –
Sustaining this Work as Early Learning Hubs

Key Learnings

- Workflow necessary to get into the process
- Champion necessary to keep the work moving forward
- Weave resources into medical visit
- Timely follow-up with parents
- Communication between clinic and early intervention is critical

Moving Forward

- Grant to support expansion into other clinics
- Coaching and technical assistance for providers
- Funding for position at WESD to facilitate conversation
- Training for Early Learning Providers on social emotional skills
- ASQ-3 and ASQ-SE Activities for providers
- Expand outreach to parents
  - Parent Education & Vroom
- YCCO considering inclusion of Early Learning supports in APM applications

hub inc.
MARION & POLK EARLY LEARNING HUB

Yamhill Community Care Organization

Thank You for your Collaboration & Inspiration

- Oregon Health Authority (Funder and Partner)
- Willamette Education Service District (Funder and Partner)
- Parent Advisors
- Partners in Marion, Polk & Yamhill Counties
  - Yamhill CCO
  - Yamhill Early Learning Hub
  - Head Start of Yamhill County
  - Yamhill County Public Health
  - Physician's Medical Center
  - Newberg School District
  - Discovery Zone Child Development Center
  - Willamette Valley Community Health
  - Marion & Polk Early Learning Hub (Hub, Inc)
  - Childhood Health Associates of Salem
  - Woodburn Pediatric Clinic
  - Marion County Health Department
  - Polk County Health Department
  - Family Link
  - Family CORE

More Information

Colleen Reuland reulandc@ohsu.edu

Lisa Harnisch lharnisch@earlylearninghub.org

Jenn Richter jrichter@yamhillcco.org

www.oregon-pip.org

Section focused on Follow-Up to Developmental Screening:

http://oregon-pip.org/focus/FollowUpDS.html

- Examples of the specific tools available on the website:
  - Asset map to document community pathways from screening to services
  - Follow-up decision tree for primary care providers based on screening result and child and family factors linking to six follow-up resources,
  - Phone follow-up script for referrals made
  - Parent Education Sheet

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

Hub Governance Meeting 1/16/18

Agenda

1. **Setting the Stage - Project Overview**
2. **Findings from Phase 1:**

   Baseline Data Collection to Understand Existing Pathways and Where Children Fall Out, Opportunities for Improvement Pilots

   - Stakeholder Engagement and Interviews (Qualitative data)
   - Coordinated Care Organization (Quantitative Data)
   - Pilot Primary Care Practice (Quantitative Data)
   - Early Intervention Data (Quantitative Data)
3. **Focus for Phase 2: Focus Areas for Improvement Pilots**
   - Pilot Site
   - Proposed pathways
   - Group-level feedback and input
   - Areas identified for improvement, but out of scope or no capacity
4. **Next Steps**

Opportunity to Focus on Follow-Up to Developmental Screening for YOUNG CHILDREN that is the Best Match for the Child & Family

- Increased focus on developmental screening across the state for children under three
  - Within primary care
  - Within home visiting
  - Within child care
- Goals of screening
  - Identify children **at-risk** for developmental, social, and/or behavioral delays
  - For those children identified, **provide 1) developmental promotion, 2) refer to services** that can further evaluate and address delays
    - Many of these services live outside of traditional health care
- Potential Future Metrics
  - On deck incentive metrics: Follow-up to developmental screening, Kindergarten readiness
  - Early Learning Hub, Early Learning Division measurement dashboard

Children Identified "At-Risk" on Developmental Screening Tools

*This report is focused on **children identified "at-risk"** who should receive follow-up services. These are children who are identified "at-risk" for developmental, behavioral or social delays on standardized developmental screening tools. In the communities of focus for this work, a majority of providers are using the Ages and Stages Questionnaire (ASQ)[3]. Therefore the children of focus are those identified "at-risk" for delays based on the ASQ domain level findings.*

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

Addressing ELH Goals and CCO Goals Related to Young Children

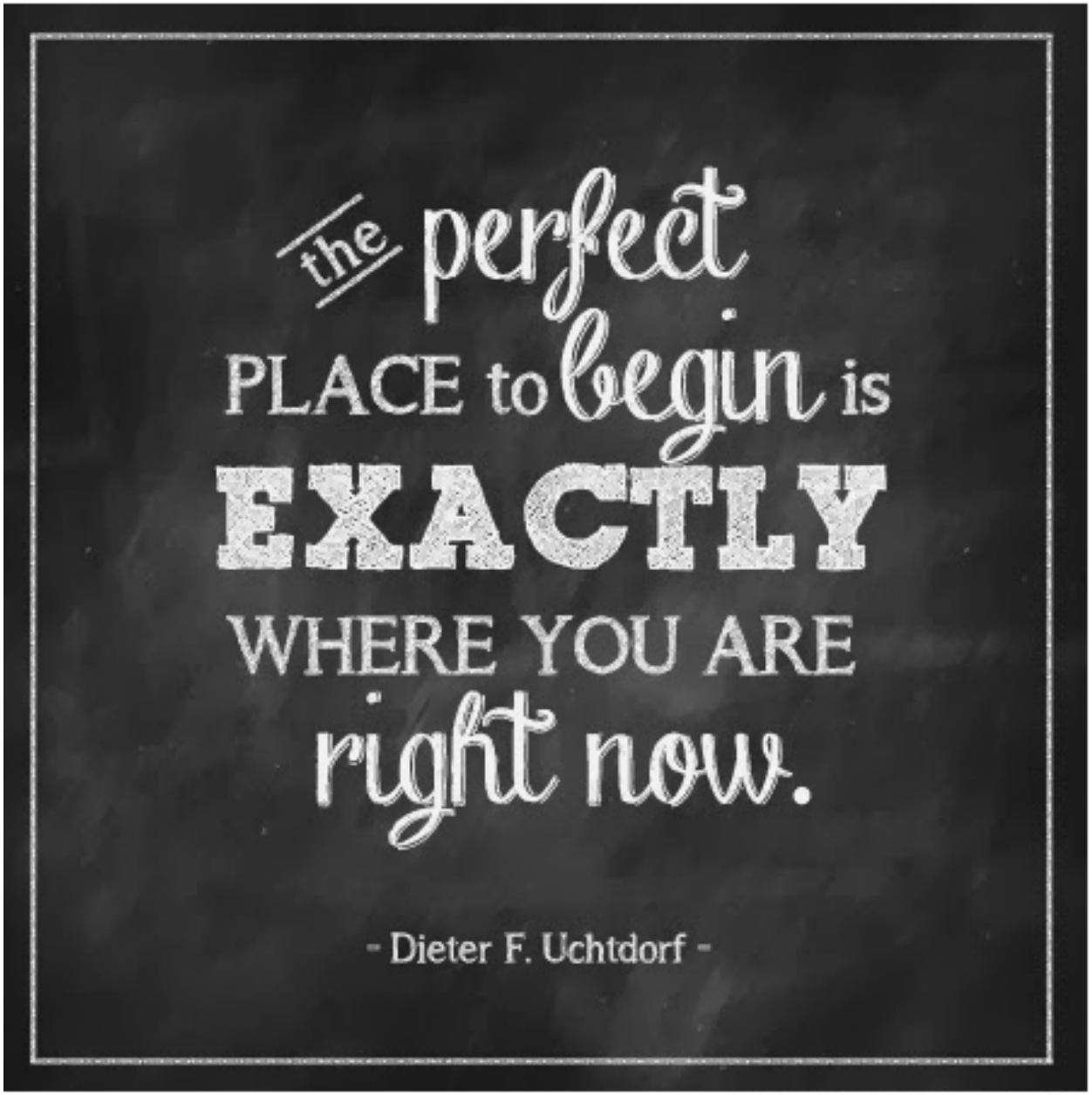
- Both OHA and ODE share a common focus on **developmental screening**
  - Developmental screening related metrics exist for CCOs, ELHs, and PCPCHs
- The goal of primary care-based screening is not merely to screen, but to identify at-risk children so that **concerns can be addressed early**.
  - Recommendations for screening in primary care were made as that is where the most "car seats" for children under three are parked
  - Addressing risks that are identified early increases the likelihood that the child will be ready for kindergarten
  - Timely receipt of services for children identified at-risk for developmental, behavioral, and/or social delays is an important element of this
  - Important focus on the younger children and before preschool
- **Kindergarten Readiness** a priority for ELH and an "on deck" measure for CCOs
  - What is measured is focused on
  - As the movement for kindergarten readiness as a metric for early childhood health gains steam, the topic of follow up to developmental screening likely to get increased attention

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 (3 Sites, One in Each Community)
    2. Early Intervention (NWESD – 3 Local Service Area Centers)
    3. Early Learning (Entities Proposed within Each Community)
- 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, Identify Where to Focus Improvement Pilots

Goal of Phase 1:

- **Understand the current pathways** from developmental screening to services in each of the three counties
- **Understand community-level assets and resources** that exist
- **Understand where and how children are falling out** of these pathways and not receiving services to address the identified risks
- Understand **priority areas to pilot improvements**

Components of Phase 1:

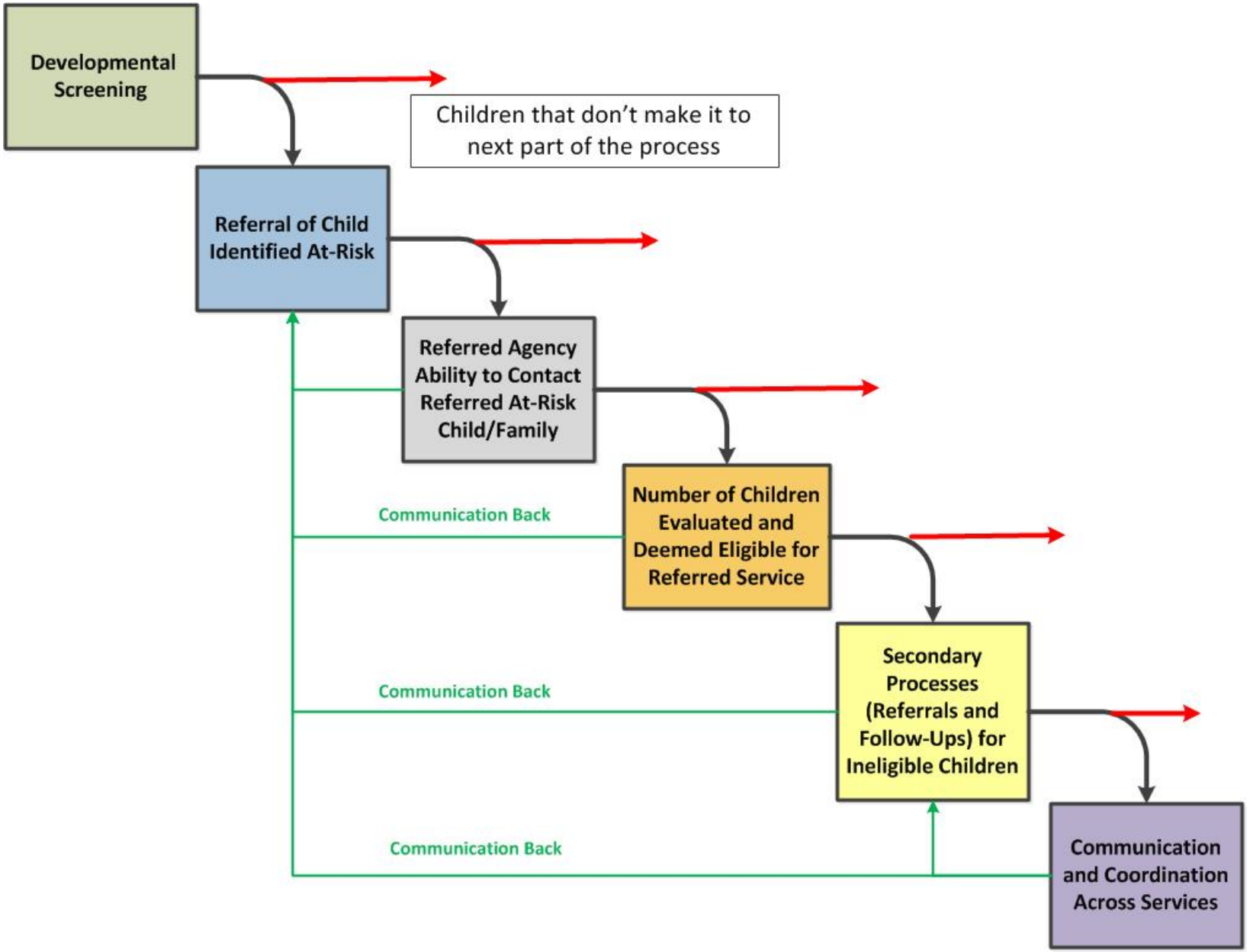
- Stakeholder engagement
  - Recruitment of parent advisors for the project
  - Individual stakeholder interviews (Qualitative data)
  - Group-level meetings to gather input and guidance (Within each county and today)
- Coordinated Care Organization (Quantitative Data)
- Early Intervention Data (Quantitative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

Phase 1: Stakeholder Interviews

- 66 Interviews completed to date across the three counties
- Individuals interviewed across seven sectors
- Purpose of Interview:
  1. Current follow-up process
     - When refer
     - How refer – what form, how tracked
     - Feedback loops – child able to be contacted, eligible, services received
  2. Opportunities
  3. Barriers
  4. Capacity within the region
  5. Hopes for the improvement pilots
  6. Identify current services to inform the **asset map, which may include places where assets are needed but not yet present**

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)	**OHSU Scappoose** **CMH** **Providence Seaside*** **TCCHC** **Legacy St. Helens*** **Adventist** **Yakima VFW*** *Will be engaged as part of the spread efforts	**Interdisciplinary teams that include health care:** **Community Connections-Tillamook** **Community Connections-Clatsop**	**Nancy Ford** (Director of Birth to Age 5 Services) **Tina Meier-Nowell** (Special Education Coordinator) **Vicki Schroeder** (EI Data) **EI/ECSE Program County Coordinators (3)** **EI Referral Intake Coordinators (4)** **EI Lead Evaluators (4)**	**Dorothy Spence** (Hub Director) **Rob Saxton** (Governance Council Chair) **Elena Barreto** (Community Navigator) **Eva Manderson** (Early Learning Program Specialist/ Preschool Promise Manager)	**Mental Health** **Columbia County Mental Health (1)** **Clatsop Mental Health (2)** **Tillamook Family Counseling Center (2)**	**Head Start & Healthy Families Home Visiting (4)** **Public Health/ CaCoon/ BabiesFirst (5)**	**CCR&R (2)** **Childcare Centers conducting screening** (Preschool Promise & SPARK 3 Star & above) • Cubs Corner/ St. Helens HS) • Tillamook Early Learning Center • Astoria School District) • Warrenton Prep **NW Parenting (5)** **Clatsop Kinder Ready** **Preschool Feasibility Study** **DHS (2)**

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



Stakeholder Interviews Findings: Developmental Screening – Punchlines

- **While CPCCO has met benchmarks and screening rates are relatively high, many children are not getting screened in primary care**
- **Group 1: Screening in Primary Care Practices (Health Care)**
  - Not all children access care, so they can't get screened
  - Not all practices that children go to are screening or screening to fidelity. Conversely, some practices are screening at every visit, which has implications related to follow-up
  - Children access care in places that are not where they are 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
  - Children age 2-3 less likely to go in for a well-visit, therefore less likely to be screened
- **Group 2: Community-Based Providers (Early Learning)**: 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)**: 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**

Stakeholder Interviews Findings: Follow-Up to Screening

- While some children receive follow-up, there is not standardization in the follow-up provided
- Follow-up anchored to individuals:
  - Knowledge of early learning services in their community
  - Perceptions about capacity of services
  - Perceptions of family's ability to access those services
  - Perception about the value of those services and what past patients referred have said
  - Perceptions about validity of the ASQ and the ASQ Scores
  - Knowledge about the family and their family context
  - Whether the referred entity communicates back
- People acknowledged making a referral does NOT equal getting a SERVICE
  - Noted barriers to access of referrals
    - Parental engagement or knowledge about why a service is valuable
    - Transportation
    - Stigma, particularly for mental health
    - Family-centered systems and processes
    - Some referrals are for an evaluation, not a service
- Value in communication to "close the loop" on referrals, which often requires a referral form

Stakeholder Interview Findings: Follow-Up for Children Identified At-Risk

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

- In some sites, significant variation by provider (particularly for sites in Tillamook)
- Varied knowledge on **developmental promotion** supports that could be provided
- **Perceptions about EI eligibility** and evaluation processes impact **whether and who they refer**
- Lack of knowledge about the full set of **early learning services** in the community
- Limited or inconsistent knowledge the **infant and early childhood mental health services** in the community
- **Barriers to referral to developmental pediatricians** located in Portland
  - Transportation and time commitment (multiple visits)
  - Wait lists for those referred to developmental pediatrician
- Rarely are secondary follow-up steps considered when a child is ineligible for the first service referred (often EI)
- Community-level variations in primary care practices. Specifically in Tillamook – request to engage Adventist

Opportunities Identified:

- Desire for better two-way communication with resources to which they refer. This would impact likelihood to refer
- **Need for better and standardized processes** (work flows & tracking) around best match promotion and referrals (who, what, where, how) aligned with community-level assets
- Need for **educational materials** for parents of children identified at-risk referred
- Need for tools and strategies to **engage families in accessing the referrals**

Stakeholder Interviews Findings: Follow-Up for Children Identified At-Risk

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

- More knowledgeable about the early learning services. Contact programs directly or meet them through ELH activities
- Have more regular and routine contact with the family to engage them on the follow-up, including promotion activities that they lead
- Use of additional tools to understand the child's needs (ASQ-SE)
- Also noted barriers to referral to developmental pediatricians located in Portland
- Noted barriers to parent engagement or agreement to go to referral
- Noted a lack of AVAILABLE resources to address risk identified (parenting classes)
- Noted past experiences that made access to mental health difficult

Group 3: Early Learning/Childcare

- Very few are screening children 0-3
- Only one 5 star program interviewed does some referring to EI when appropriate. Work with family to determine best process. Currently no communication to the PCP.

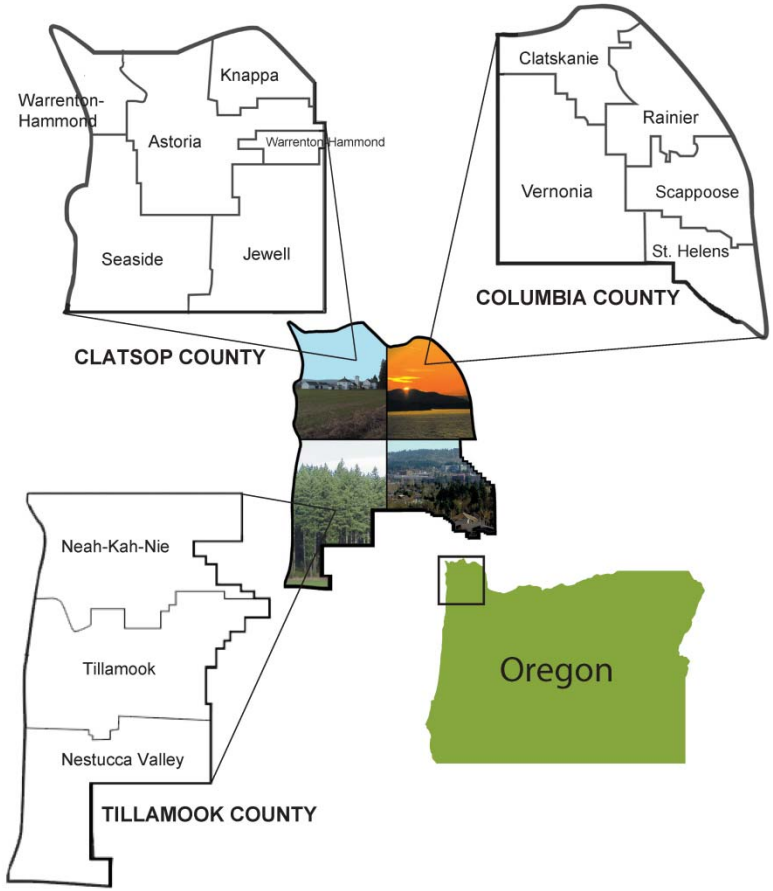
Using Data to Inform Our Discussions and Proposed Priority Areas of Focus for Our Community-Based QI Project

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

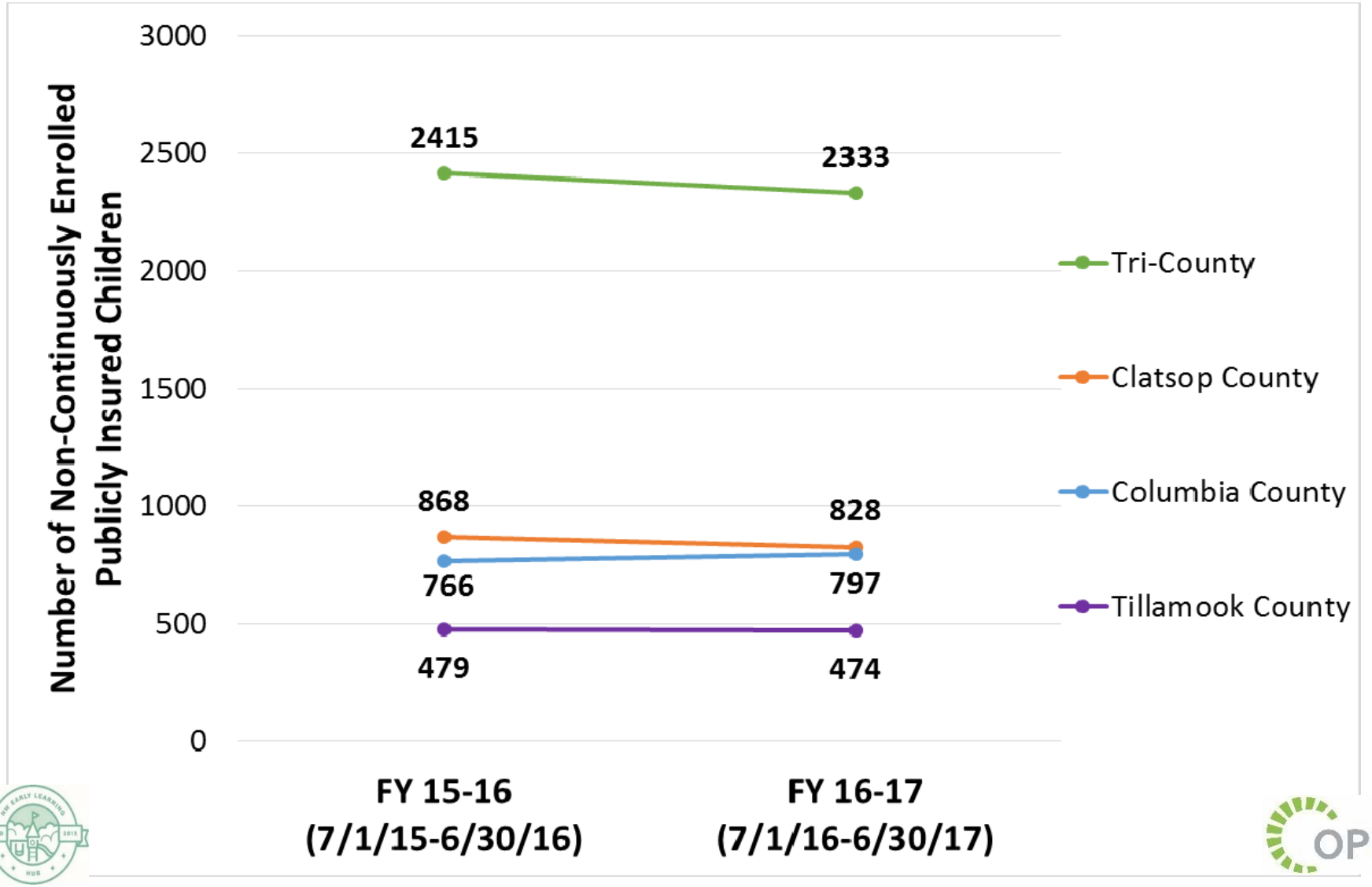
- **Population of Focus for the Project:** Children 0-3 identified on developmental screening tools as at-risk for developmental, behavioral or social delays
- **Available Data That will be Examined**
  1. Census Data – How many children 0-3
  2. Columbia Pacific Coordinated Care Organization (CPCCO) 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: Examples from OHSU Scappoose (a Pilot Site)
     - Children practice identifies as their patient
     - 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. Early learning providers (Tracking data will be collected for any specific pilot sites to evaluate pilot)

Children 0-3 in Tri-County Region

	Total Children 0-3	Children Covered by CPCCO	Of those: Children Continuously Enrolled for 12 months
Clatsop	1,250	828 (66%)	452
Columbia	1,635	797 (49%)	419
Tillamook	655	474 (72%)	280
Total: Tri-County	3,540	2,333 (60%)	1,227

