



# Ensuring Young Children Identified on Developmental Screening Receive Follow-Up:

## *Lessons From A Community-Based Approach Engaging Primary Care, Early Intervention, and Early Learning System Providers*

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# Momentum Around Developmental Screening in Oregon

## *Within **Health Care**:*

- Coordinated Care Organization  
Incentive Metric – Developmental Screening
- Oregon Patient Centered Primary Care Homes (PCPCH) Standards - Includes Developmental Screening as “Must Pass” Standard

## *Within **Early Learning**:*

- Early Learning Hub Metrics
  - 1<sup>st</sup> wave Included CCO Developmental Screening Incentive Metric
- High quality child care – part of highest level designation



## 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 Early Intervention (EI) have increased, but not proportional to screening rates
  - Number of children served by EI also did not increase 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).



# Key Components of Community-Based Improvement Efforts to Increase the Number of Children Receiving Follow-Up

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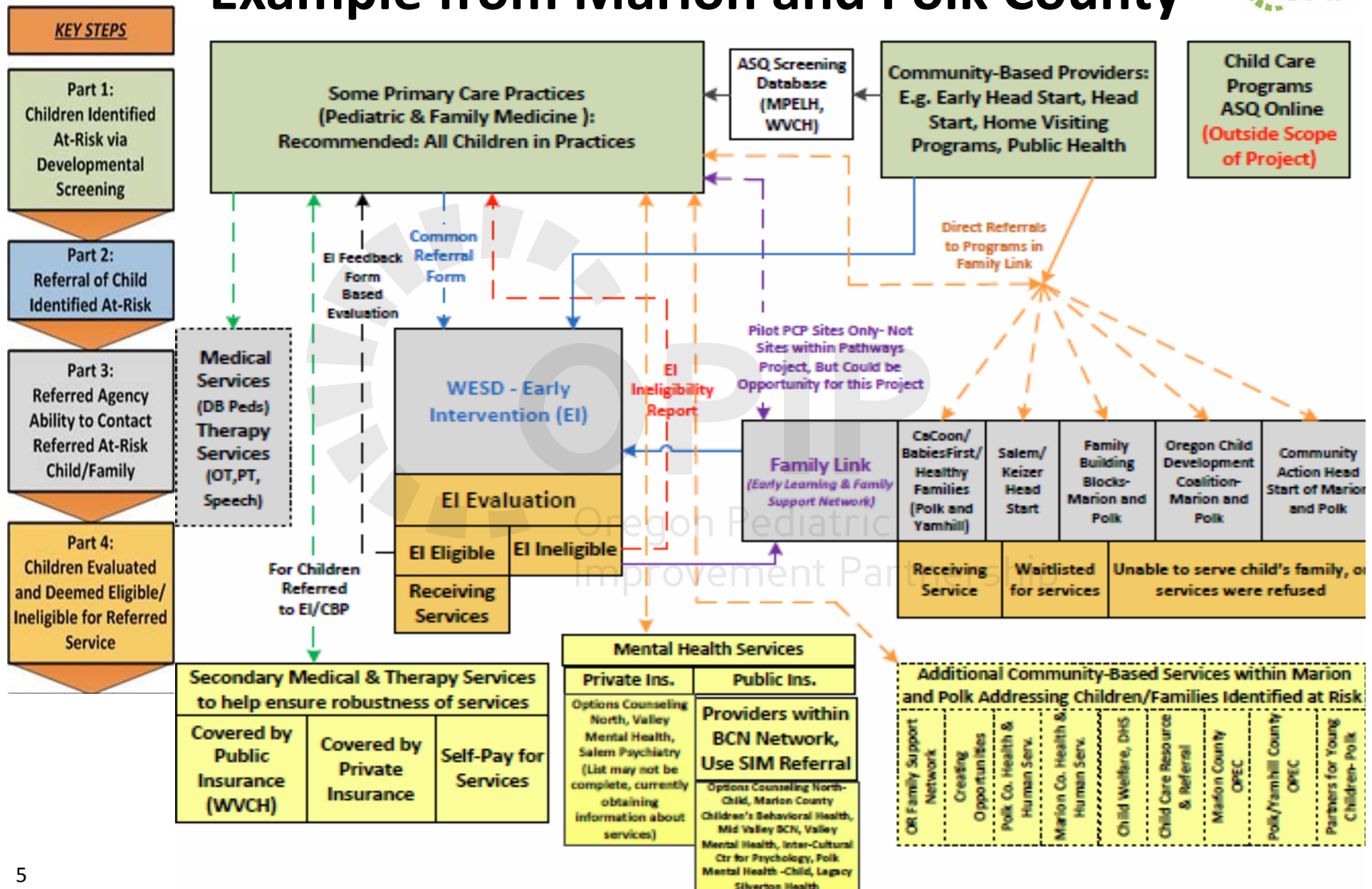
1. Community-level Stakeholder **Engagement** Across Six Sectors, Including Parent Advisors:
  - ❖ **Understand** Current Pathways,
  - ❖ Identify **existing community assets**
  - ❖ Prioritize **where** to focus pilots of improved follow-up
2. **Pilots to improve** the number of children who receive follow-up and coordination of care.

*Key partners in implementing these pilots:*

- A. Primary Care Providers
- B. Early Intervention
- C. Early Learning



# Current Pathways and Community Asset Map: Example from Marion and Polk County



# Community-Based Improvement Opportunity: Pilot Sites Implementing Efforts to Improve Follow-Up



## 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 HUB (e.g. VROOM, ACT Early, ASQ Learning Activities)
- 2) NEW referrals from PCP/EI being to:
  - Centralized home visiting referral
  - Evidence based parenting classes

# 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)

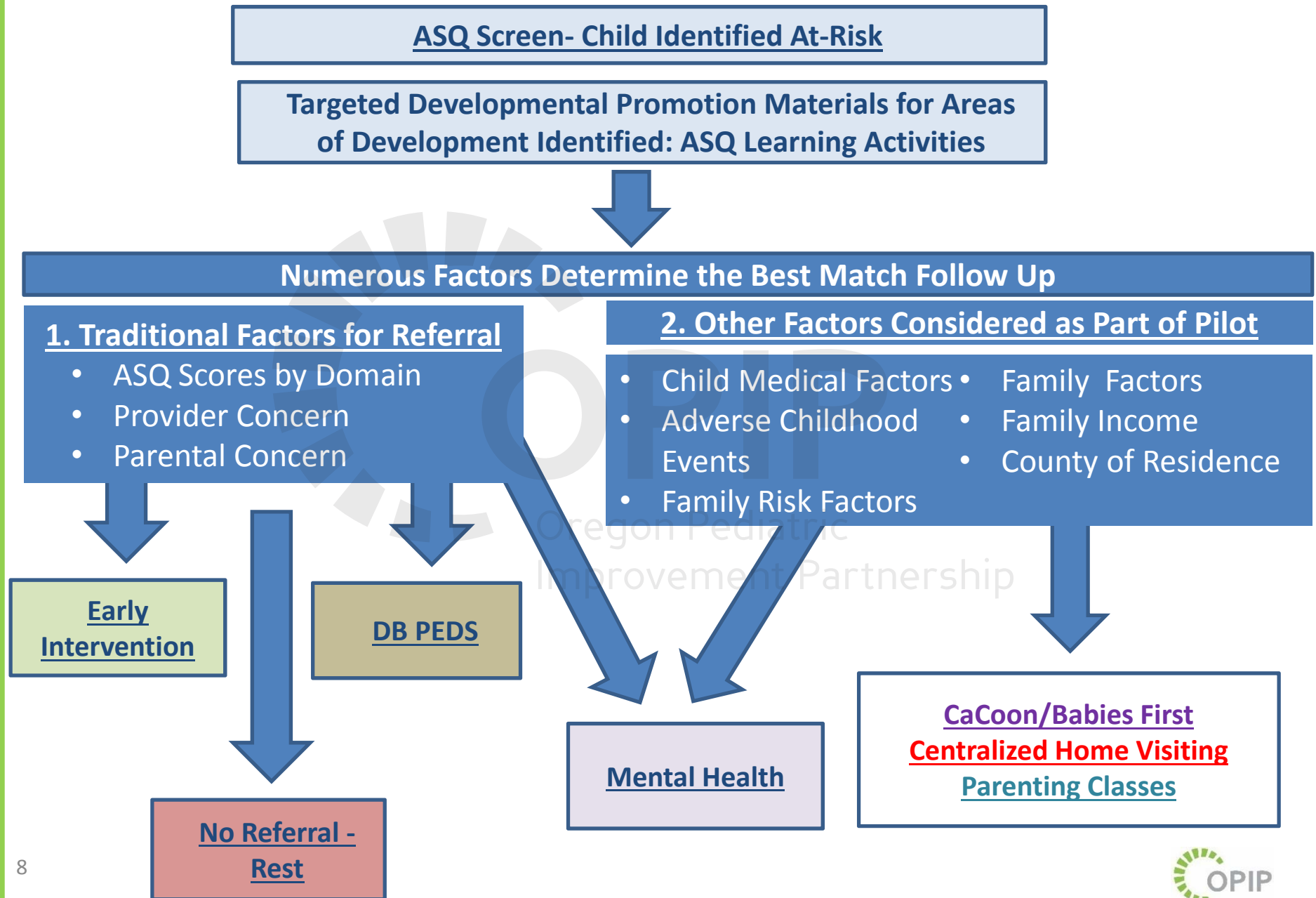
3. **CaCoon/Babies First**

4. **Centralized Home Visiting Referral** (Includes Early Head Start and Head Start)

5. **Parenting Classes**

6. **Mental Health**

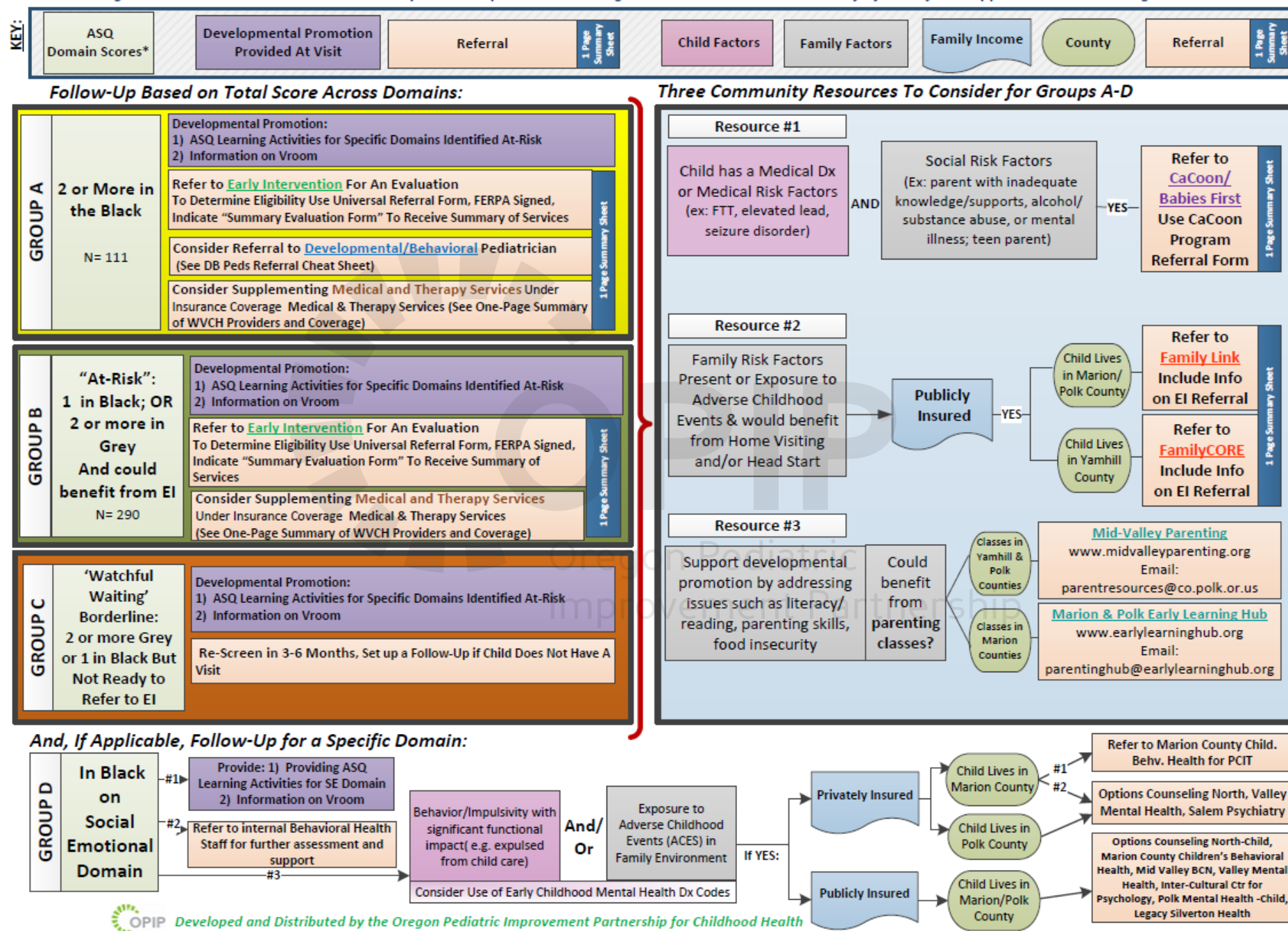
# Determining the “Best Match” Follow Up for the Child and Family