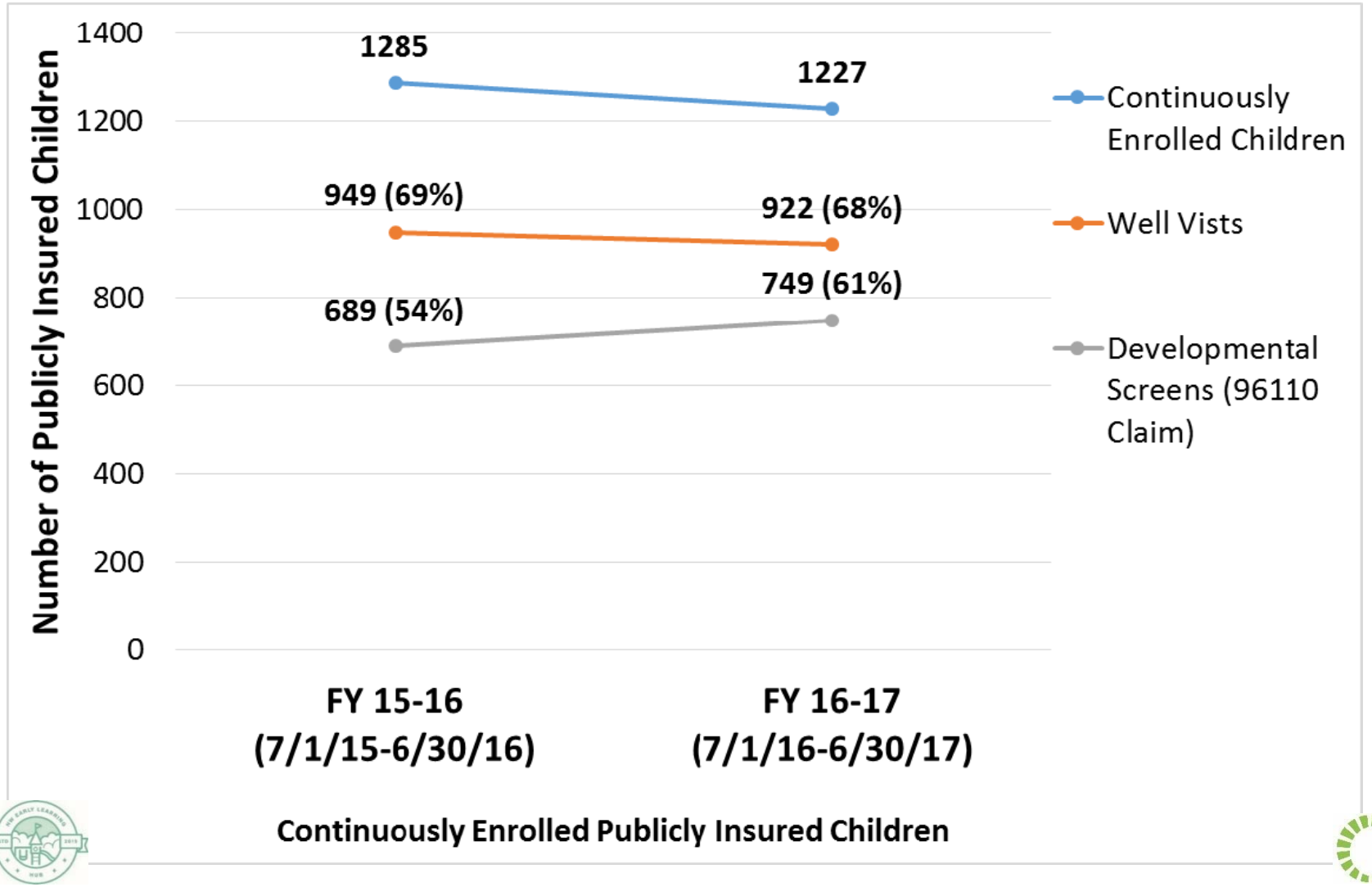


Number of Children 0-3 Publicly Insured in CPCCO (No Continuous Enrollment Requirement)



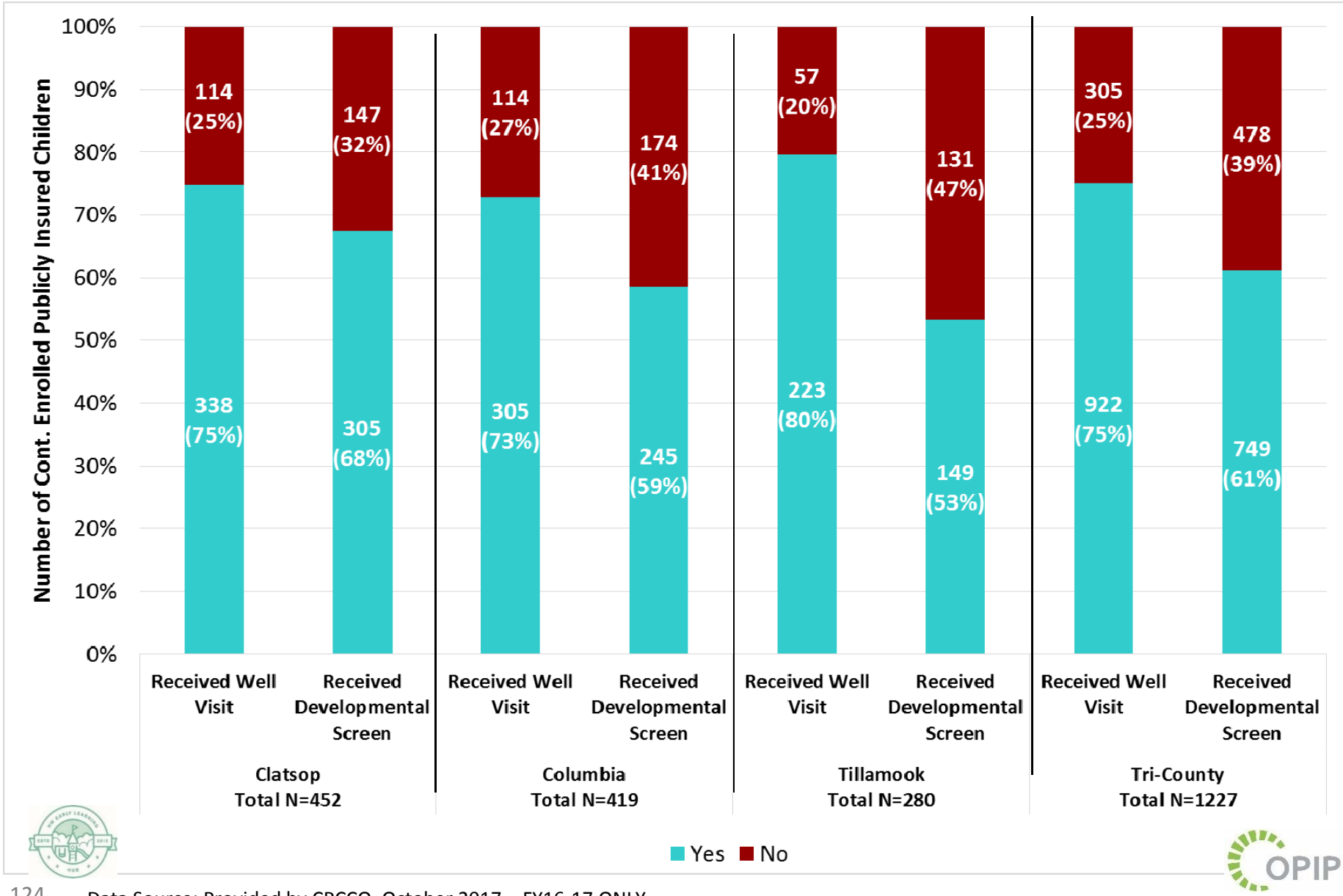
Data Source: Provided by CPCCO, October 2017

Publicly Insured Children Under Three Years Old: Number Continuously Enrolled – Of those: Proportion Who Received a Well Visit, Developmental Screen (96110 Claim)



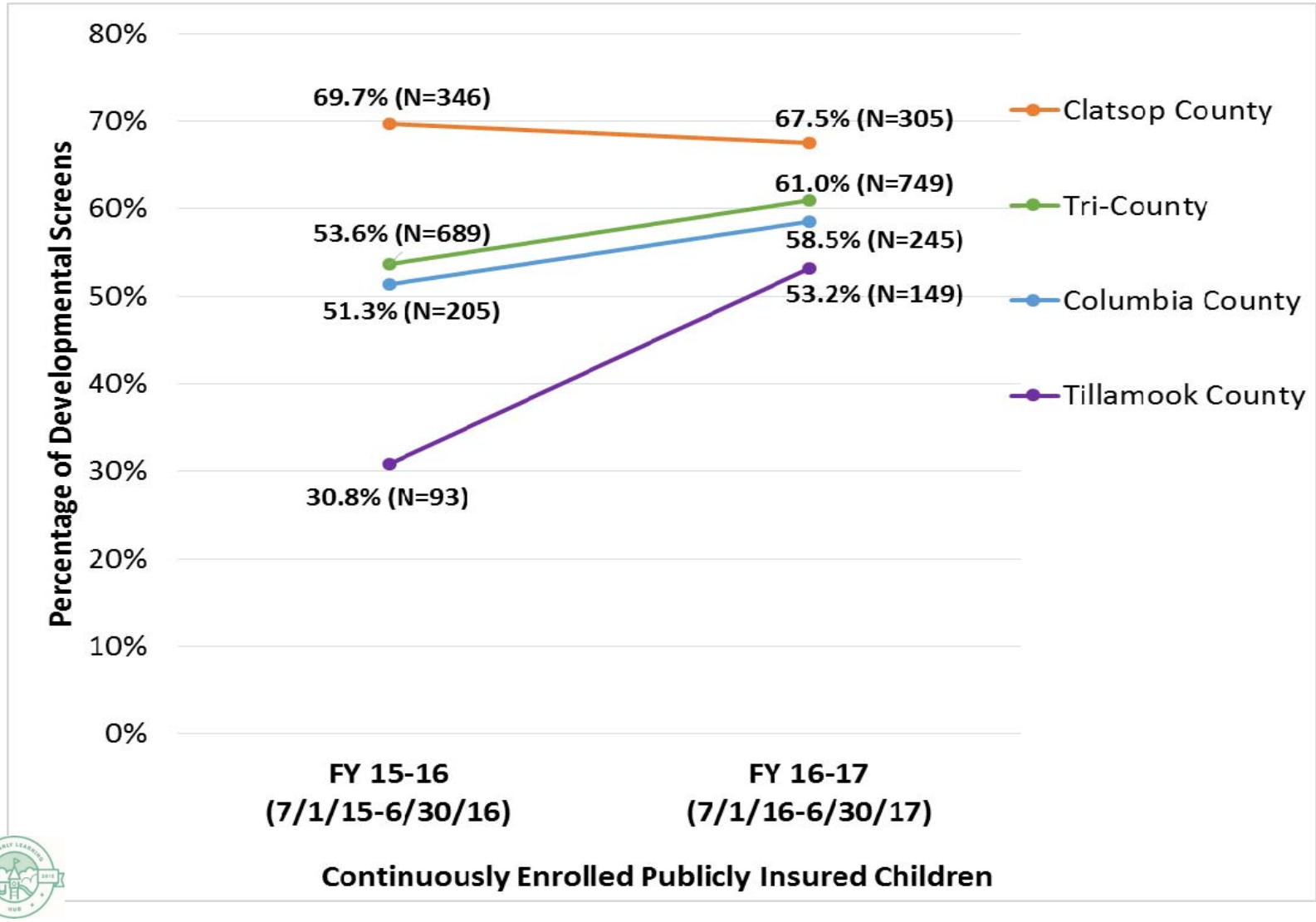
Data Source: Provided by CPCCO, October 2017

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



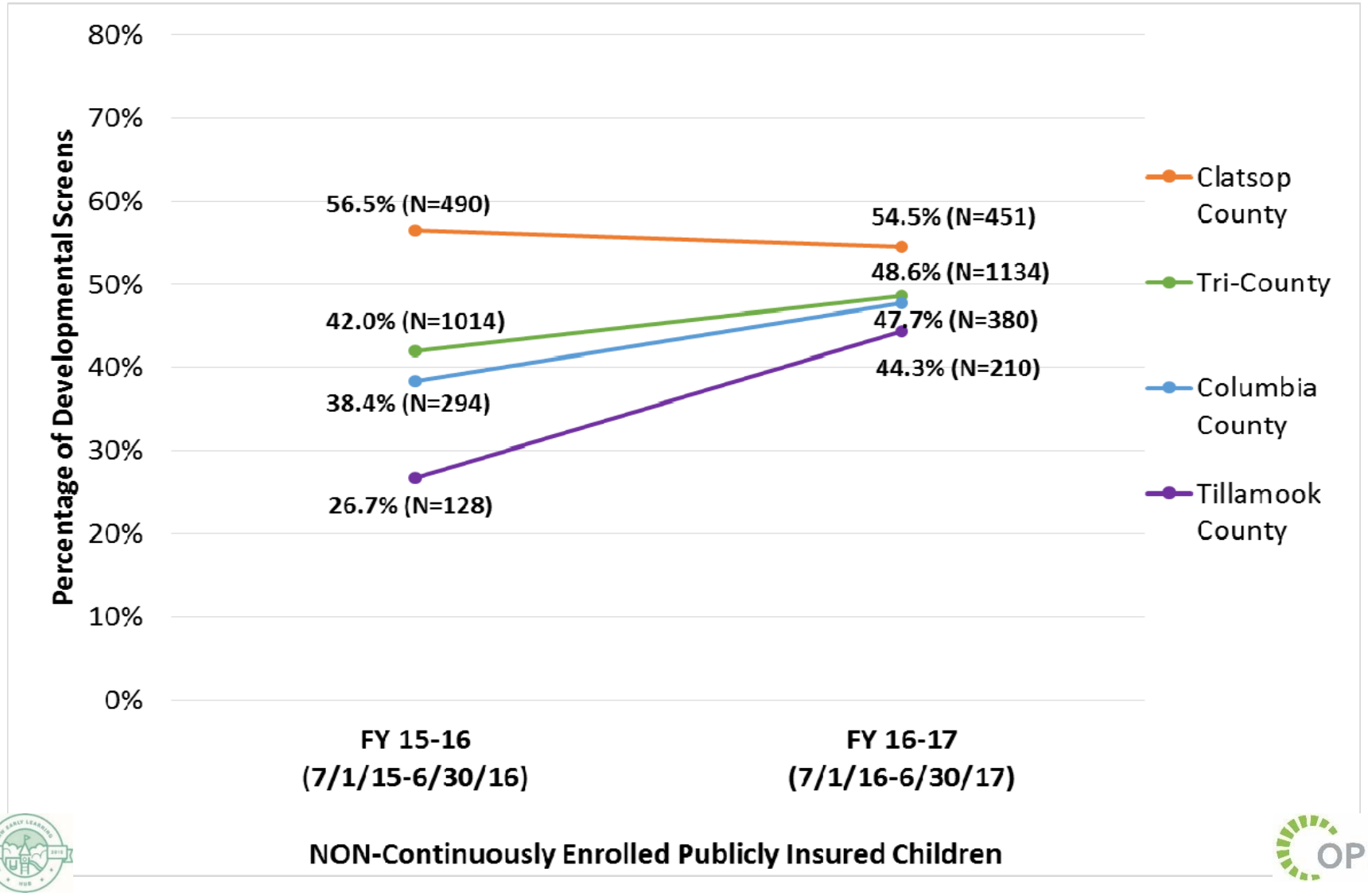
Data Source: Provided by CPCCO, October 2017 – FY16-17 ONLY

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



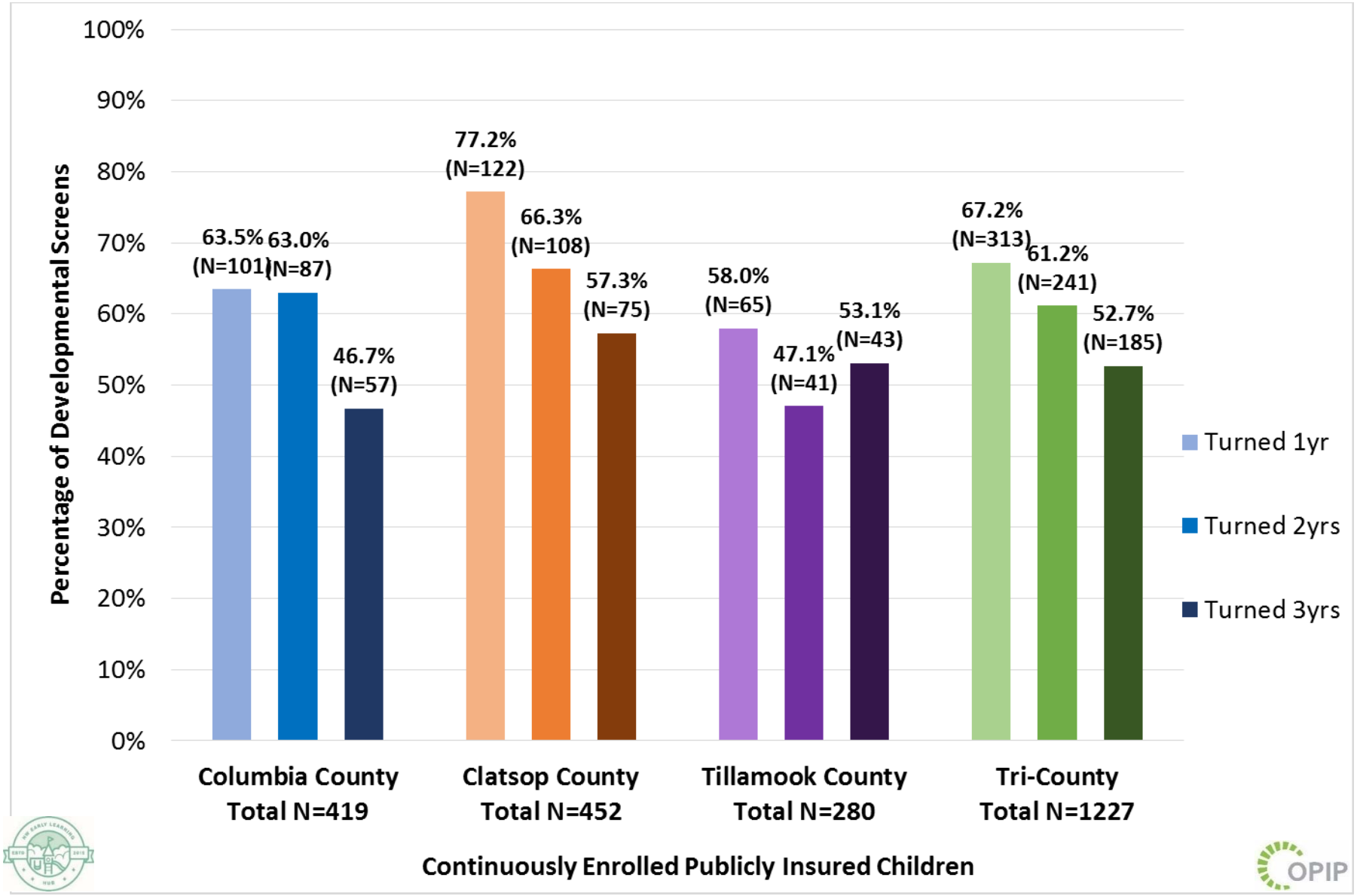
Data Source: Provided by CPCCO, October 2017

Developmental Screening Rate for the Tri-County CPCCO Region for NON-Continuously Enrolled Children



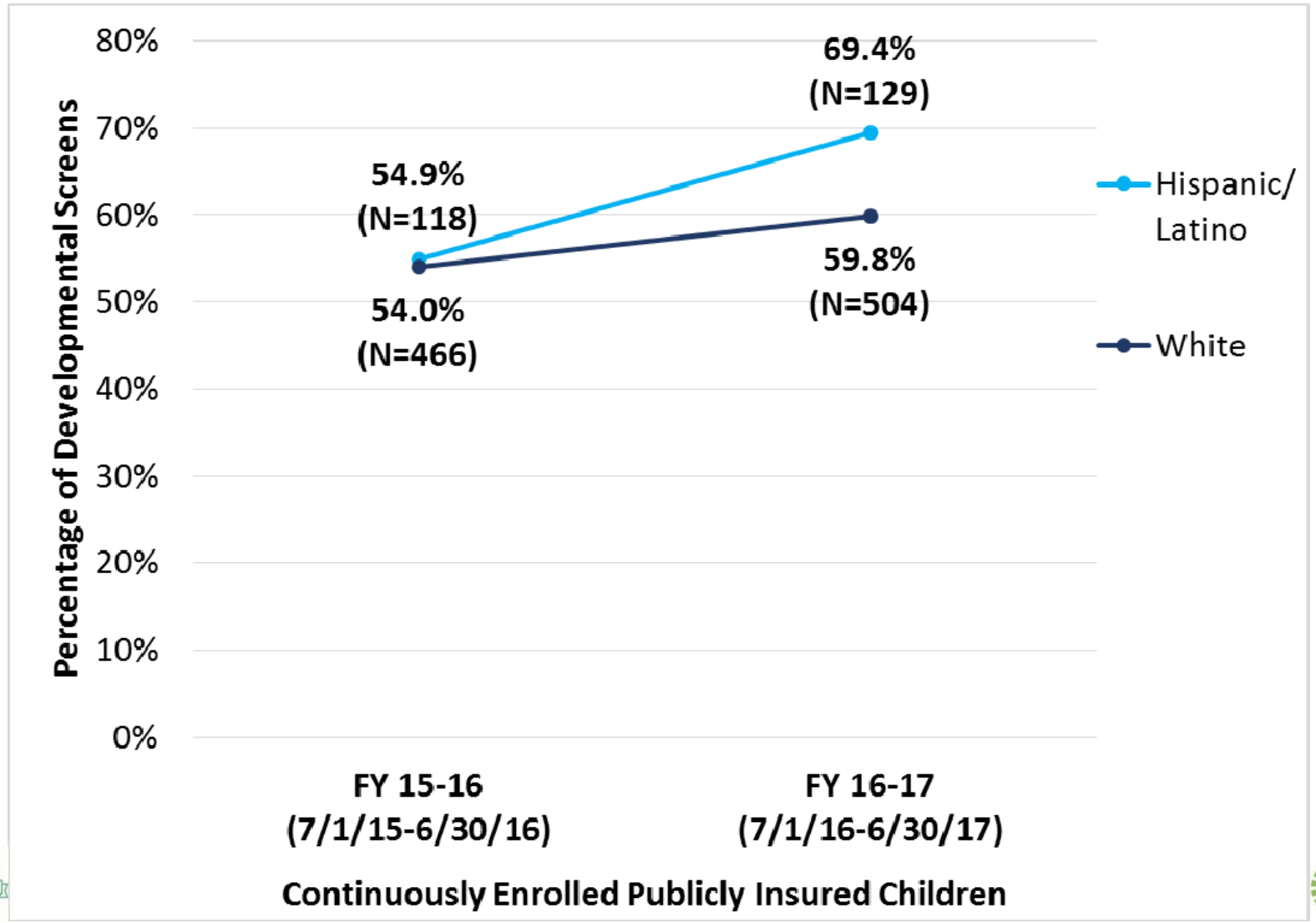
Data Source: Provided by CPCCO, October 2017. Developmental Screens according to 96110 Claims.

Developmental Screening Rates by Age of Child



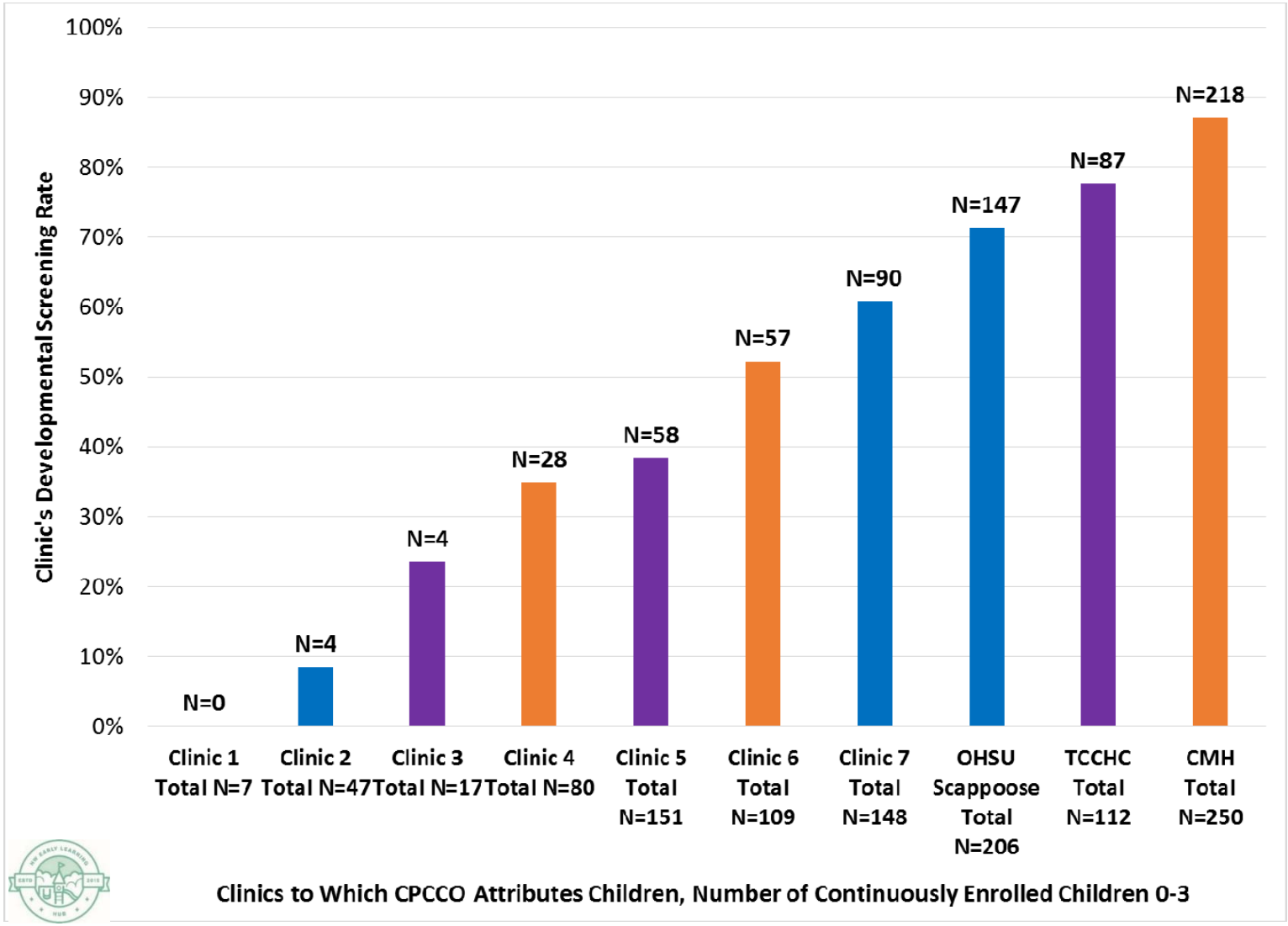
Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

Developmental Screening Rates by Race/Ethnicity – CONTINUOUSLY ENROLLED CHILDREN



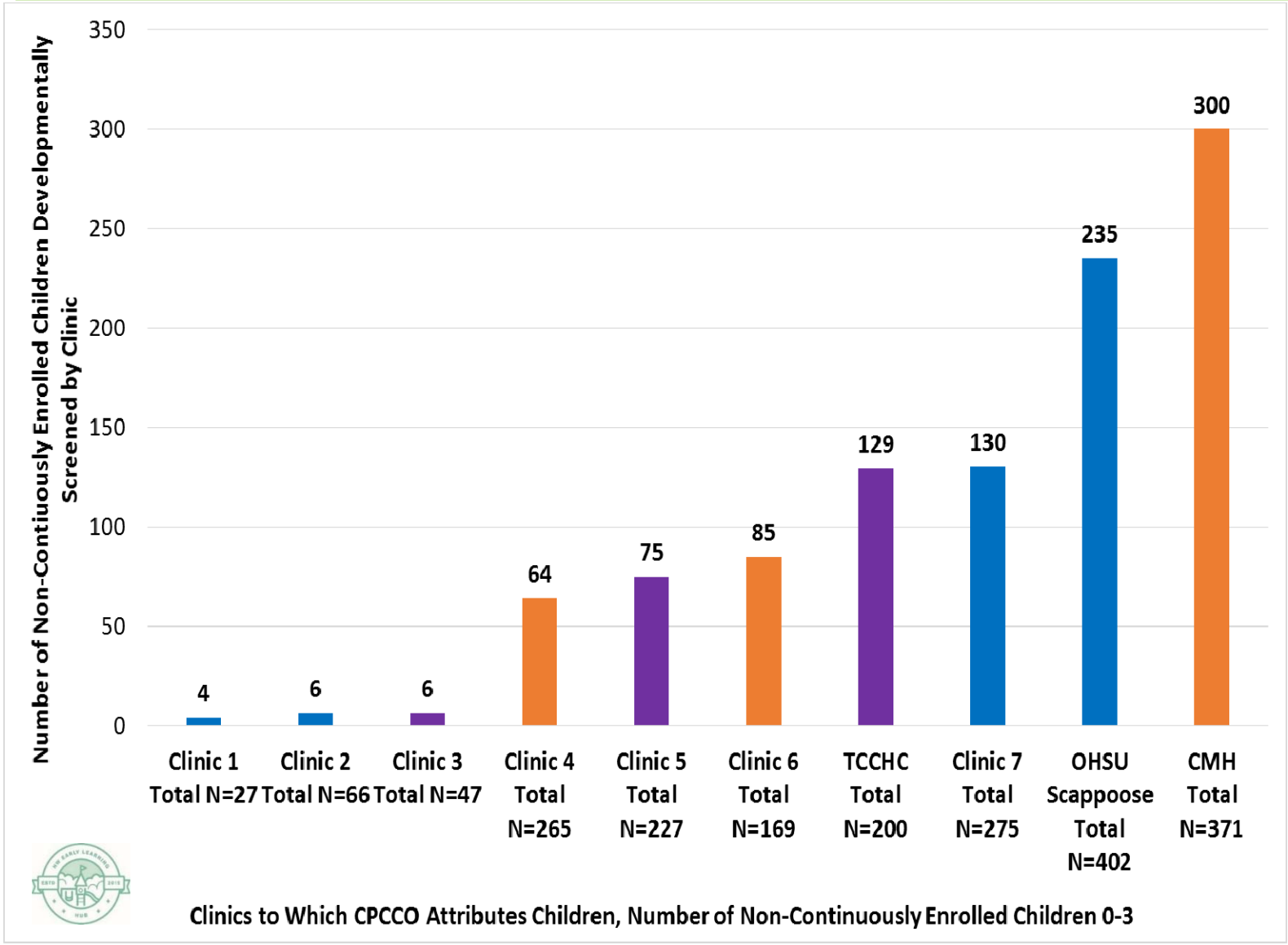
Data Source: Provided by CPCCO, October 2017

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



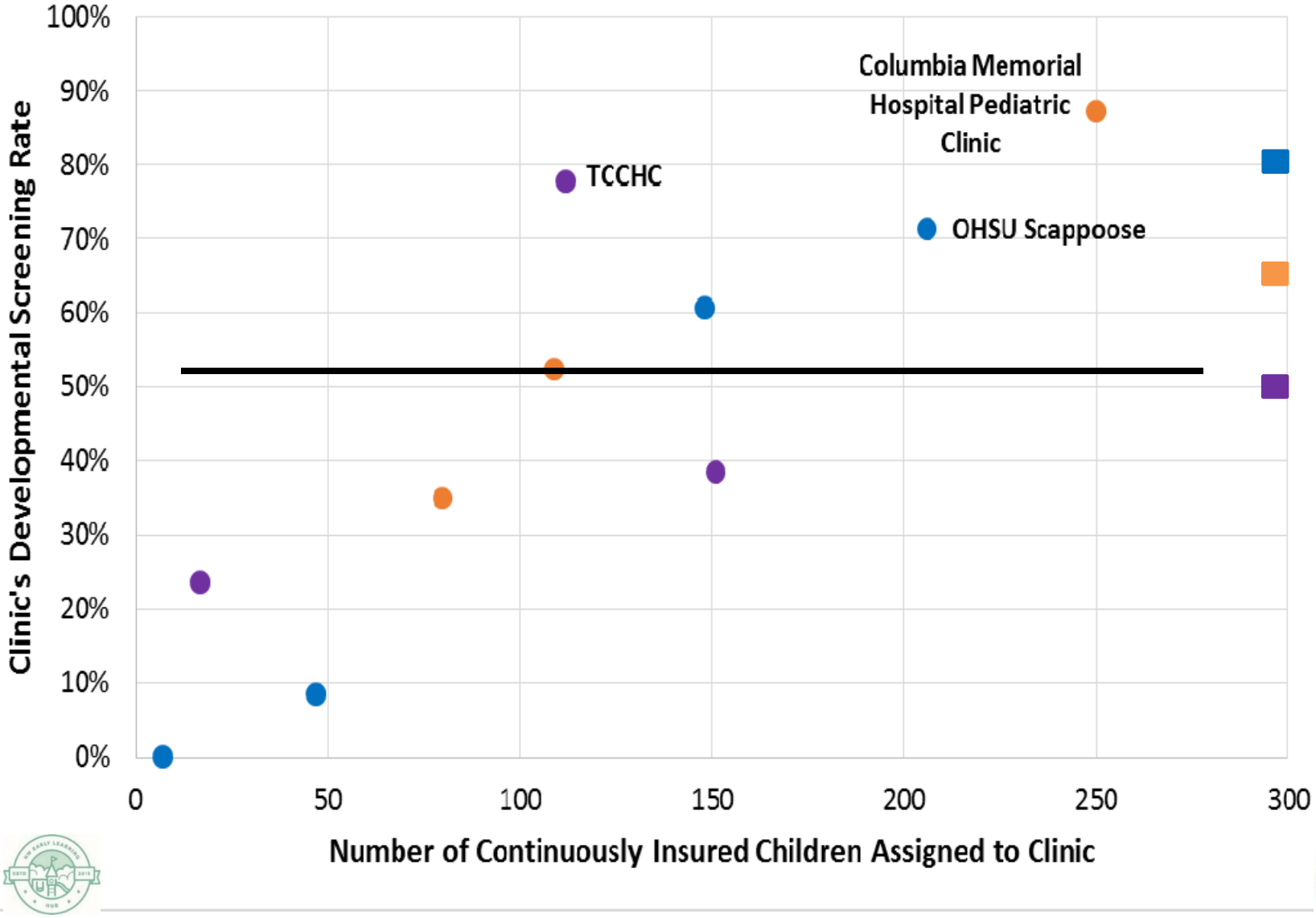
Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

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



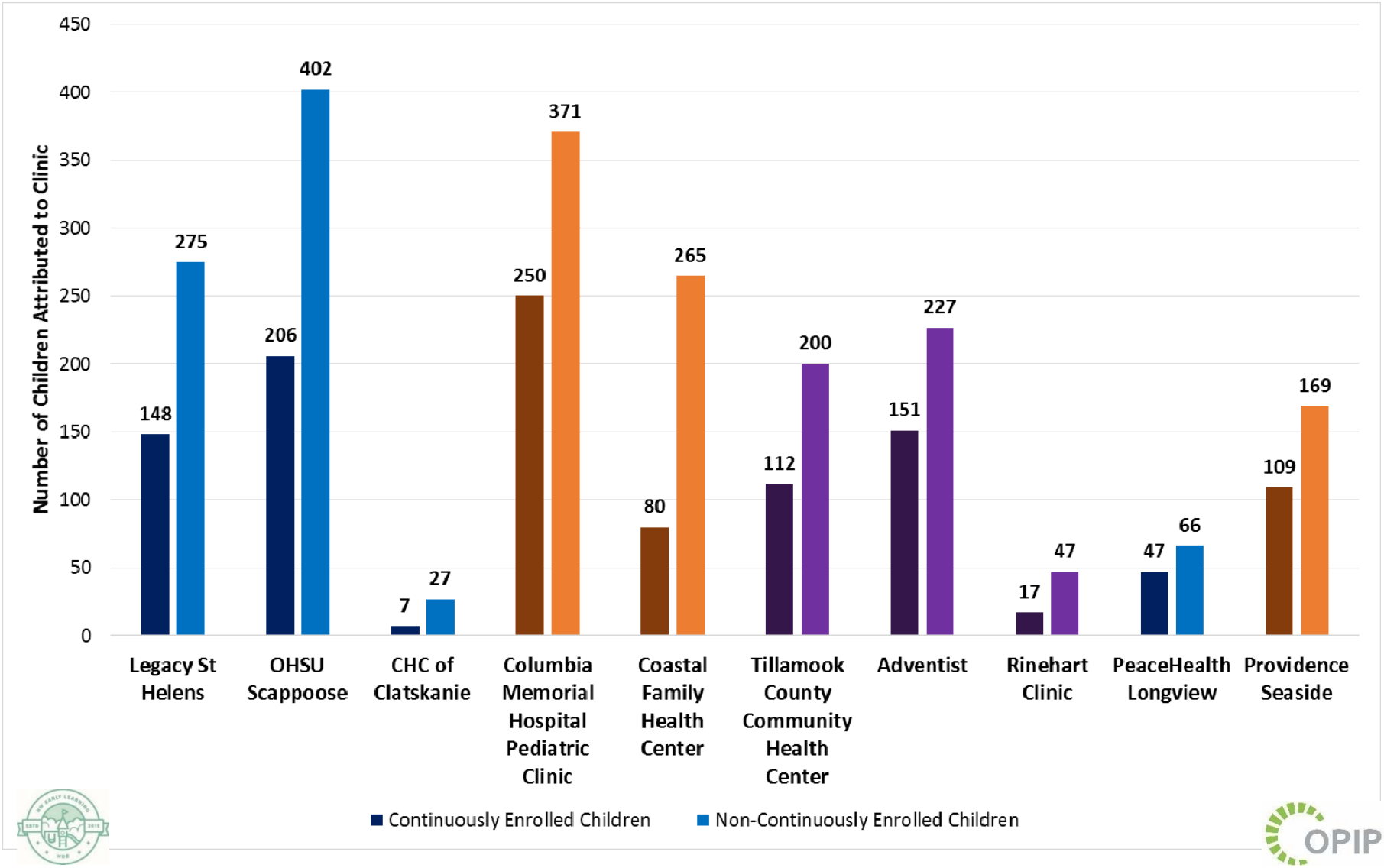
Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

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



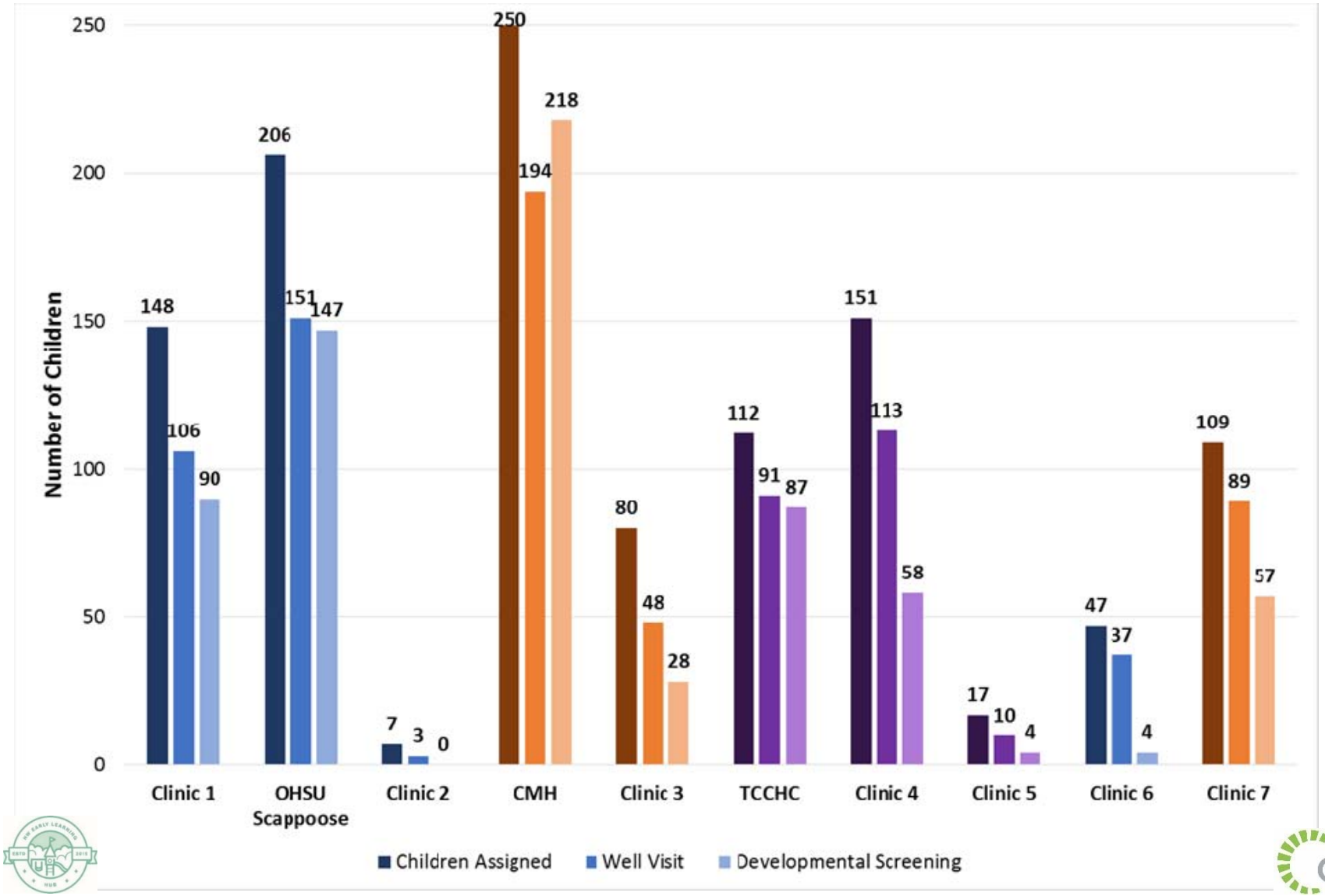
Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

Number of Continuously Enrolled vs. Non-Continuously Enrolled Children Attributed to Each Clinic



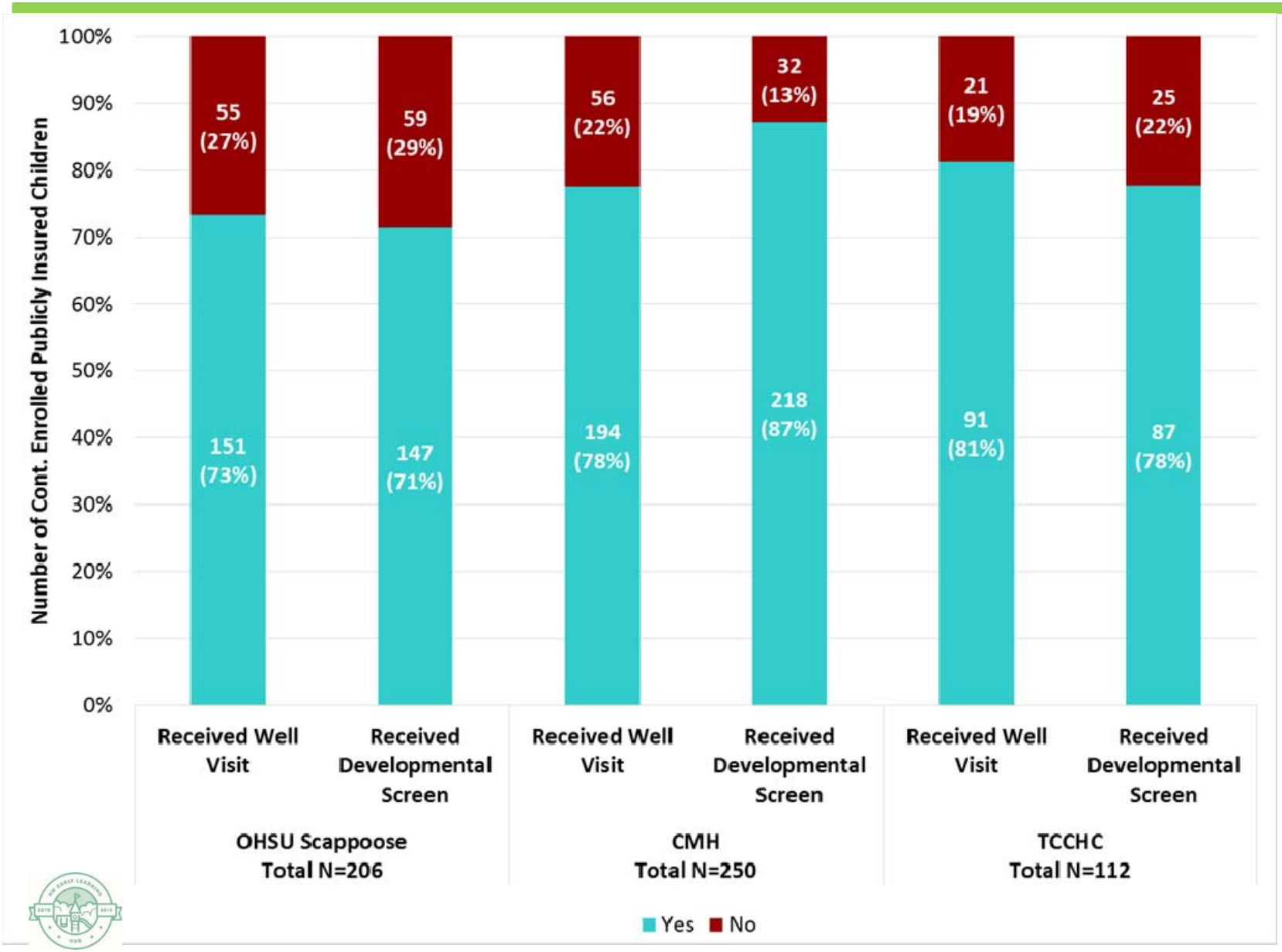
Data Source: Provided by CPCCO, October 2017- FY 16-17 ONLY

Number of Continuously Enrolled Children Attributed to Each Clinic and Well-Visit and Developmental Screens



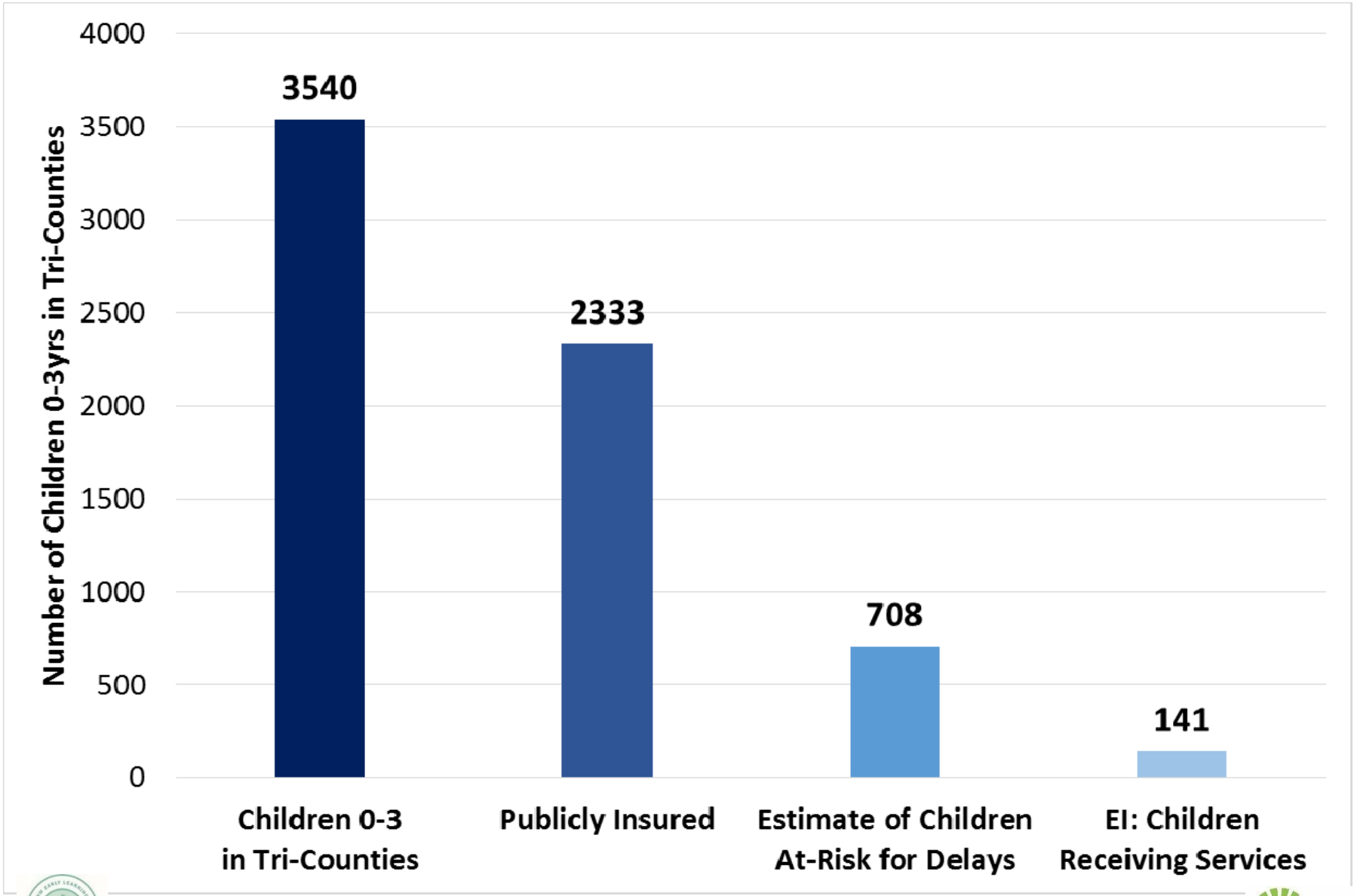
Data Source: Provided by CPCCO, October 2017- FY 16-17 ONLY