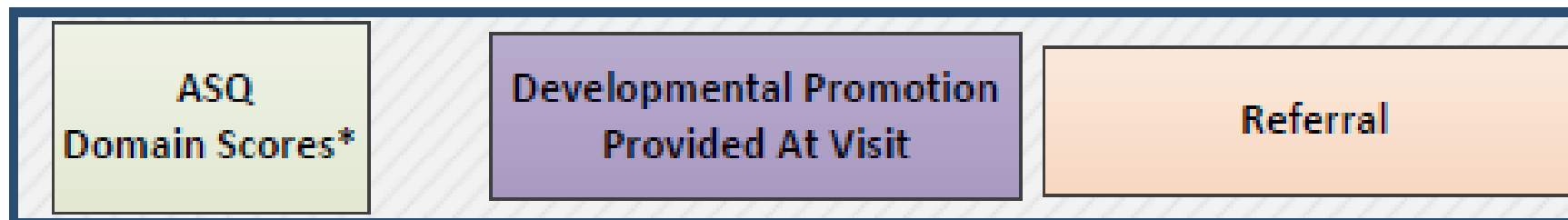




# Pathways for Follow-Up to Development Screening for Children 0-3 in Marion and Polk County

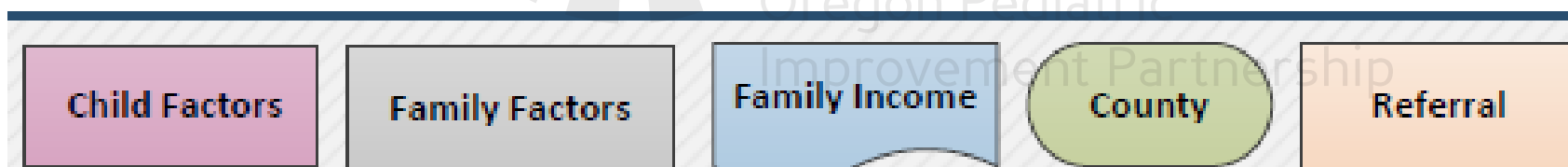
Figure 1.0: Decision Tree - Pilot to Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks





Left Side:

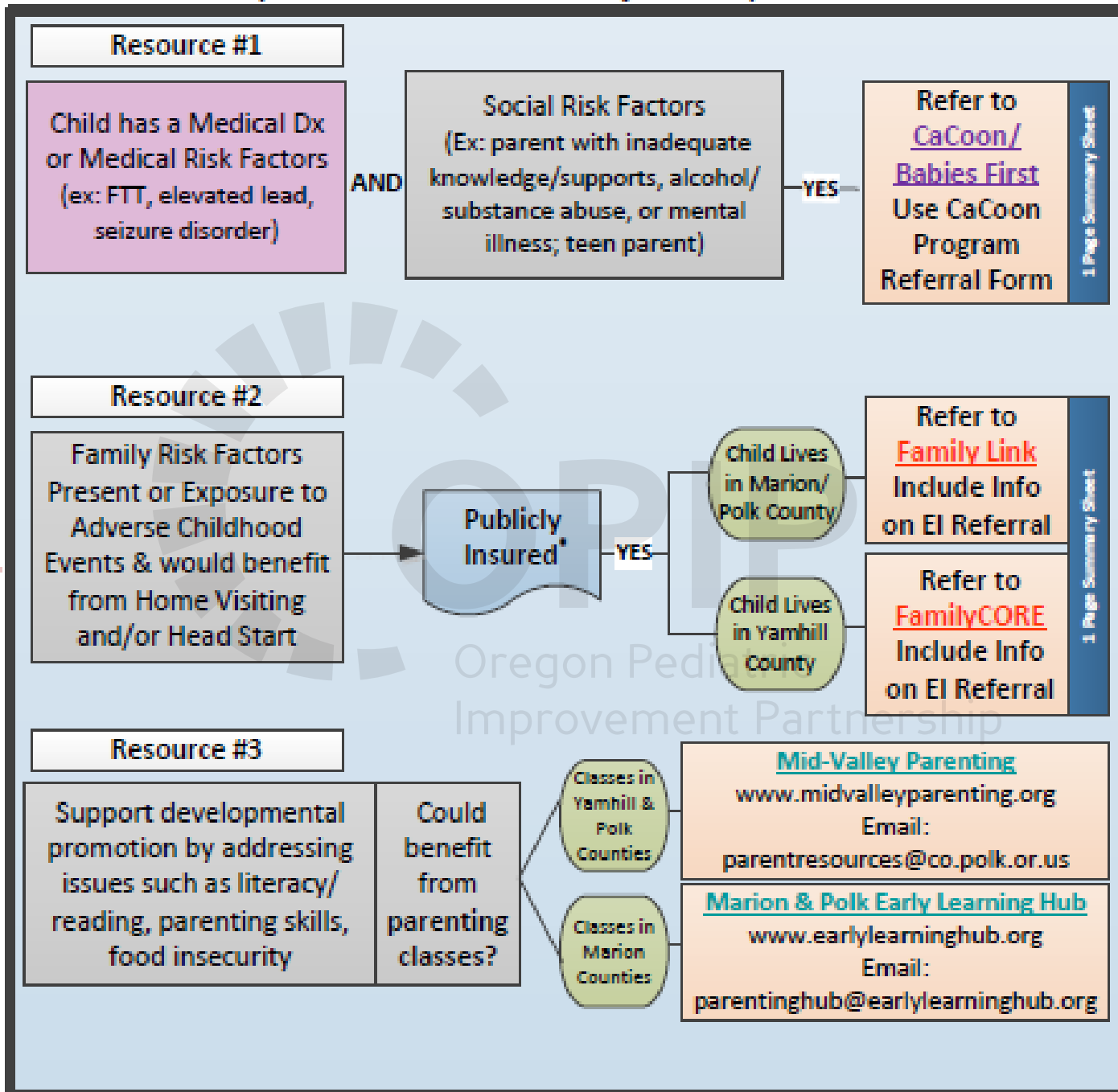
- Anchored to ASQ Scores
- Promotion that should happen that day
- When and who to refer to Early Intervention (EI)
- When and who to refer to a Developmental Pediatrician for evaluation



Right Side

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

## Three Community Resources To Consider for Groups A-D



# Pilot EI Communication Form to Inform Possible Secondary Referral

A new Individual Family Service Plan (IFSP) was developed for your patient \$Fname on \$ifsp. These services will be reviewed again no later than \$nextifsp.

IFSP Services:

Early Intervention Goal Areas: Cognitive ☐ Social Emotional ☐ Motor ☐ Adaptive ☐ Communication ☐

	Services Provided by:	Frequency	Current Provider
<input type="checkbox"/>	Early Intervention Specialist	_____	_____
<input type="checkbox"/>	Occupational Therapist	_____	_____
<input type="checkbox"/>	Physical Therapist	_____	_____
<input type="checkbox"/>	Speech Language Pathologist	_____	_____
<input type="checkbox"/>	Other	_____	_____

Please contact \$service coordinator 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 by this process.*

# Family Supports in Navigating Referrals

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Informed by parent advisors, developed tools and 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](http://www.ode.state.or.us)

#### Parenting Support

**Classes located in Marion County**  
Veronica Mendoza-Ochoa  
(503) 967-1183  
[earlylearninghub.org](http://earlylearninghub.org)

**Classes located in Polk County**  
(503) 623-9664  
[midvalleyparenting.org](http://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:** Yvette Guevara  
Referral Coordinator  
503-990-7431 ext: 122  
[familylink@familybuildingblocks.org](mailto: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](http://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 Specialists:** 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

*For children referred, better parent support:*

- 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

# More Information

## 1. Colleen Reuland

- reulandc@ohsu.edu
- 503-494-0456

## 2. [www.oregon-pip.org](http://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