Pilot Site Well-Visit and Developmental Screening Rates

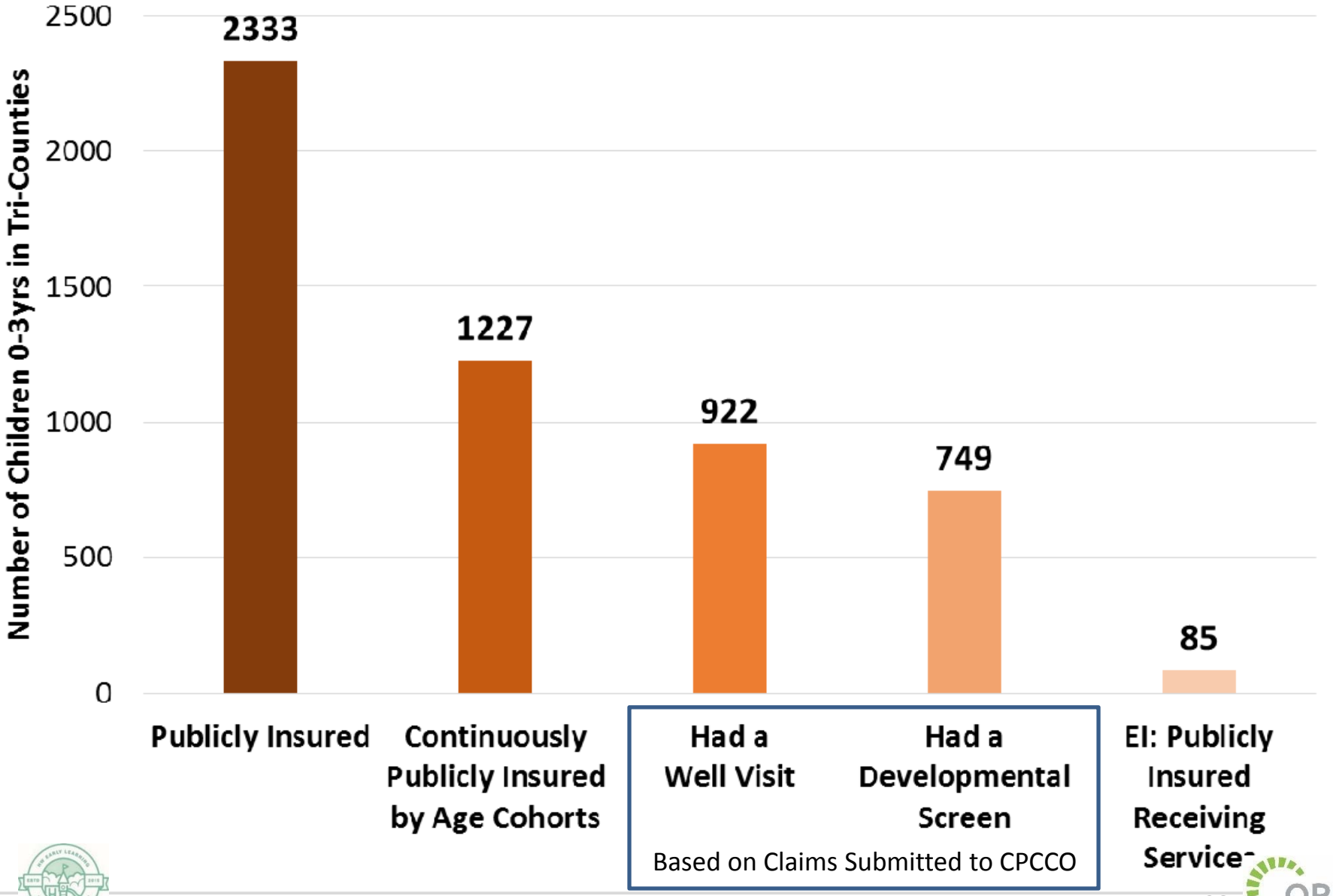


Data Source: Provided by CPCCO, October 2017- FY 16-17 ONLY. Continuously Enrolled Children Only

The Story of Young Children in the Tri-Counties



The Story of PUBLICLY INSURED Young Children in the Tri-Counties



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 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: Example from 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)

Purpose of the Baseline Data Collection in the Primary Care Pilot Sites

- Baseline Data:
  - Inform **Community-Level Conversations** Meant to Understand Current Population, Referral Patterns, and Opportunities for Improvement → Share at Community-level Stakeholder Meetings
    - ✓ 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

Barriers to Measurement of Follow-up to Developmental Screening… All Associated with Lack of and Variation in Follow-Up to Screening

- **No claims** related to the denominator or numerator for a measure of follow-up:
  - Screened children, identified at risk (Denominator for a measure of follow-up)
  - Follow-up promotion and referrals (Numerator)
    - Possible to examine claims related to services within health care: Developmental and Behavioral pediatrician evaluation, OT/PT, Speech. Limitations of this approach however.
- Therefore, need to examine the **electronic medical record**
  - 2 sites are on OCHIN EPIC, 3rd site on a different EMR
  - Within OCHIN EPIC, standardized fields related to:
    - Whether ASQ Flowsheet Used (One site can not run a report for this)
    - ASQ Domain level scores as entered by the MA and interpretation of scores
    - Overall Interpretation, Titled "Follow-Up" but searchable fields are "1=Above Cut off, No Further steps Needed, 2= Close to Cut Off, Monitoring Needed, 3- Below cut off, further evaluation needed
  - Not all children screened have a 96110 claim, can't use the claim to identify population screened
  - Many children received multiple screens given these sites screening at every visits vs. rec. periodicity
  - Therefore, charts for children identified at-risk had to be manually reviewed for each of the possible follow-up
  - That being said, found a number of gaps in documentation related to follow-up. Primary referrals documented.
- Site capacity related to measurement and reporting
  - OHSU Scappoose, received centralized reports to run reports and then did manual chart review for all those identified at-risk.
  - TCCHC was not able to run this report, so manually reviewed all the well-visits. Feasible given their relatively low Ns.
  - CMH Astoria's EMR has no searchable fields related to ASQ, ASQ Scores, or Follow-up. However, they see a much larger number of children. Therefore a standardized sampling procedure will need to be created for their medical chart reviews.

Example from One Site: OHSU Scappoose & Developmental Screening

- Large teaching practice
  - 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

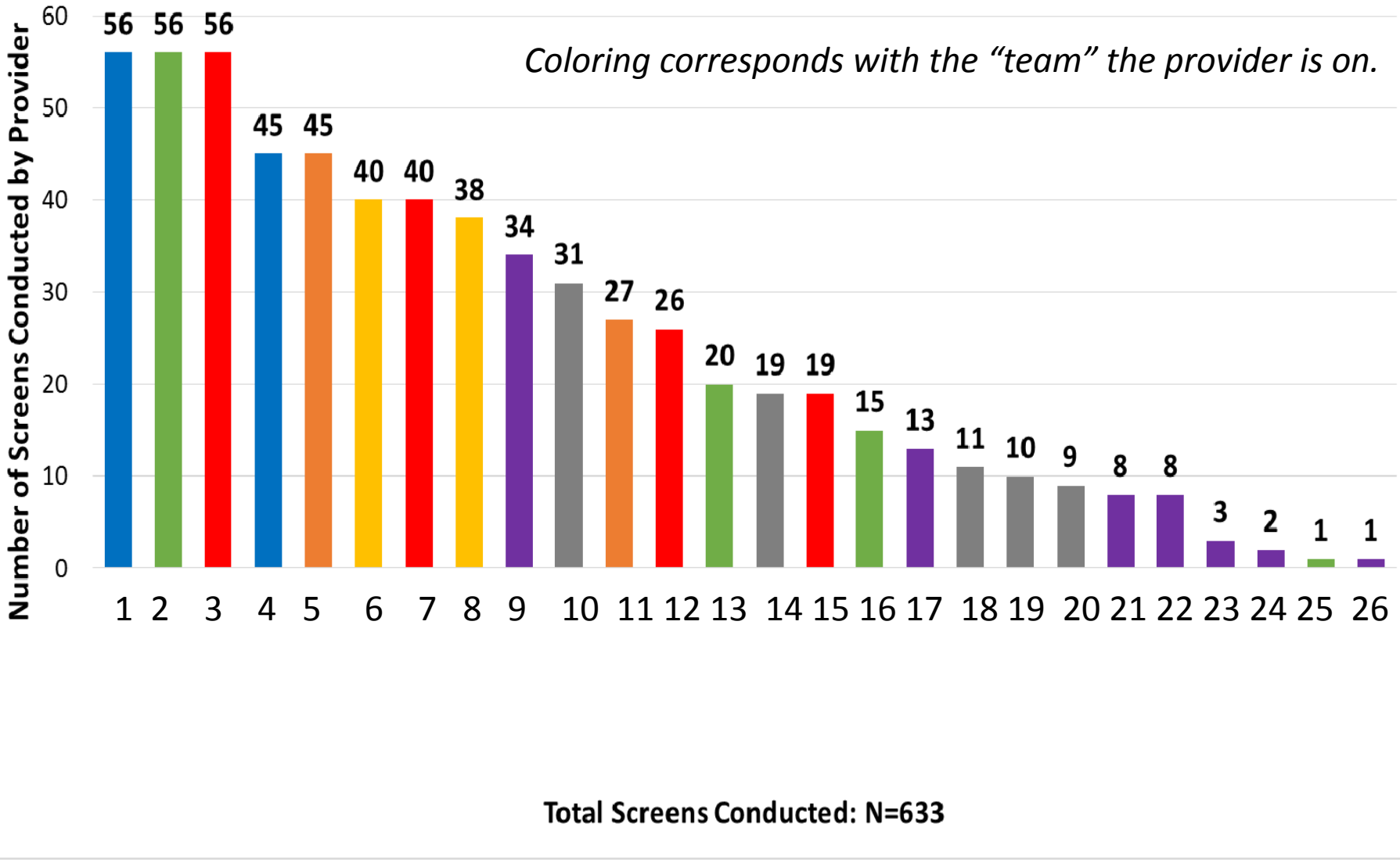
OHSU Scappoose Baseline Data

- **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
       - OCHIN Follow-Up Interpretation (Above Cut Off, Close to Cut Off, Below Cut Off)
       - 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
       - Developmental Promotion
       - Rescreen of child (Assumed done at every visit, however a schedule of an earlier visit would be recommended for two year olds)
       - Internal mental health
       - 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)

OHSU Scappoose Baseline Data

- Number of Providers in OHSU Scappoose that Interpreted a Developmental Screen
  - N=26 Providers completed an ASQ flow sheet for a child under 3 (Includes Residents)
- Panel of Children Under 3: N=**497**
  - Children Who had a Well-Visit in Last Year: **N=477**
  - Of the Visits with a Developmental Screen: 62% are for children with Medicaid
- Developmental Screens for Children Under 3
  - 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
  - Number of 96110s Billed: N=344
    - 54% of the time a 96110 claim was submitted when a screen done
  - Number of Multiple Screens: N=298
- Child-Level Screening
  - Number of Children Screened: **N=335**
  - 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

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

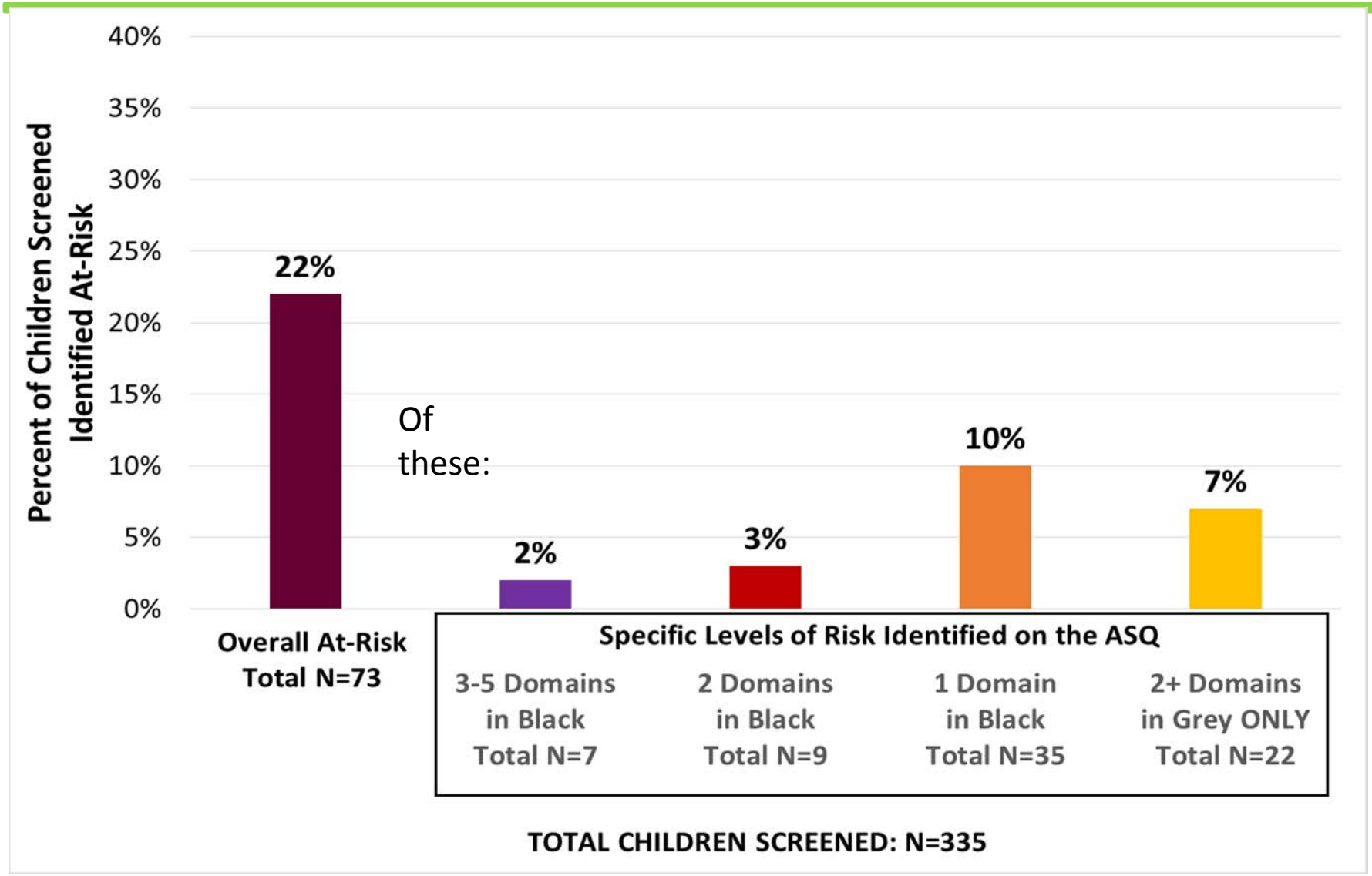


Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years.

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

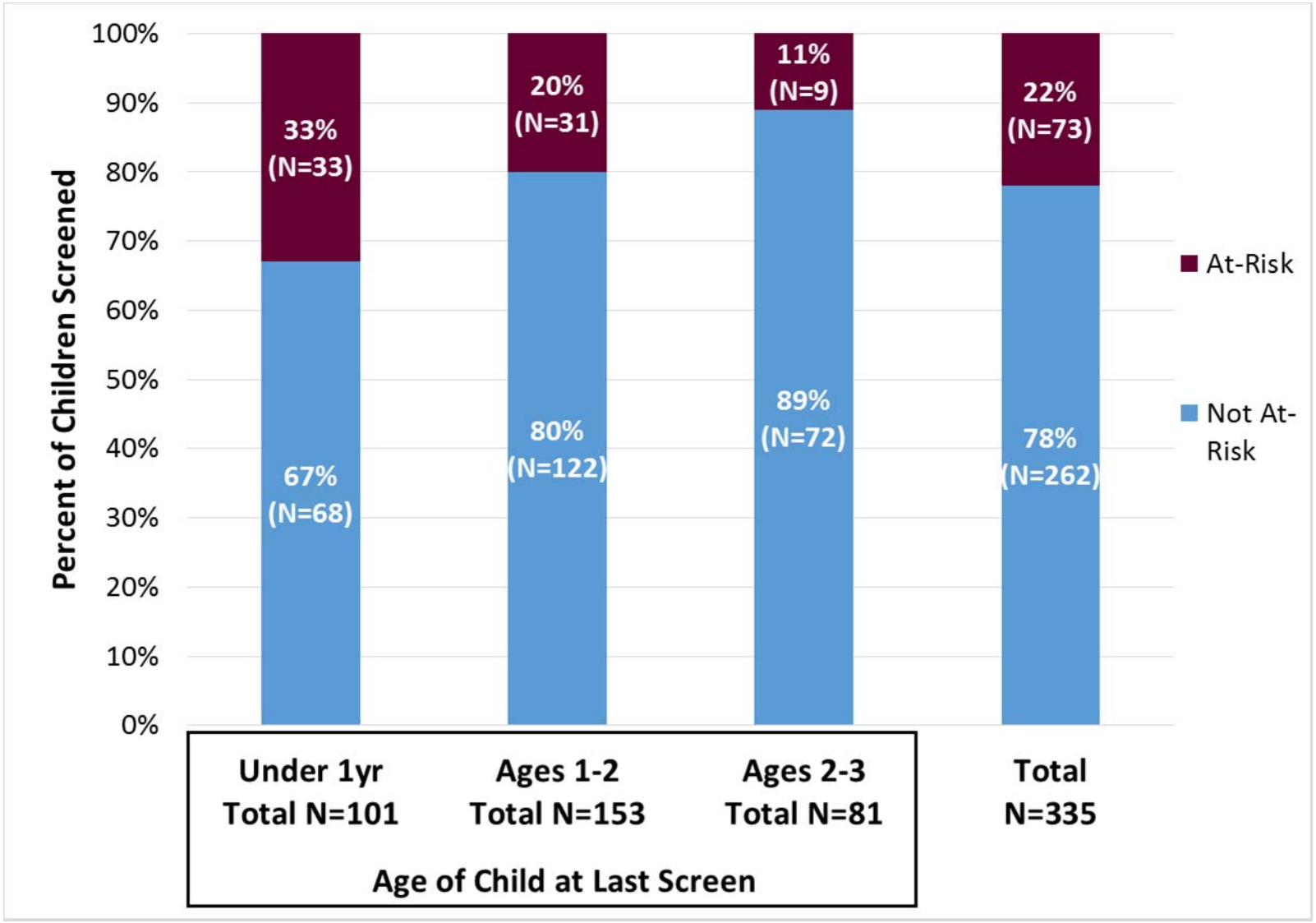
- Scoring of "At-Risk" Based on the Ages and Stages Questionnaire
  - At Risk= 1 or more in the Black (2 STD from Normal) AND/OR
    2 or more in the Grey (1.5 STD from Normal)
- Bright Futures Recommendation for **Follow-Up for At-Risk**
  - Screen at 9, 18 and 30 month visit (or 24 if not doing the 30)
  - Refer all to Early Intervention and Developmental and Behavioral Pediatrician (DB Peds)
- For the analysis shown:
  - Given 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

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



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.

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.

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

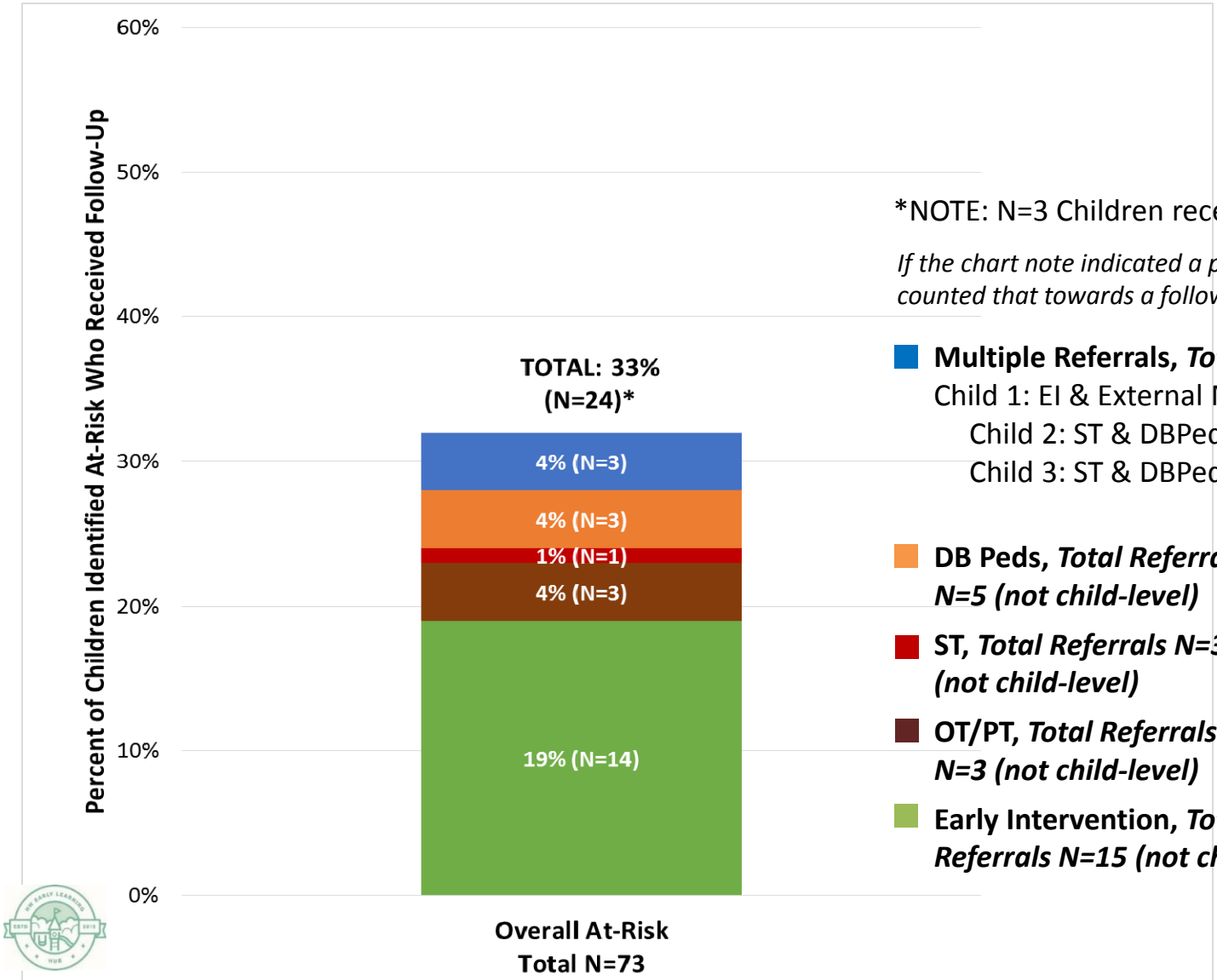
Aspects of **follow-up to developmental screening** able to examined in the chart, if documented in the note or referral tracked:

- Specific Referrals
  - Referral to Early Intervention (Bright Futures Recommendation)
  - Referral to OT/PT
  - Referral to Speech Therapy (ST)
  - Referral to Developmental Behavioral Pediatrician (Bright Futures Recommendation)
  - Referral to External Mental Health

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

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

Follow-Up Documented in Chart (Child-Level): 1 in 3 At-Risk Children Received Some Level of Follow-Up



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

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

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

DB Peds, *Total Referrals N=5 (not child-level)*

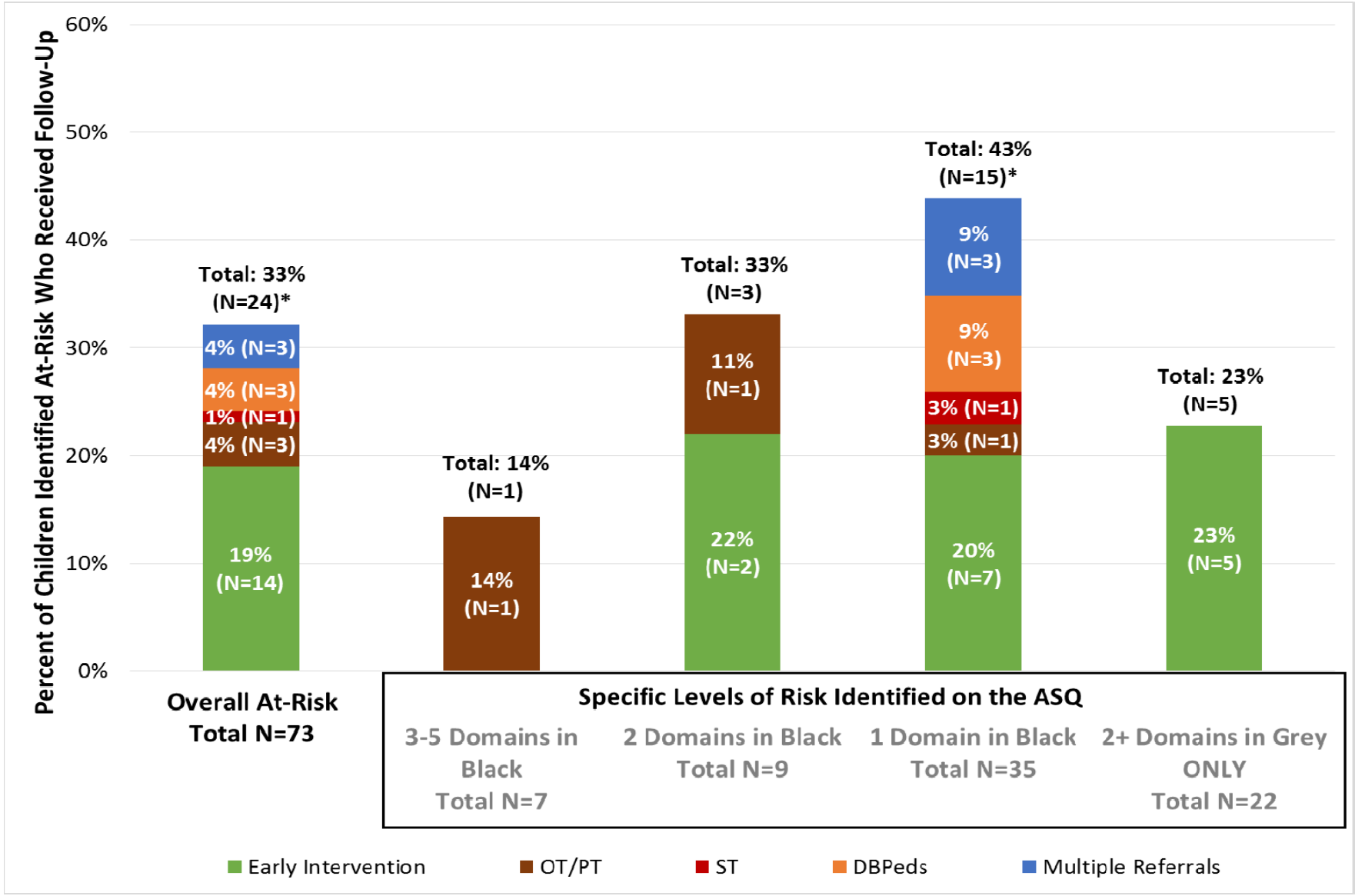
ST, *Total Referrals N=3 (not child-level)*

OT/PT, *Total Referrals N=3 (not child-level)*

Early Intervention, *Total Referrals N=15 (not child-level)*

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.

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



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.

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

Data from

Northwest Regional Education Service District (NWRESD) for the Tri-Counties (Clatsop, Columbia, Tillamook)

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

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

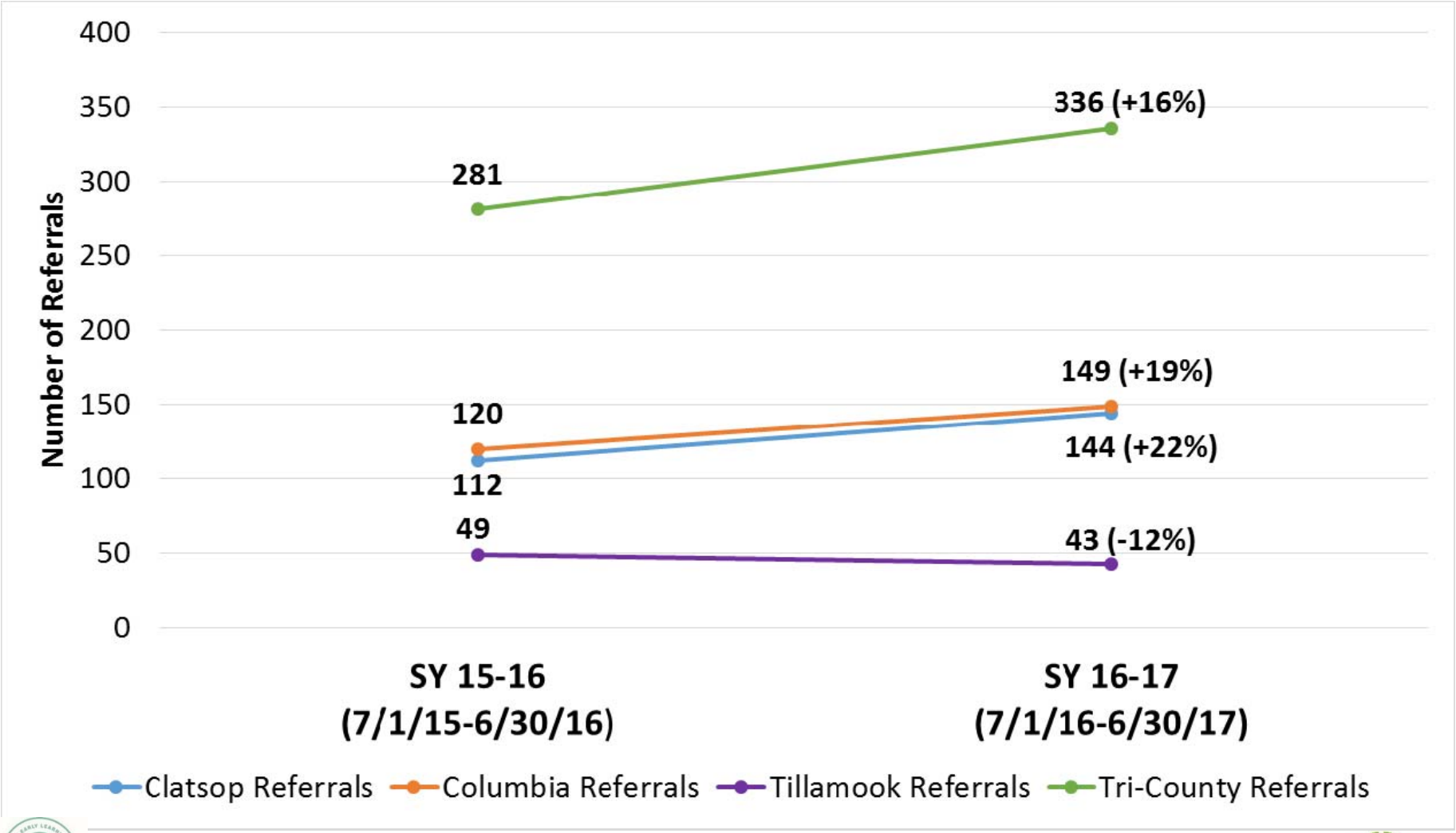
#1: Indication of Follow-Up to Developmental Screening

- 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

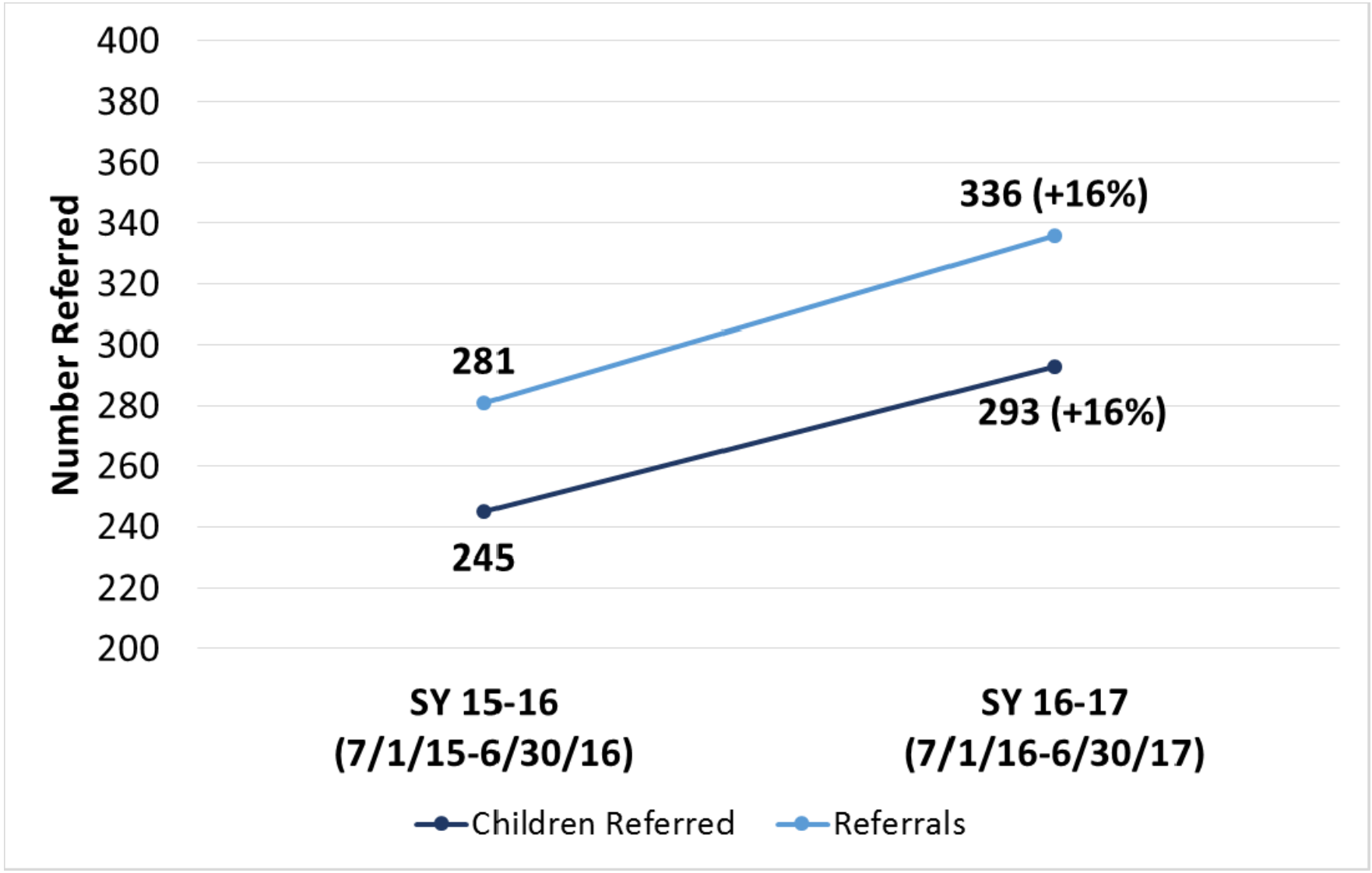
- Evaluation Outcome Results by Referral and Child Characteristics

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



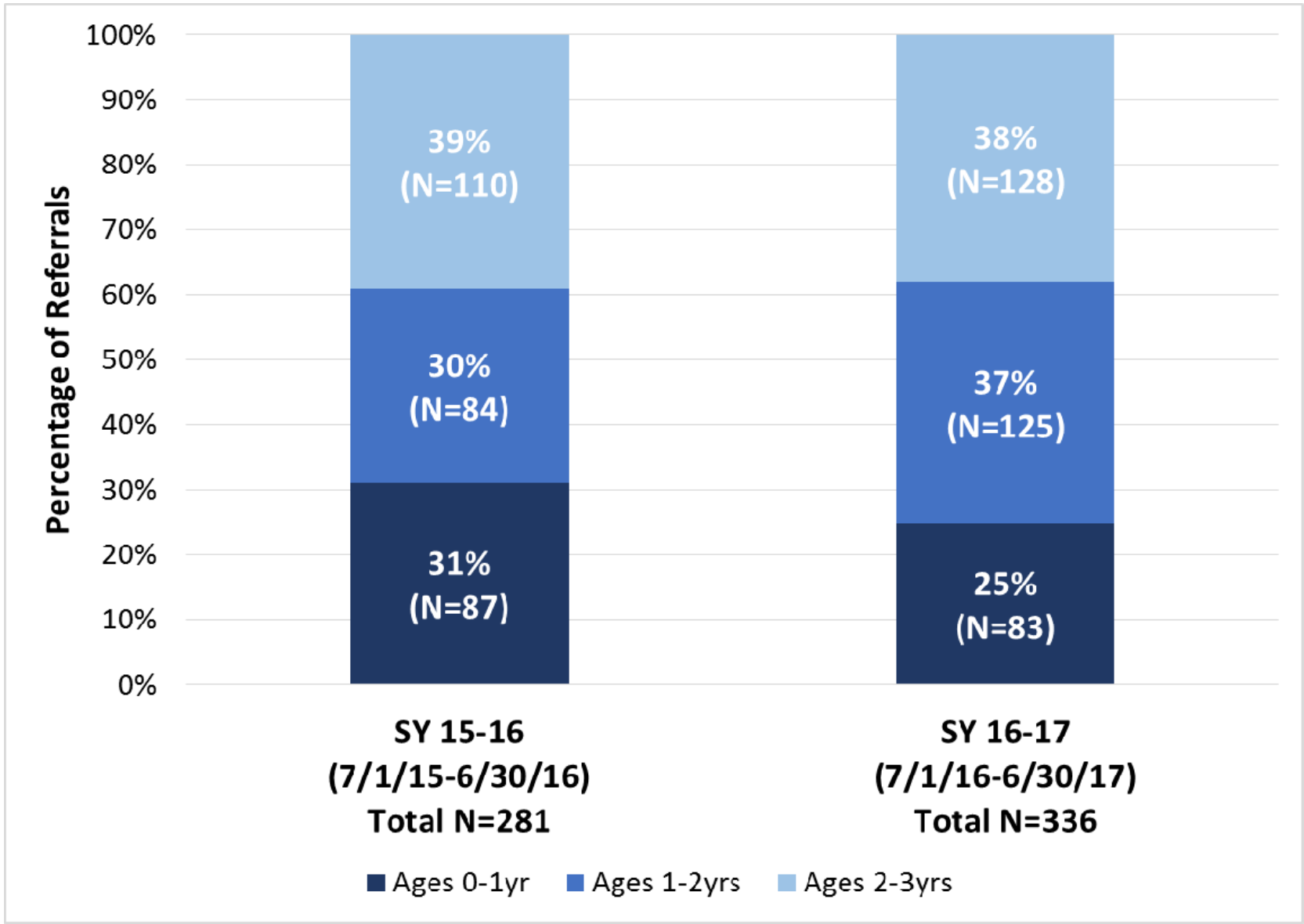
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Number of Early Intervention Referrals vs Number of CHILDREN Referred in Tri-Counties



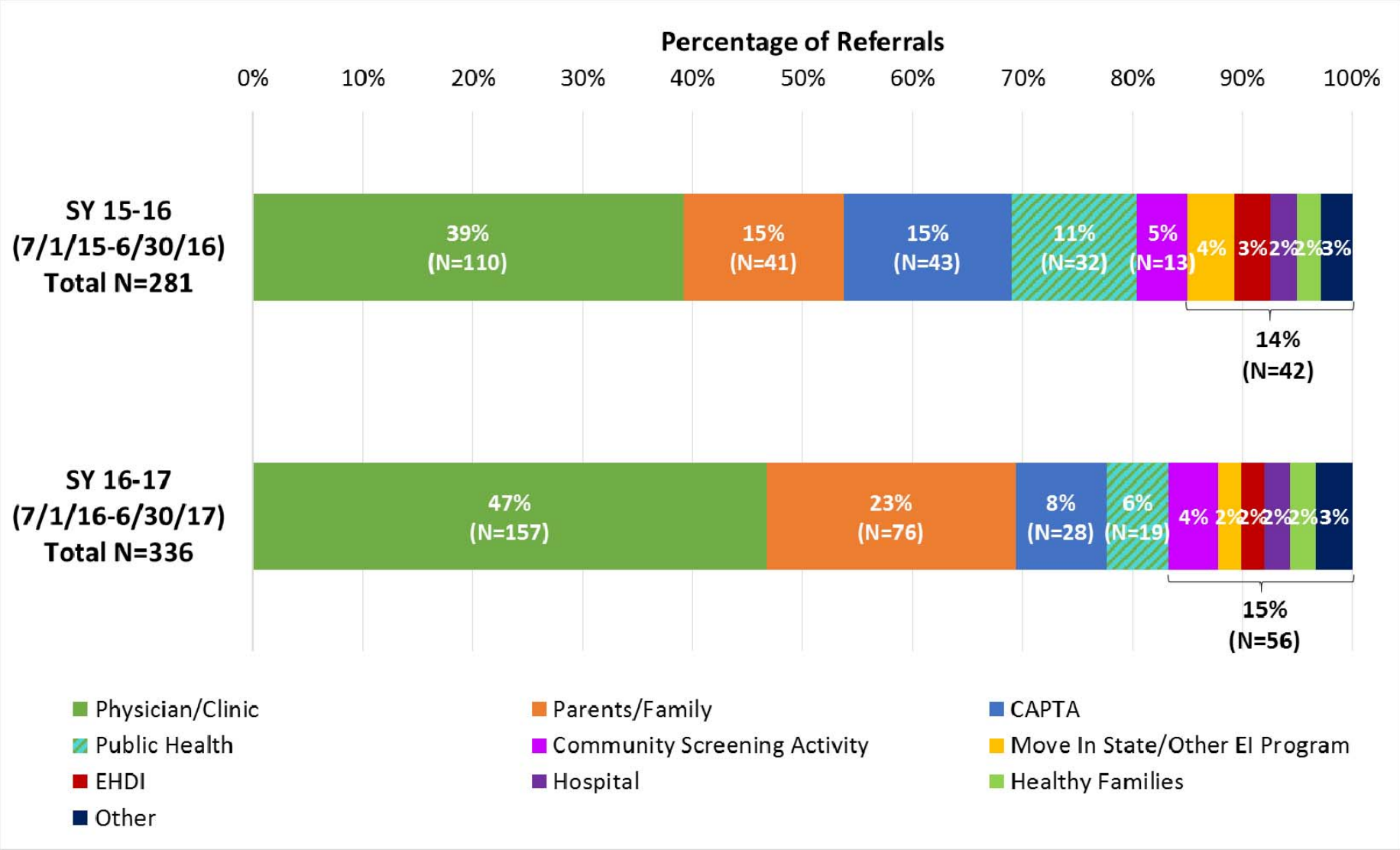
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Early Intervention (EI) Referrals by Age of Child



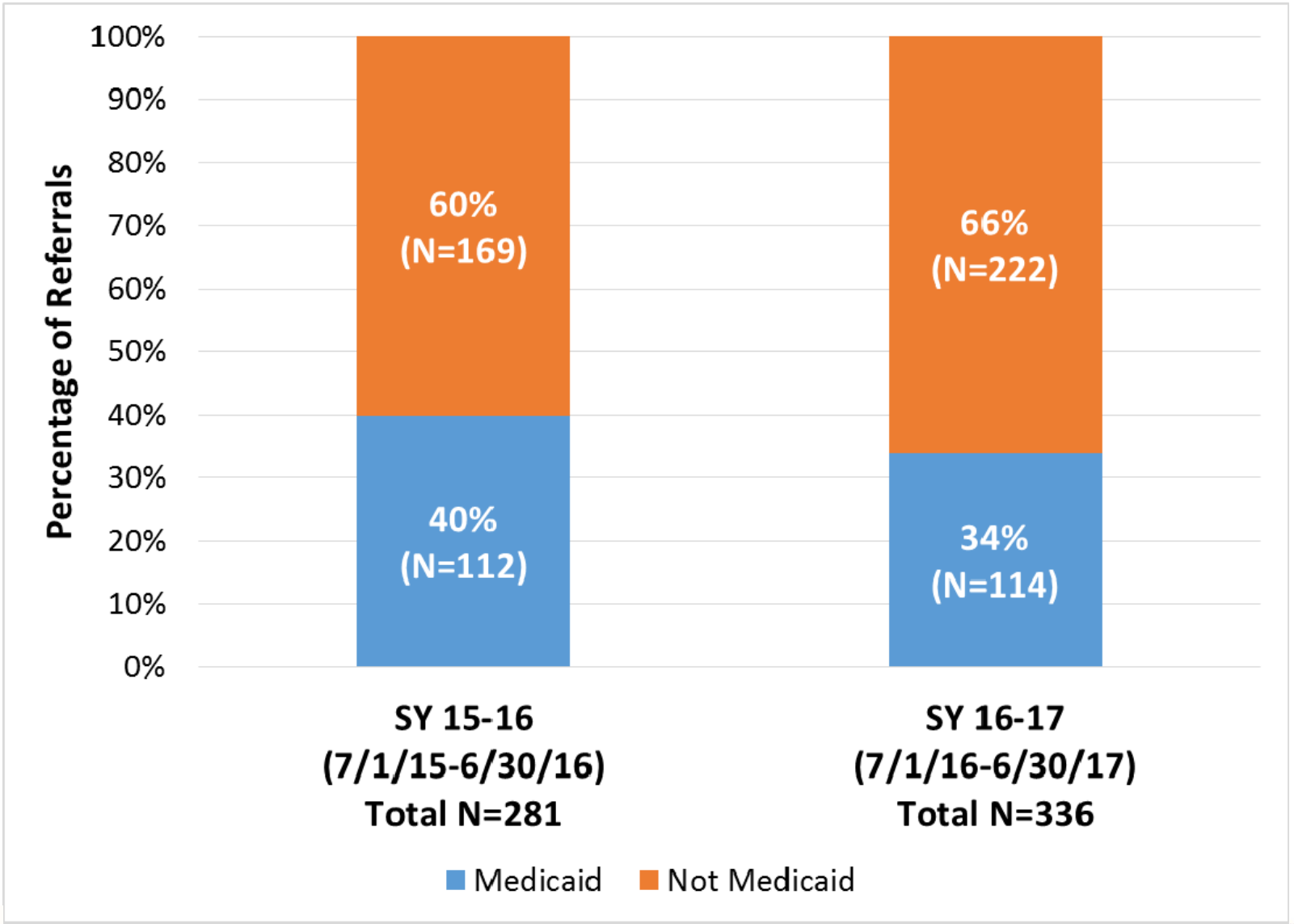
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

EI Referrals by Referral Source As Documented in EC Web



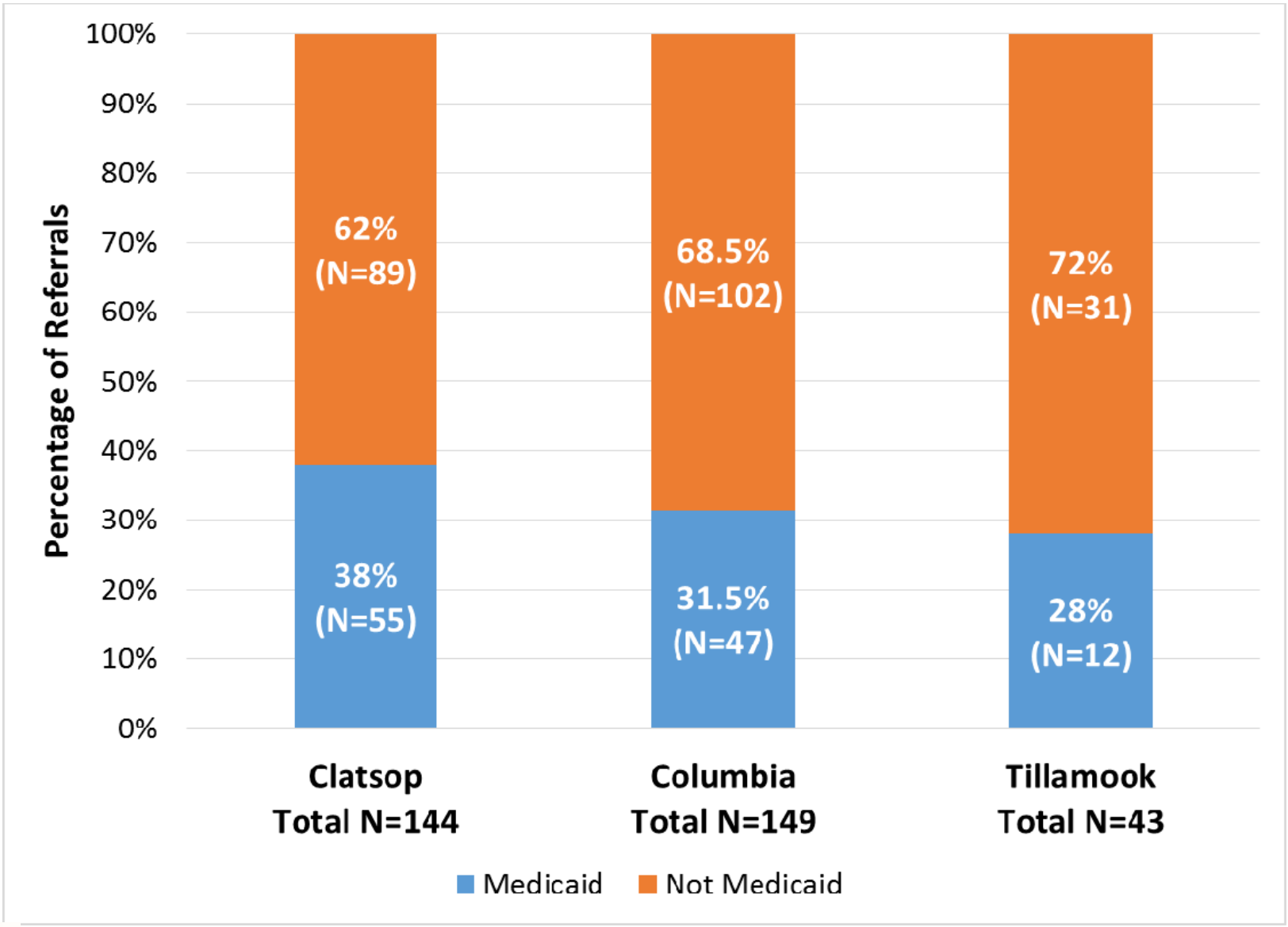
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Tri-County EI Referrals by Whether Child Has Medicaid



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

Tri-County EI Referrals by Whether Child Has Medicaid



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

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

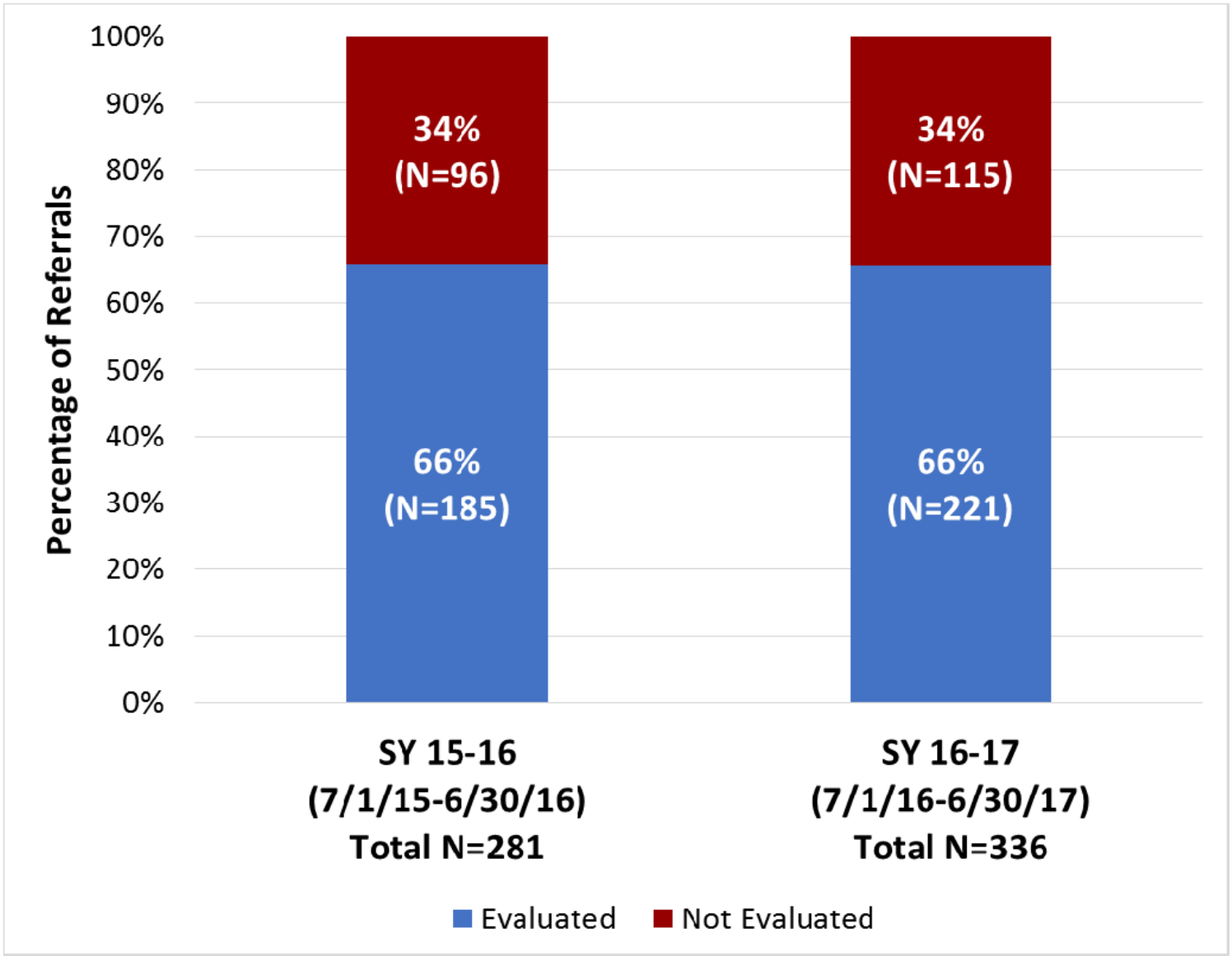
#1: Indication of Follow-Up to Developmental Screening

- 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

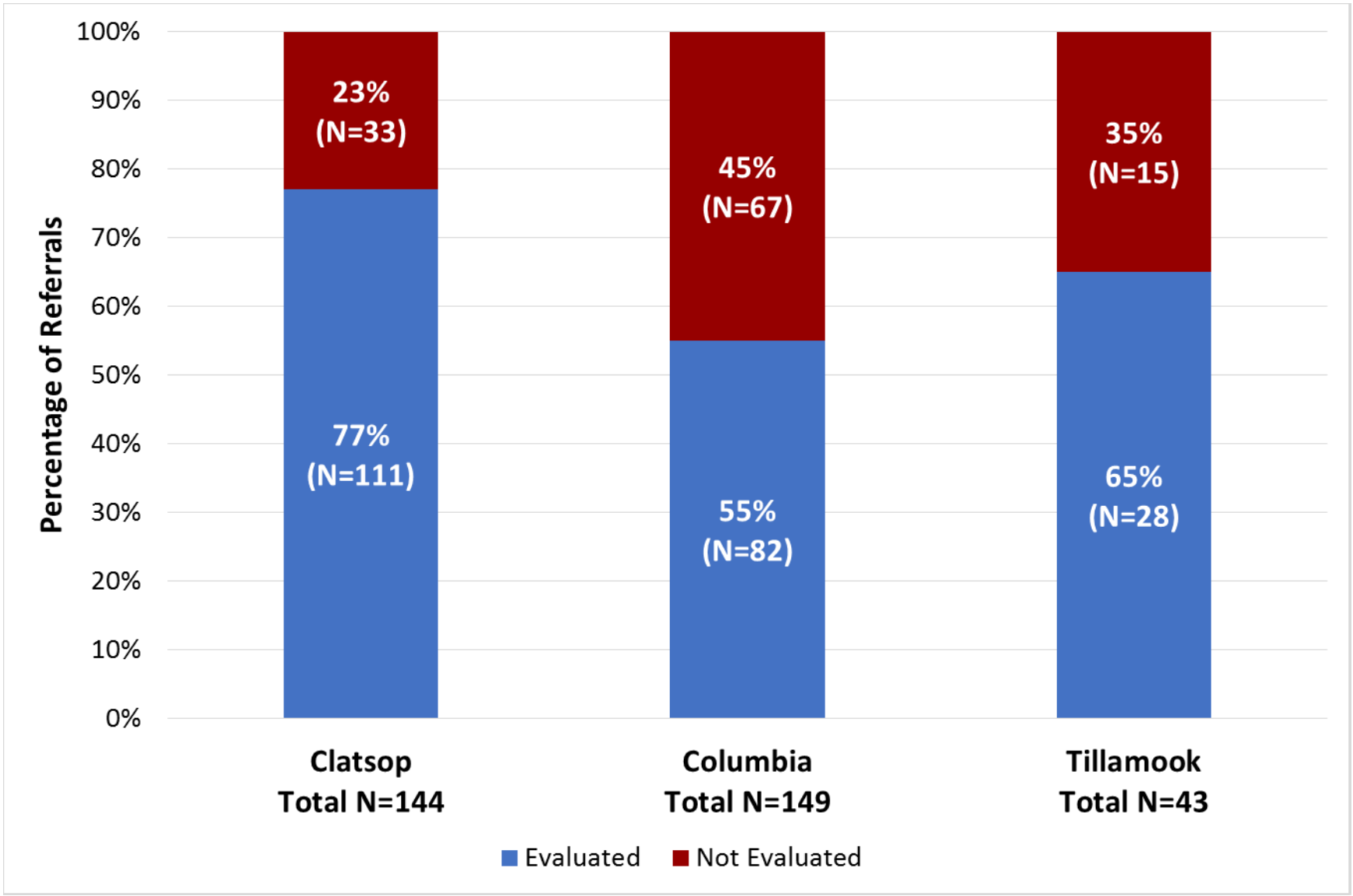
- Evaluation Outcome Results by Referral and Child Characteristics

Percentage of Tri-County EI Referrals Able to Be Evaluated by EI



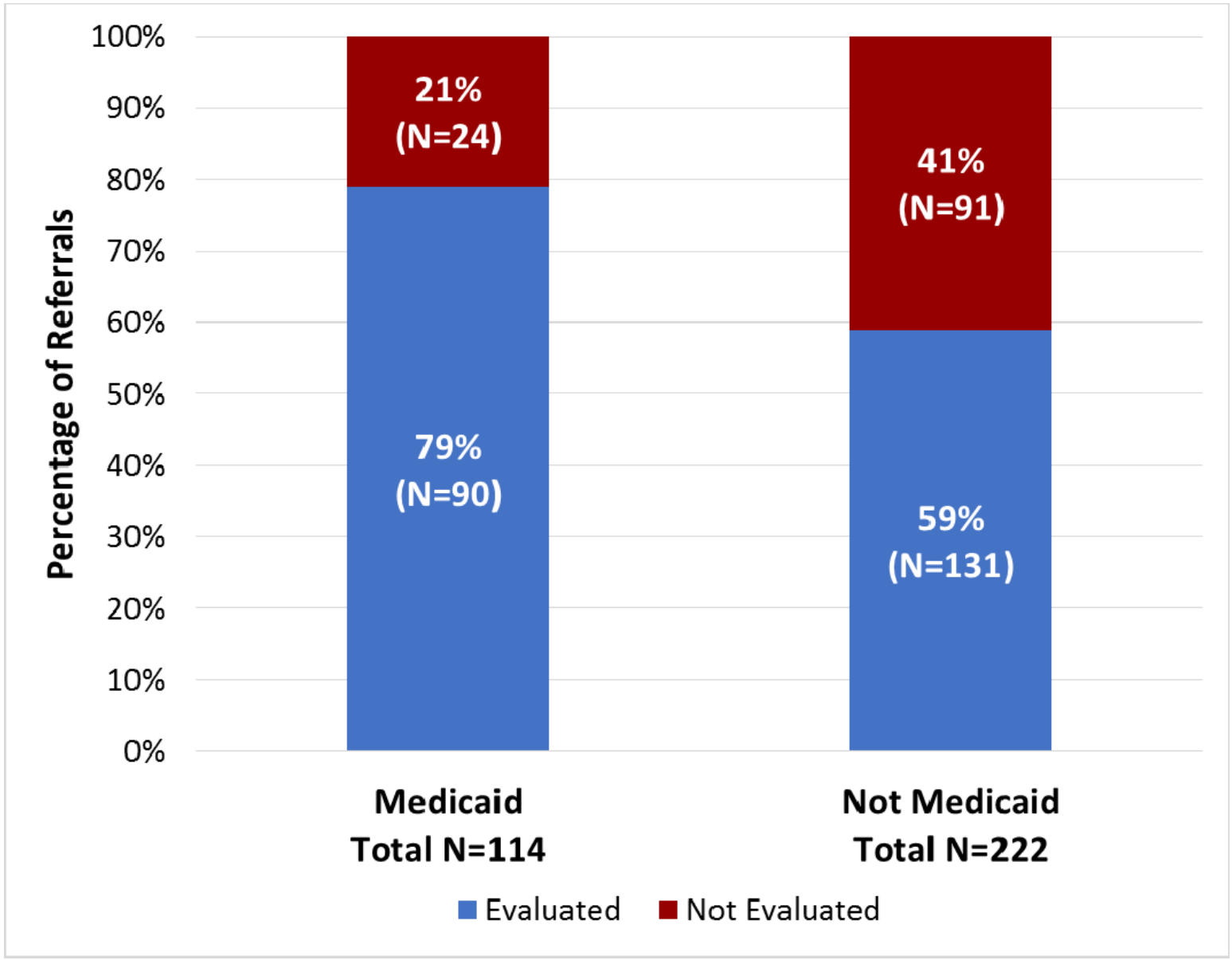
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Percentage of Tri-County EI Referrals Able to Be Evaluated by EI in SY 16-17: By County



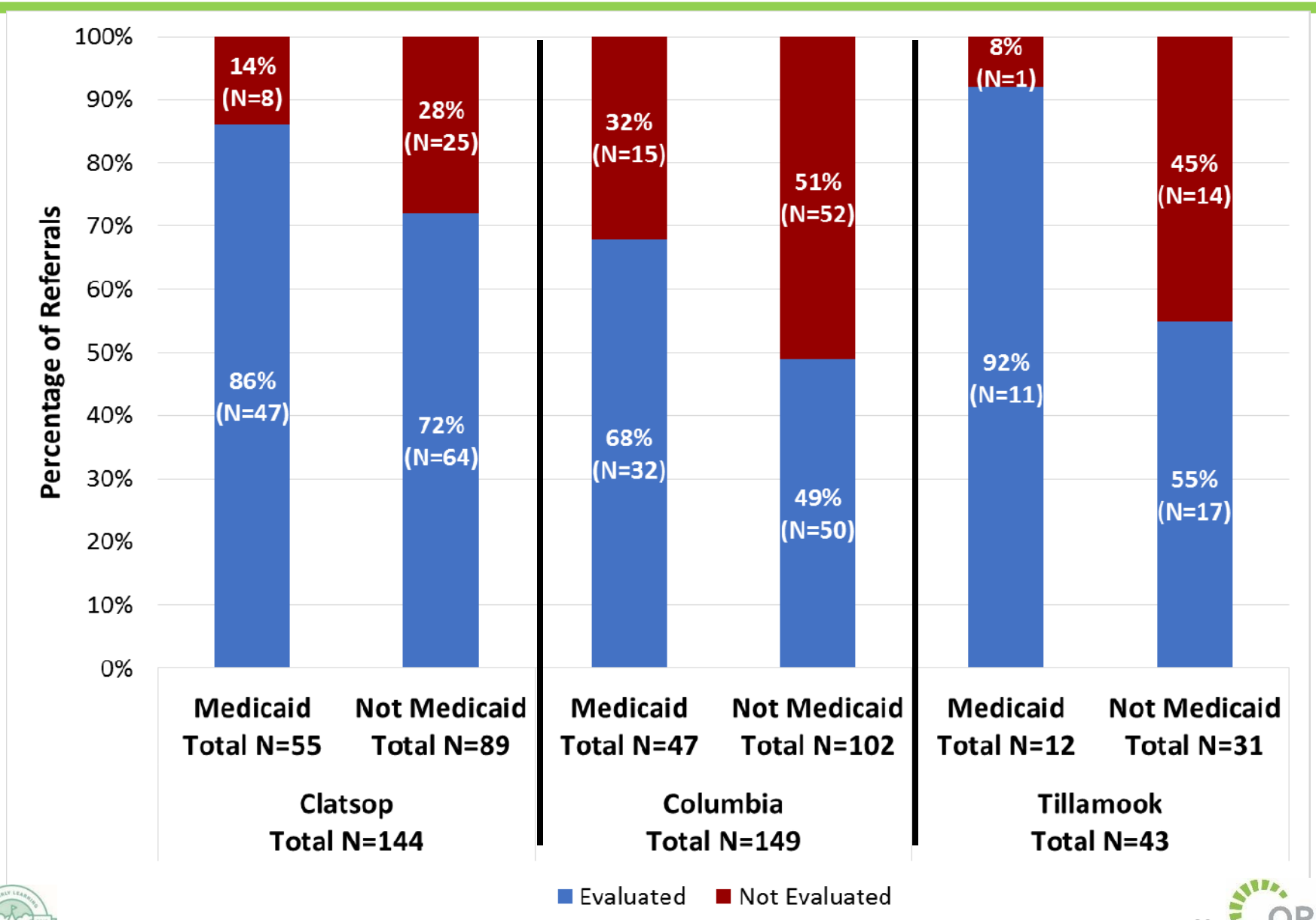
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Tri-County EI Evaluations BY Medicaid Insurance



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

EI Evaluations BY Medicaid Insurance in SY 16-17: By County



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

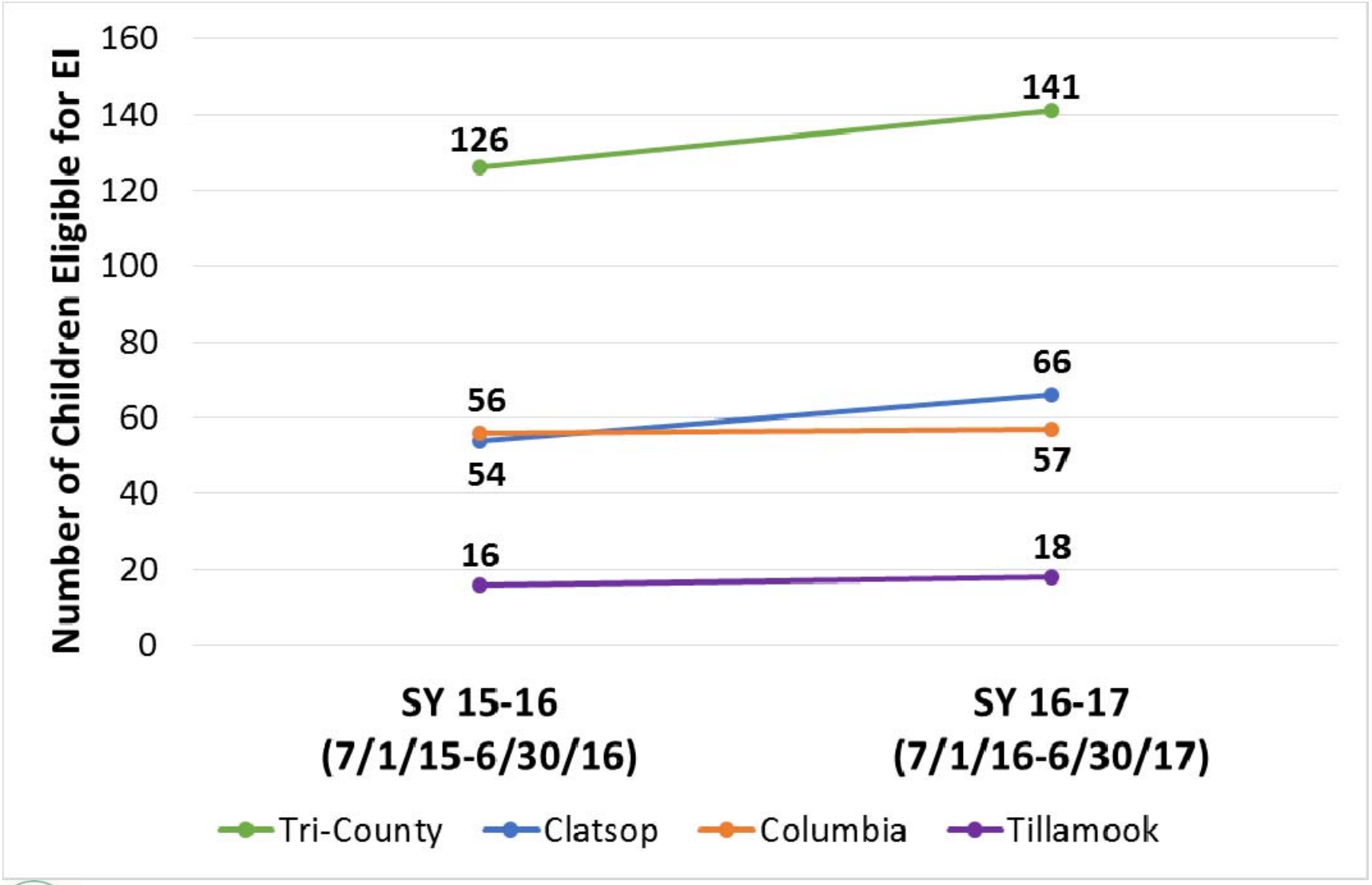
- Evaluation Outcome Results and Characteristics of Ineligible

Examined by Age of Child, Referral Source, Medicaid Insured

- Examined referrals by:
  - Age of Child: Birth to 1, 1-2, 2-3
  - Referral Source
  - Race-ethnicity
  - Medicaid Insured

- Due to time constraints today, we don't have time to review all findings but they have been used to inform our recommendations

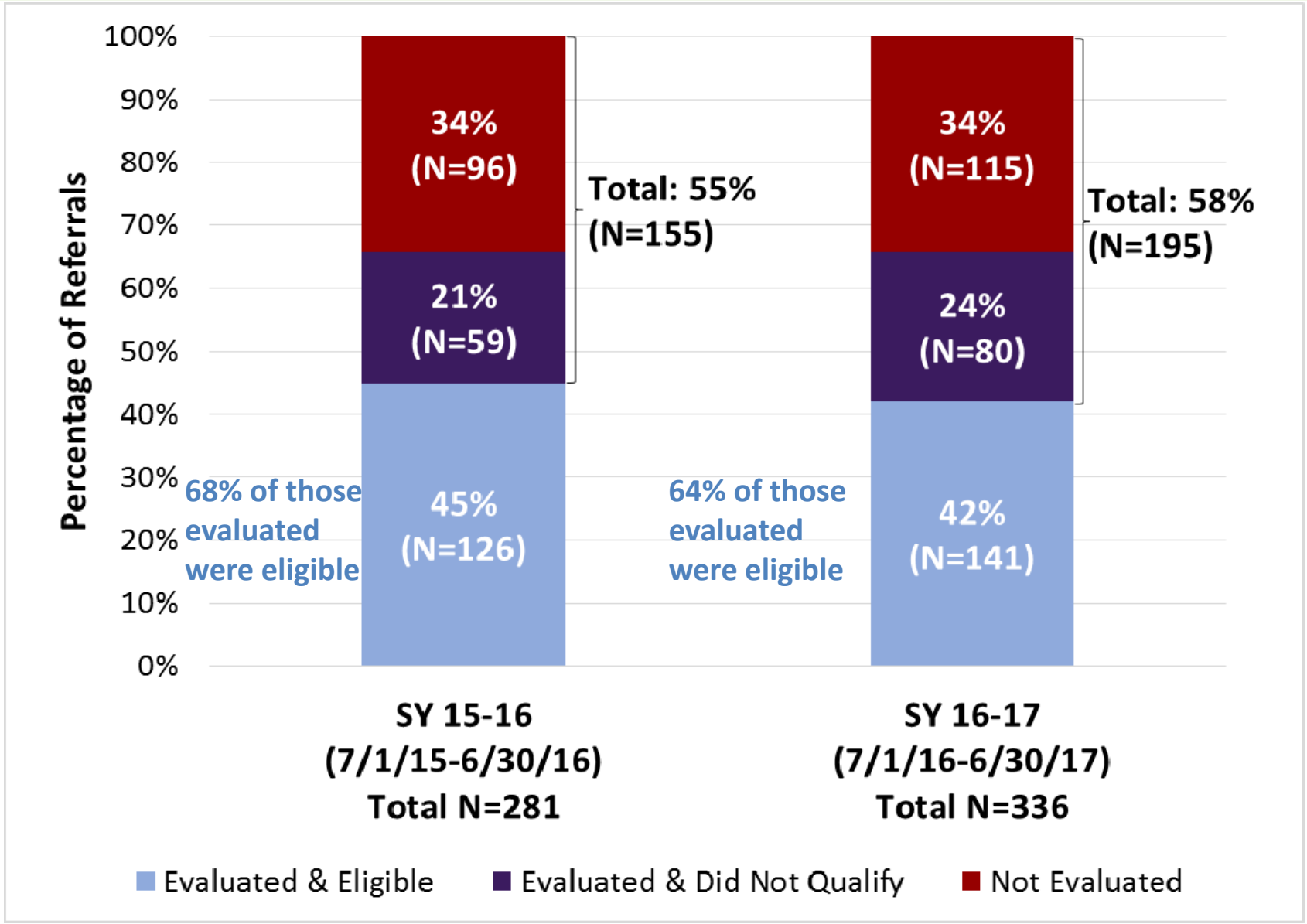
Number of Children Found Eligible in the Tri-Counties



Percent Increase in Tri-Counties from 2016 vs. 2017: 11% (N=15)

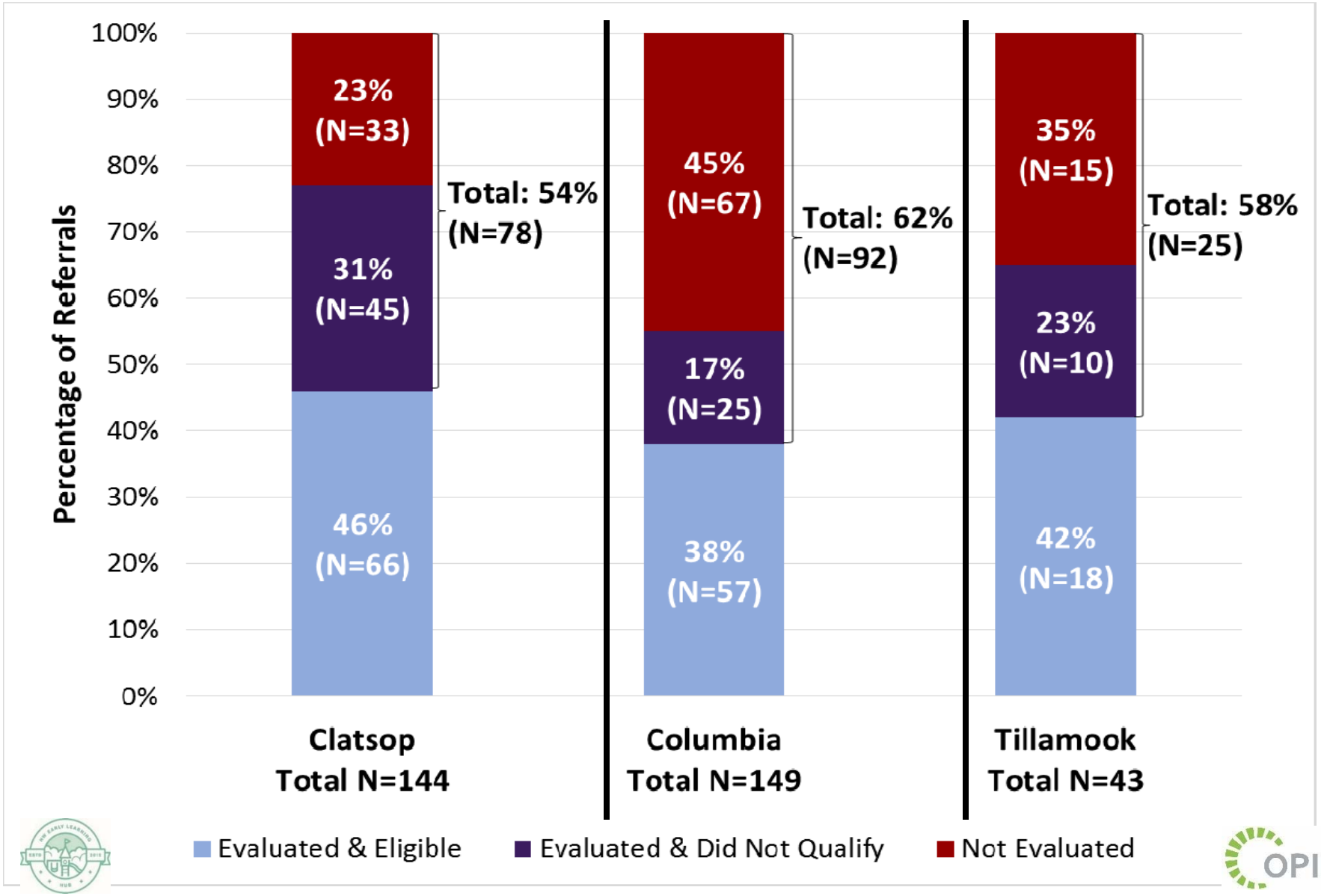
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

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



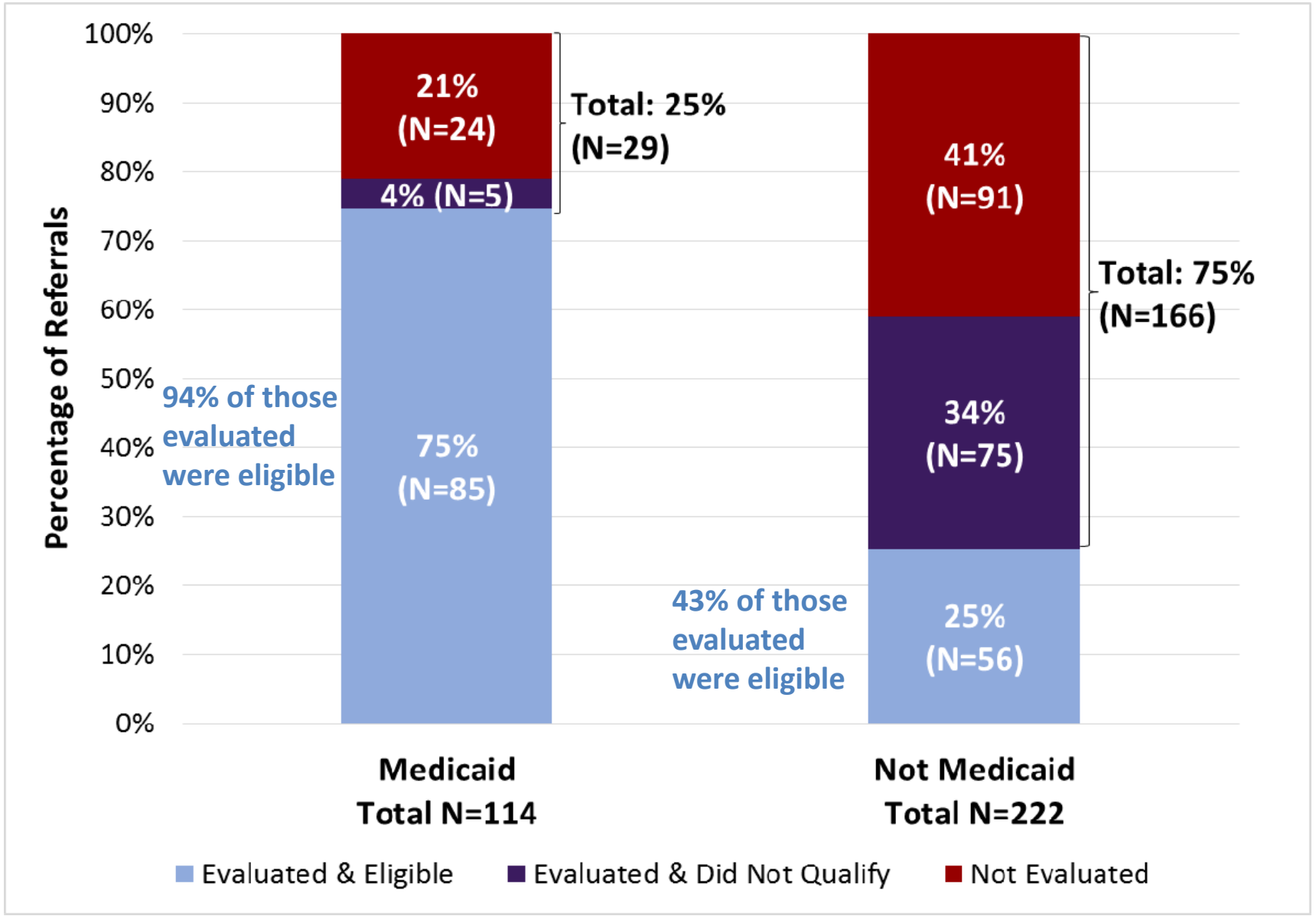
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Percentage of EI Referrals
Able to Be Evaluated & Eligible for EI in SY 16-17: By County



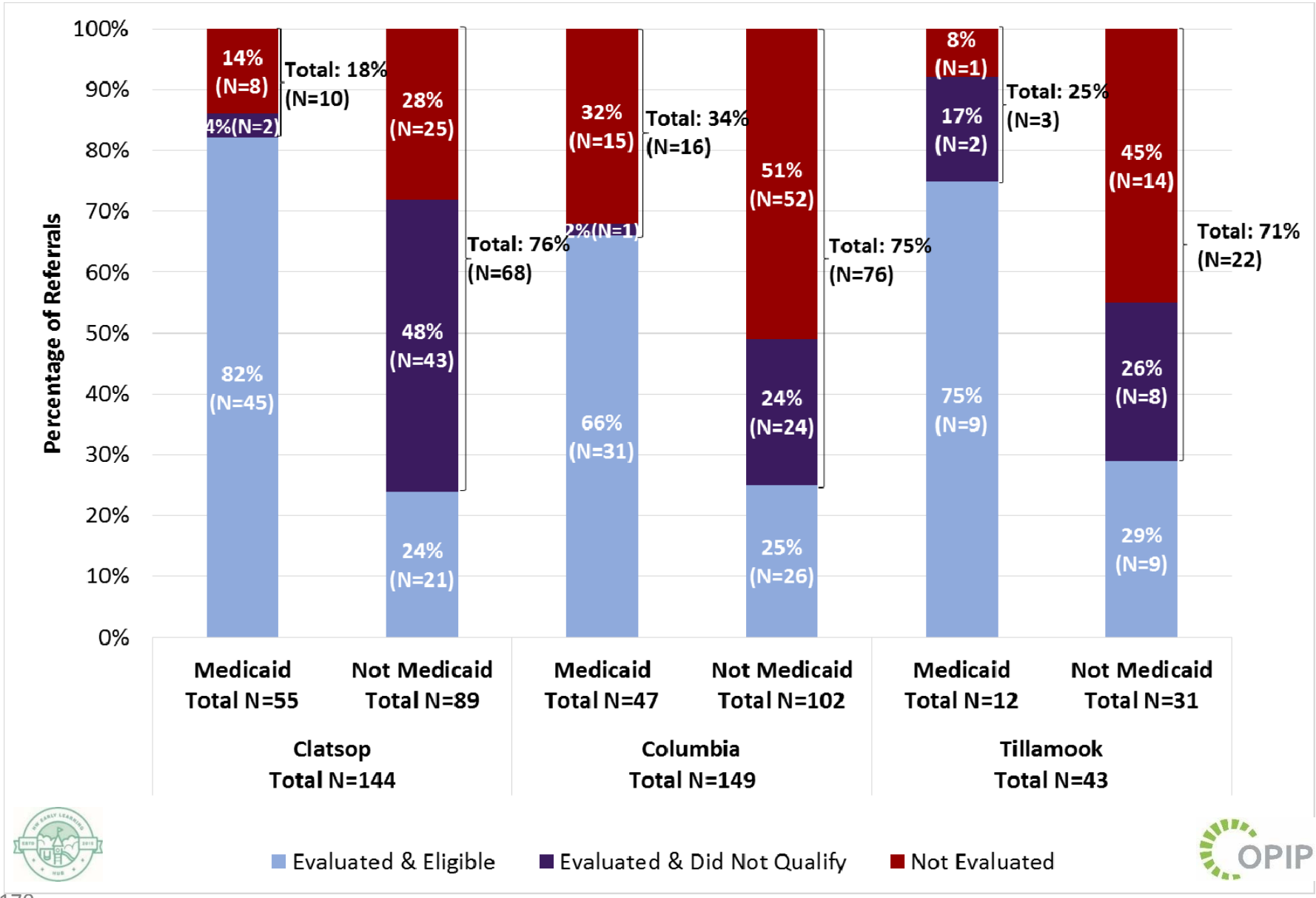
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

EI Referral Outcomes by Medicaid Eligibility



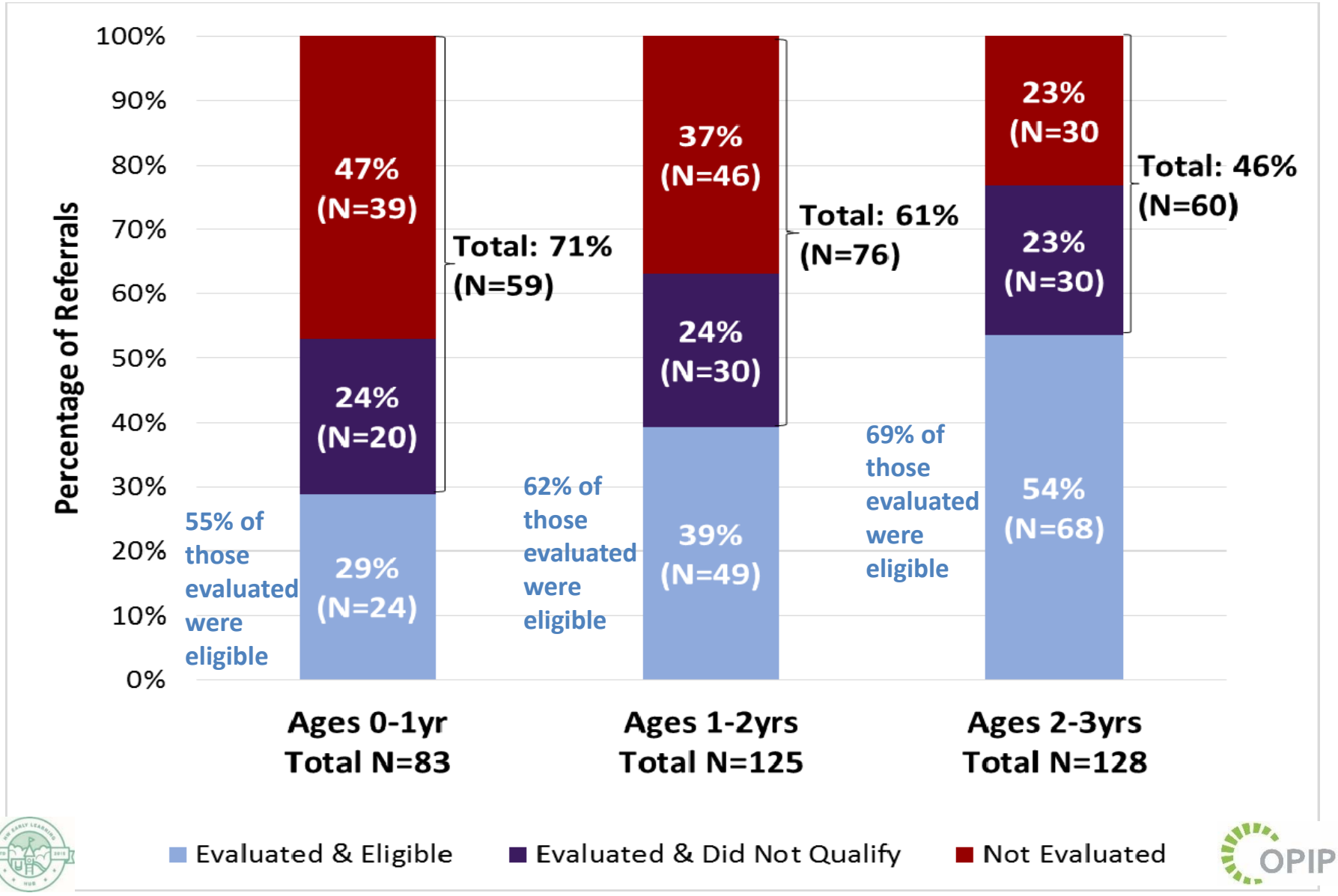
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

EI Referral Outcomes by Medicaid Eligibility in SY 16-17: By County



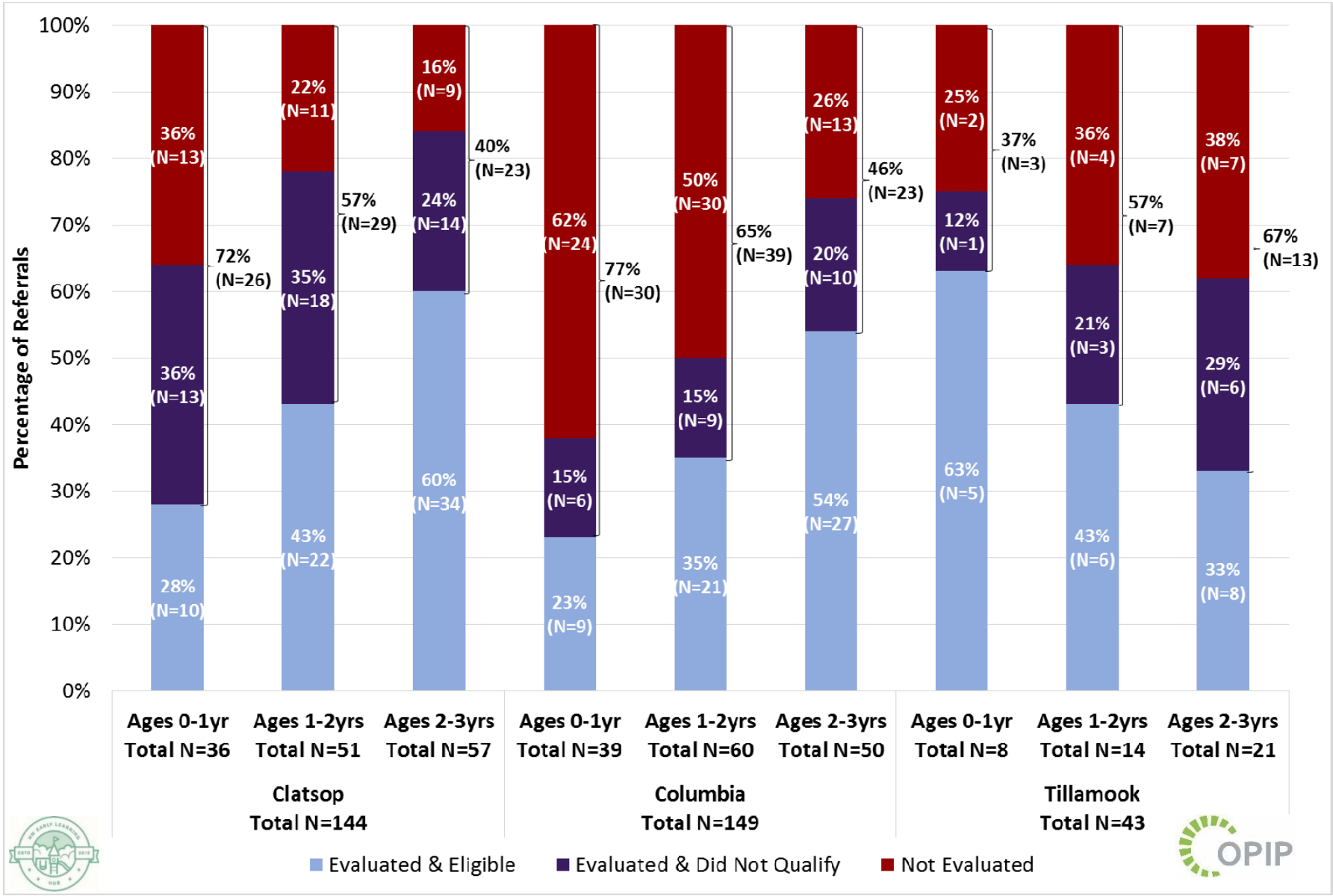
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

EI Referral Outcomes by Age of Child



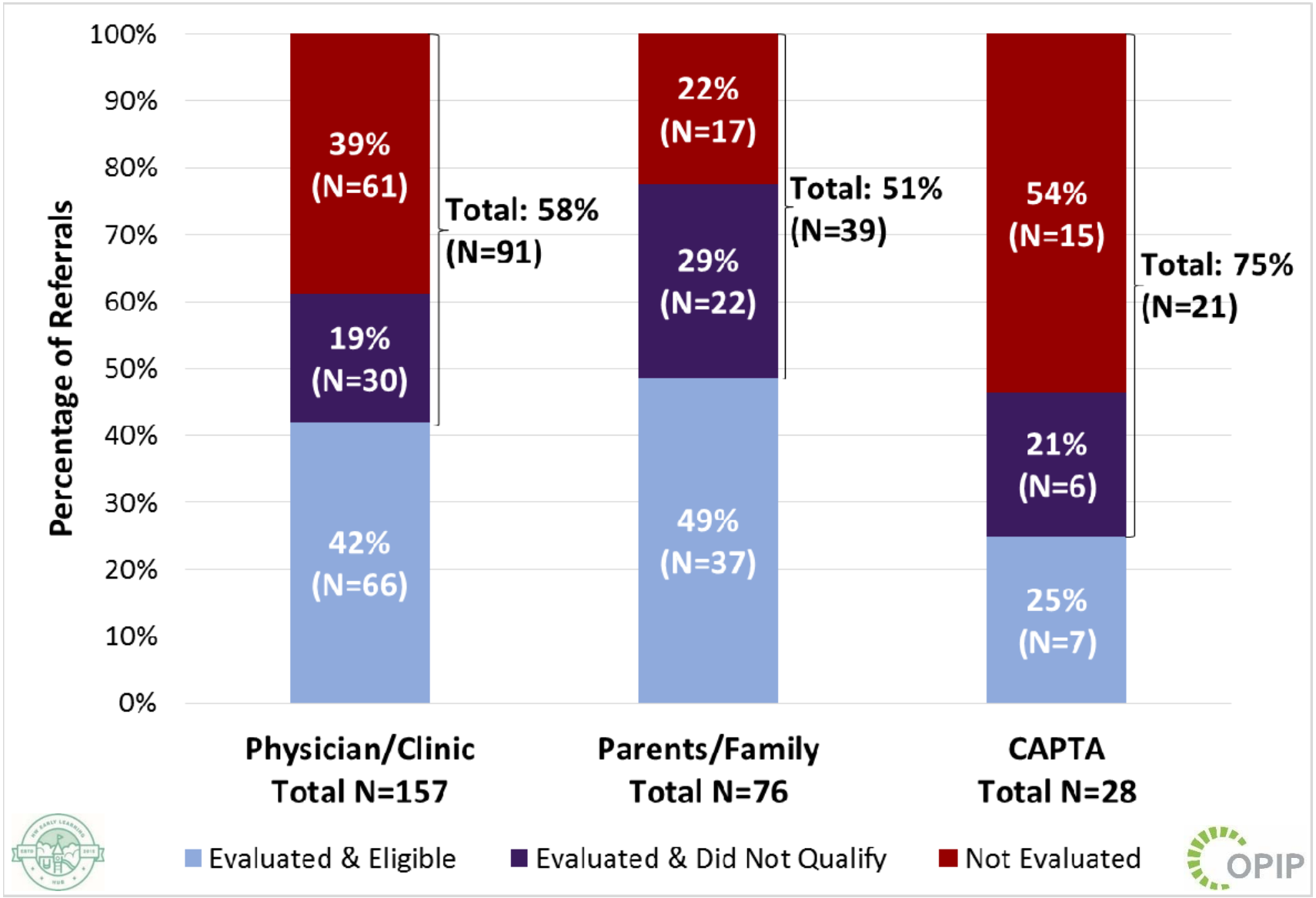
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

EI Referral Outcomes by Age of Child in SY 16-17: By County



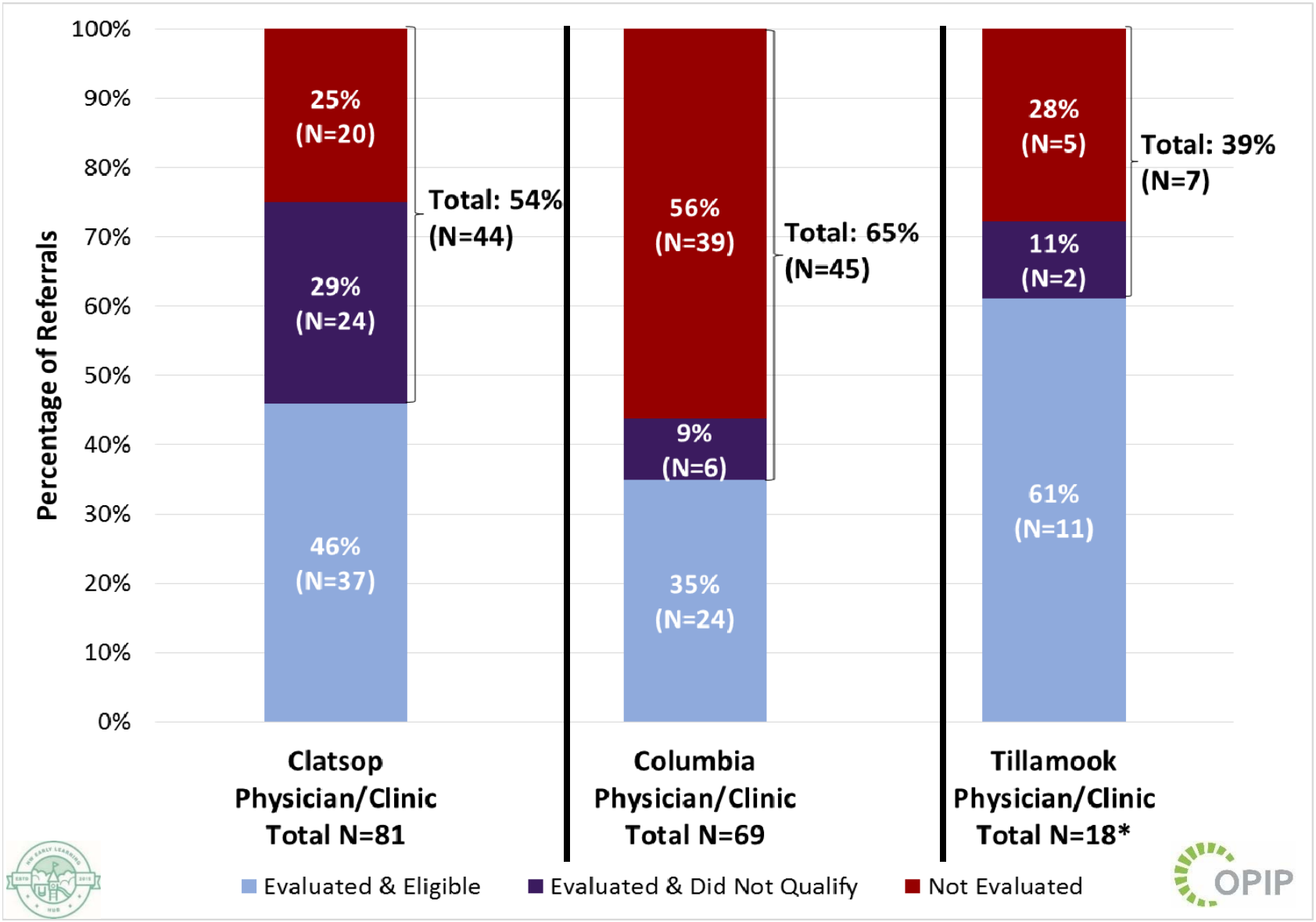
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

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



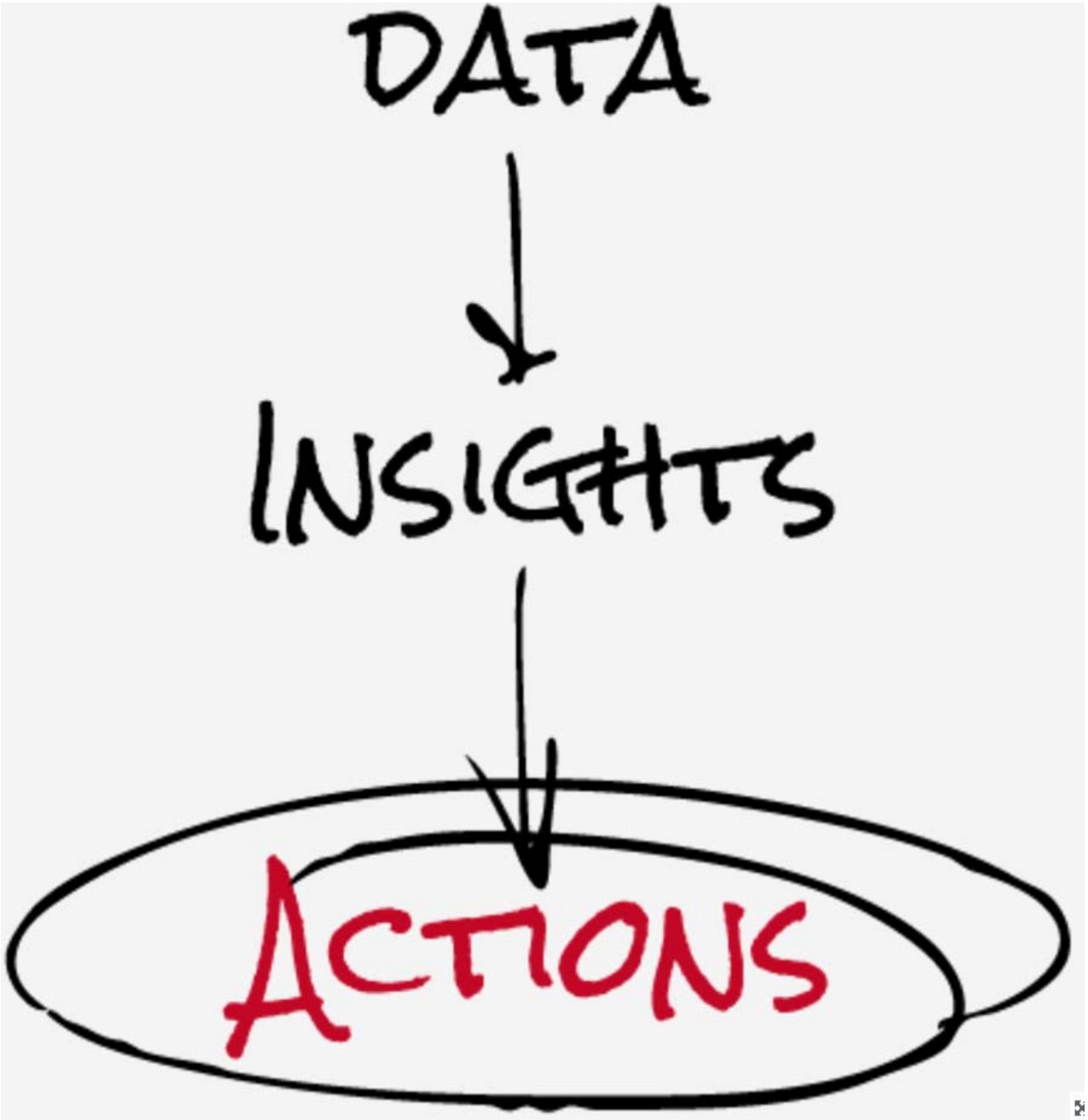
Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

SY 16-17 Outcomes of Evaluation for Tri-Counties By Physician/Clinic Referrals – By County



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

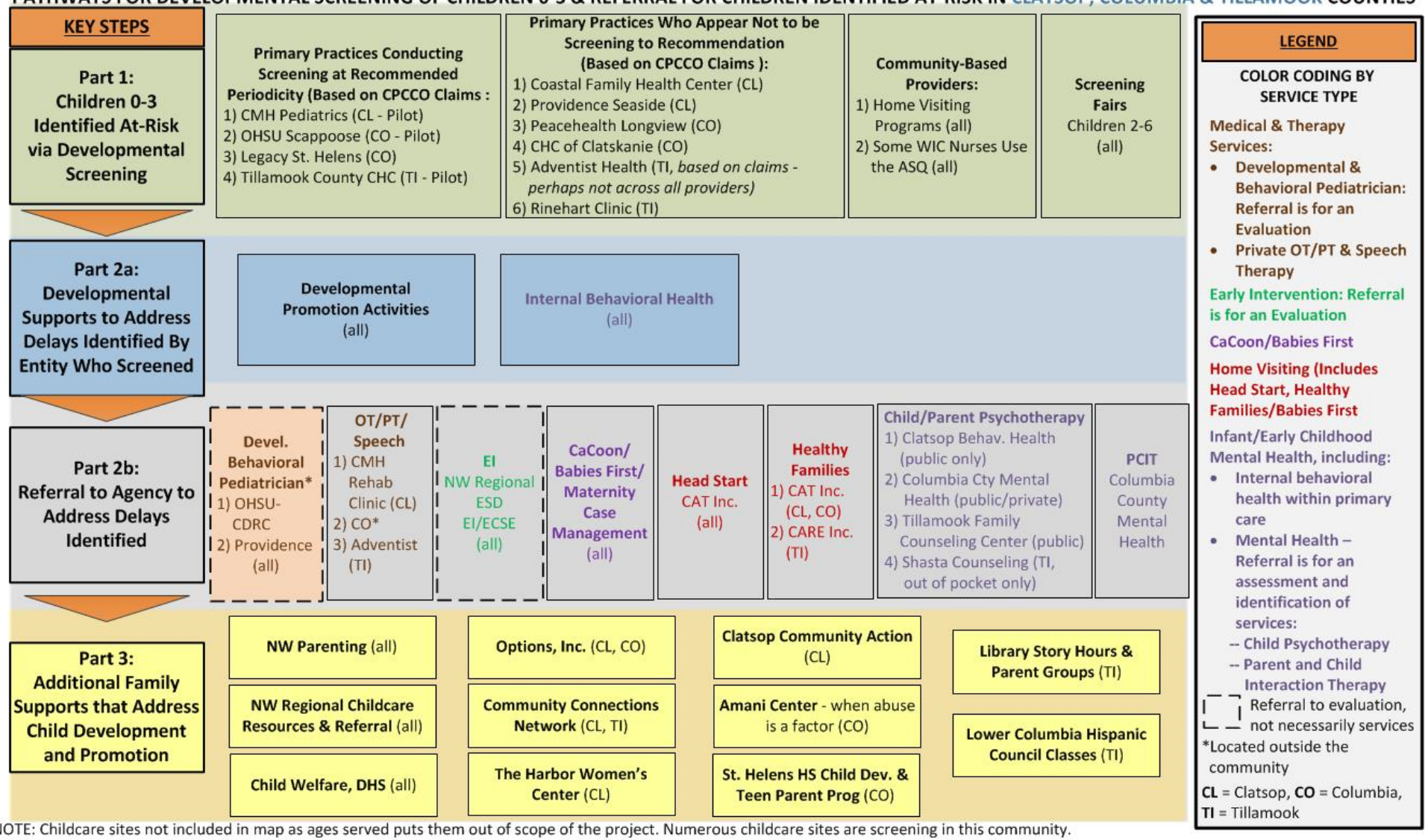
Part 2: Based on these Learnings, What do We Focus On



Community-Level Assets Identified Through Phase 1

- Each interview asked people to identify resources in the community that can provide follow-up specific for children identified at-risk.
  - People interviewed across seven sectors
- Cataloged resources by whether they were:
  - A primary referral that provides a service directly related to risk identified
  - A secondary support for the family
  - Some resources address delays or promote developmental promotion, but eligibility and inclusion don't map to screening periodicity (e.g. Healthy Families)
  - Some resources don't serve children 0-3 (Head Start)
  - Some resources exist, but haven't been used for young children yet (PCP internal behavioral health)
- Tracked resources people noted that they wished existed, but didn't
  - Robust parenting classes and support, parenting supports for specific issues
  - Family nurse partnerships, more expansive home visiting
  - Mental health
  - PCIT (In one of the three counties)
  - Relief Nursery
  - Early Head Start
  - Quality medical translation services
    (For screening and to support follow-up)

PATHWAYS FOR DEVELOPMENTAL SCREENING OF CHILDREN 0-3 & REFERRAL FOR CHILDREN IDENTIFIED AT-RISK IN CLATSOP, COLUMBIA & TILLAMOOK COUNTIES



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.

Part 2b – Expanded View:
Referral to Agency to Address Delays Identified

	Devel. Behavioral Pediatrician	OT/PT/Speech	EI	CaCoon/ Babies First/ Maternity Case Management	Head Start	Healthy Families	Child/Parent Psychotherapy	Parent & Child Interaction Therapy
Clatsop	X	Yes	Yes	Yes	Yes	Yes	Yes, public only	X
Columbia	X	X	Yes	Yes	Yes	Yes	Yes	Yes
Tillamook	X	Yes	Yes	Yes	Yes	Yes	Yes, public and out of pocket only	X
Outside Community	OHSU CDRC Providence							

Note about the Future & Potential Role of NWELH

Community Level Need:

- Throughout all the interviews, the value of having a master document of resources in the community that serve these young children was noted as valuable
- That said, resources change and their contact information change
- It is also valuable to understand the capacity of those resources
- It also would be valuable to add in WHO to refer (eligibility criterion) and HOW to refer to those resources and whether there are models of two-way communication

Opportunity:

- This may be a good role for the ELH to play as part of family resource management to periodically update this document and set of resources and identify best dissemination methods
- That said, it is integral that resources within health care (beyond just within CCO) be included in this map

Phase 2: Improvement Pilots

- Baseline information and community-level input and priorities would guide areas of focus in each of the three counties.
- In proposal, sites that **pilot the improved processes (as defined in the project)**:
  1. **Primary care practice in each county** serving a large number of publicly insured children that, based on claims data, was conducting developmental screening: **OHSU Scappoose**, **CMH Astoria, Tillamook CHC**
  2. **Early Intervention** – Northwest Regional Education Service District local Service Centers
  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, early learning providers)*

Phase 2: Improvement Pilot Focus Areas

- Meetings held in Clatsop and Columbia Counties; Tillamook happens on 2/7 to review and confirm priorities
- Need for county-level variation
  - Primary care level of follow-up and knowledge of engagement with early learning providers varied
  - Resource availability different in each of the counties
  - Partners interested and invested in piloting new methods vary
- Areas Similar Across the Counties
  1. **Primary Care**: Enhance follow-up given majority of at-risk children do NOT receive follow-up
     - Decision tree for who, how and when to refer, including "dot connection" to early learning
     - Developmental promotion supports provided to the family that day
     - Parent education and shared decision making supports
     - Track the referrals made for at-risk youth
     - Care coordination and supports
     - Secondary referrals and supports depending on eligibility
  2. **Early Intervention**
     - Inform decision tree on best referrals to EI given EI eligibility standards
     - Children Referred, **Not Evaluated**: Communication and coordination to enhance rate
     - Children Evaluated, **Not Eligible**: Communication, Where applicable secondary referral to mental health
     - Children Evaluated, Eligible: Communication about services provided to inform secondary referral steps

Phase 2: Improvement Pilot Areas in Early Learning

- Early Learning Provider Pathway – Breadth Strategy
  - Asset map to share with stakeholders about WHAT exists in the community
  - In all three counties, the decision tree created for primary care will identify specific children who should be referred to specific community-level early providers
- Early Learning Pathway – Mental Health: In **Clatsop (CBH)** and **Columbia (CCMH)** Counties: Pilot of Specific Strategies to Engage Families with Young Children Identified with Social Emotional Delays and/or Delays and Exposure to ACES
  - Services exist within these communities
  - The mental health agency staff in these community want to pilot better connections between primary care and mental health for young children
  - Many people noted negative experiences with referrals for children, opportunity to address past experiences and create a "new narrative"
  - Stakeholders noted a number of barriers that the pilot could try and address ways to improve access of this pathway
    - Knowledge in primary care about the services
    - Talking points for PCPs in talking to families about the services
    - Ways to refer to mental health, ways to leverage internal primary care behavioral health services
    - Way to engage the family in the referral, including referral forms, "warm handoffs"
    - Two-way communication and feedback loops
  - Value in a small pilot that within just the pilot primary care sites and for applicable EI Ineligible children given concerns about what it will take and concerns about capacity of the system

Phase 2: Improvement Pilot Areas

In Tillamook County:

- EI referral rates are an issue, appears to be underuse of early learning resources
- Provider-level variation – two providers seem to be driving the follow-up that is occurring
- Within CPCCO, Adventist attributed slightly more young children than TCCHC to provide primary care
  - However, according to claims data, Adventist did not appear to be screening to periodicity or across their providers, early learning providers report majority of providers not screening
  - Therefore, TCCHC was chosen to be pilot site given they had the largest number of children screened
  - Community-partners repeatedly noted wanting Adventist to be engaged
  - Referral rates from Adventist to EI and Early Learning relatively low and largely driven by one provider highly respected in the community and by early learning providers
  - Adventist sponsors the Screening Fairs
  - In interview, Adventist noted they wanted to be engaged in this effort and that Child Health is a priority, noted that they are screening, but variation in provider-level knowledge of claims and follow-up
  - The provider who saw the most children in TCCHC (Pilot site) left in mid-January to join Adventist
- Therefore, if Adventist providers agree on 1/17, then we are proposing on February 7th:
  - OPIP provide Adventist follow-up to screening tools and support in exchange for Adventist agreement to address spread to the other providers in their system
  - Expands the breadth of this strategy to be engaging the two primary care sites to which 90% of CPCCO children are attributed to for primary care
  - Focus on how primary care – at large – can enhance best match referrals to the early learning providers in the community

Community-Level Desire for Focus of Improvement Pilots Out of Scope of the Project, But Important to Note

- **General Understanding and Support for Developmental Promotion and Addressing Delays in Young Children:**
  - **General messaging-** synergistic approaches to addressing existing misperceptions in the community around the importance of screening and developmental promotion in general. Value of activities to promote children ready for kindergarten
  - **Address Stigmas-** Community wide approaches to address existing stigmas impacting families from following through on recommendations around development
- **Upstream Approaches to Engage Families and Provide Developmental Support to Prevent Delays:**
  - More universal home visiting services for all parents.
  - Parenting classes and parenting supports for all families.
  - Focus on access of mental health for children 3-5.
- **Work with practices not screening or not screening to fidelity to get them screening and then to do follow-up, work with all practices in the community**
- **Address children who lose continuous insurance coverage and potential access to care**
- **access of well-child care for children 2-3 years old**
- **Address attribution methods and understand better the differences between practice-level and system-level report of the number of children not coming in, to inform population management**
- **Develop capacity of existing systems, build capacity and existence of services**

Next Steps

- Follow-up to questions or needs for additional information raised today
- 2/7 Tillamook Meeting
- Baseline PCP data collection in 3rd site, CMH Astoria (ahead of timeline of project)
- 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 Board Meeting the Findings will be Shared: June 2018**

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:

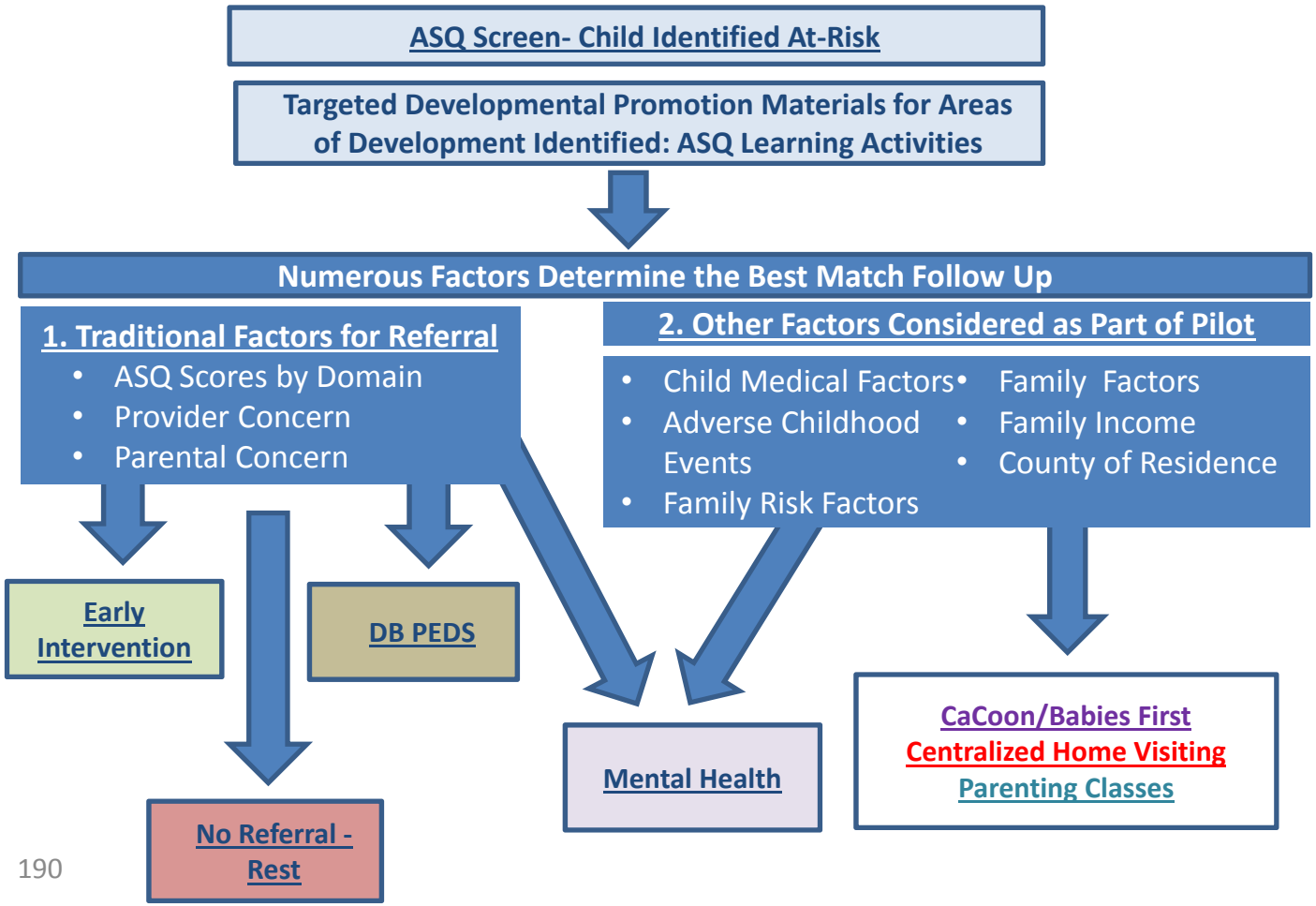
We Will Prioritize Group Discussion Over Reviewing these Details

Support to Primary Care Pilot

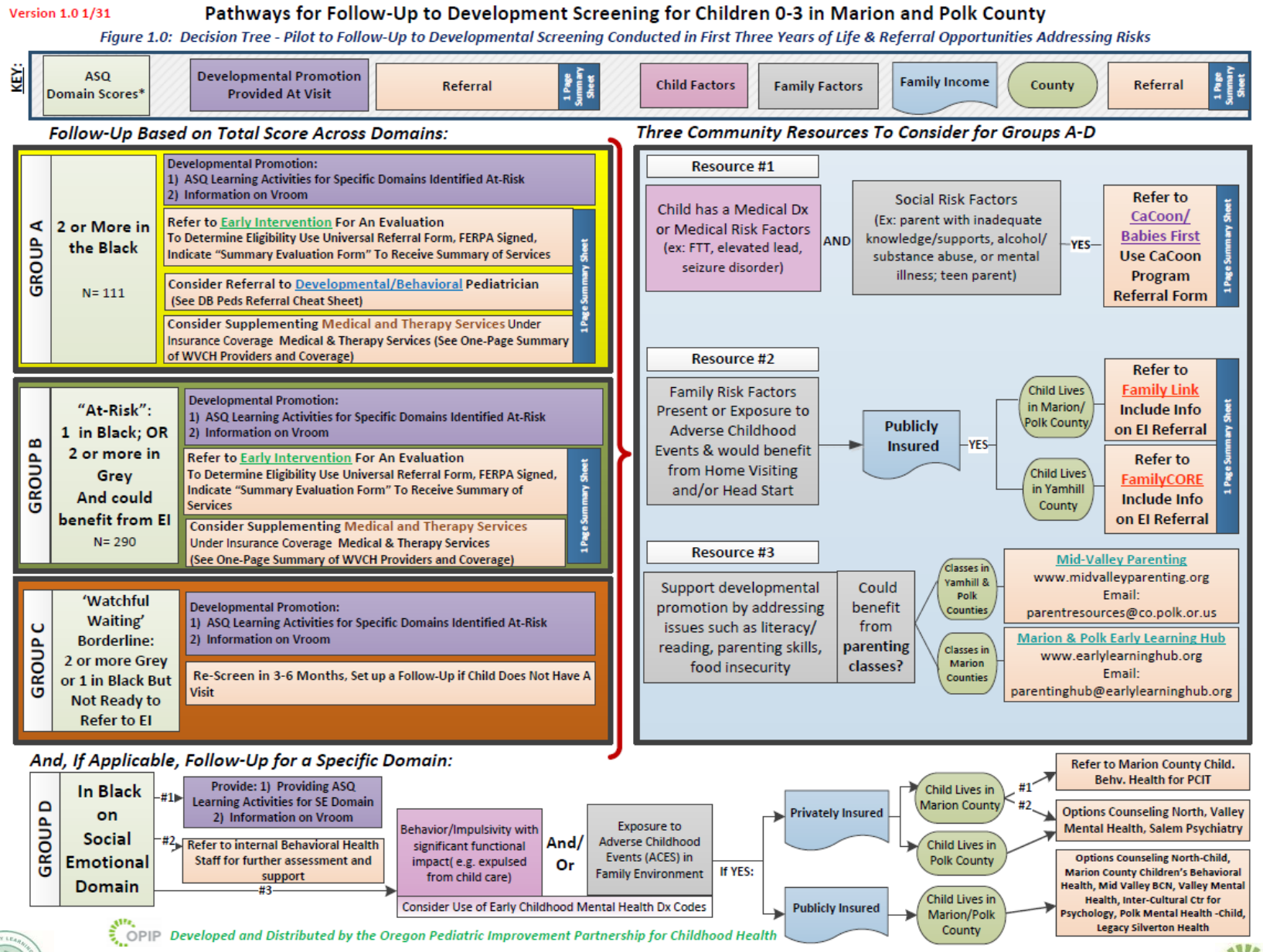
- **OPIP will develop new tools to enhance promotion and follow-up for all children identified at-risk**
  - Improved **developmental promotion activities** at the time of the visit
  - Education tools about concept of "kinder readiness"
  - **Referral/Getting to Referral**- Improve workflows and processes 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

☐ 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

☐ 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

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**

Designed and distributed by Oregon Pediatric Improvement Partnership. Version 2.0 1/31

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)

- 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.

Proposed Early Learning Provider Pathway

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 (Columbia Only)

Pilot would include

- **Patient-Centered Methods for Engagement and Referral to MH from Pilot Primary Care Practices**
  - **Referral processes-** pilot an improved referral process between Primary Care and MH, including workflow utilizing internal behavioral health resources at PCP (when available), and implementing new processes to expedite MH assessment processes, and improved collaboration between the two entities
  - **Referral processes-** pilot an improved referral process between EI and MH
  - **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, MH 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

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

KEY STEPS

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

Part 2:
Referral to Agency to Address Delays Identified

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