



# Pathways from Developmental Screening to Services: Spotlight of Efforts, Learnings and Future Opportunities to Better Serve Children 0-3 Identified At-Risk for Delays

Presentation to the House Committee on Early Childhood and Family Supports

Colleen Reuland, MS

Director, Oregon Pediatric Improvement Partnership

Instructor, Department of Pediatrics at Oregon Health & Science University

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# Agenda

- **Background & context**
  - Overview of Oregon Pediatric Improvement Partnership (OPIP)
  - Momentum related to developmental screening
- **Opportunity to focus on follow-up to developmental screening: Spotlight of an effort in three counties**
  - Data gathered and primary opportunities identified
  - Pilot tools and strategies developed and being implemented by health care and early learning
- **Key Learnings and Future Opportunities**

# Oregon Pediatric Improvement Partnership (OPIP)

- OPIP supports a meaningful, **long-term collaboration of stakeholders** invested in child health care quality, with the common purpose of **improving the health of the children and youth** of Oregon.
  - **OPIP staff and projects focus on building health and improving outcomes for children and youth by:**
    - 1) Collaborating in **quality measurement and improvement** activities;
    - 2) Supporting **evidence-guided quality activities**;
    - 3) Incorporating the **patient and family voice** into quality efforts; and
    - 4) Informing **policies that support optimal health** and development
  - OPIP uses a **population based approach – starting with child/family**
    - Work with the multiple kinds of providers who serve children
  - Primarily contract and grant funded
  - Based out of Oregon Health & Science University (OHSU), within the Pediatrics Department
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# Level Set: What is Developmental Screening?

- Developmental screening is the use of a **brief, standardized questionnaire** used to check on a child's general development
- Developmental screening identifies children developing on schedule, children who might **benefit from support**, and children **at risk for a developmental, behavioral and/or social delays**
- National Recommendations within Health Care
  - Developmental screening recommended to occur three times in the first three years of life
    - 9 month visit, 18 month visit, and 30 month visit
- In Oregon, the most commonly used screening tool in both the health and early learning sectors is the *Ages and Stages Questionnaires®*, Third Edition (ASQ-3)
  - The ASQ-3 is a parent-completed questionnaire that assesses child development between ages one month to 5.5 years in five domains: communication, gross motor, fine motor, problem solving and personal-social

# Momentum Around Developmental Screening

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

- Coordinated Care Organization Incentive Metric
  - Developmental Screening
- Patient Centered Primary Care Homes (PCPCH) Standards
  - Includes Developmental Screening

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

- Early Learning Hub Metrics
  - Includes CCO Developmental Screening Incentive Metric
- High Quality Child Care

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

## Goals of screening

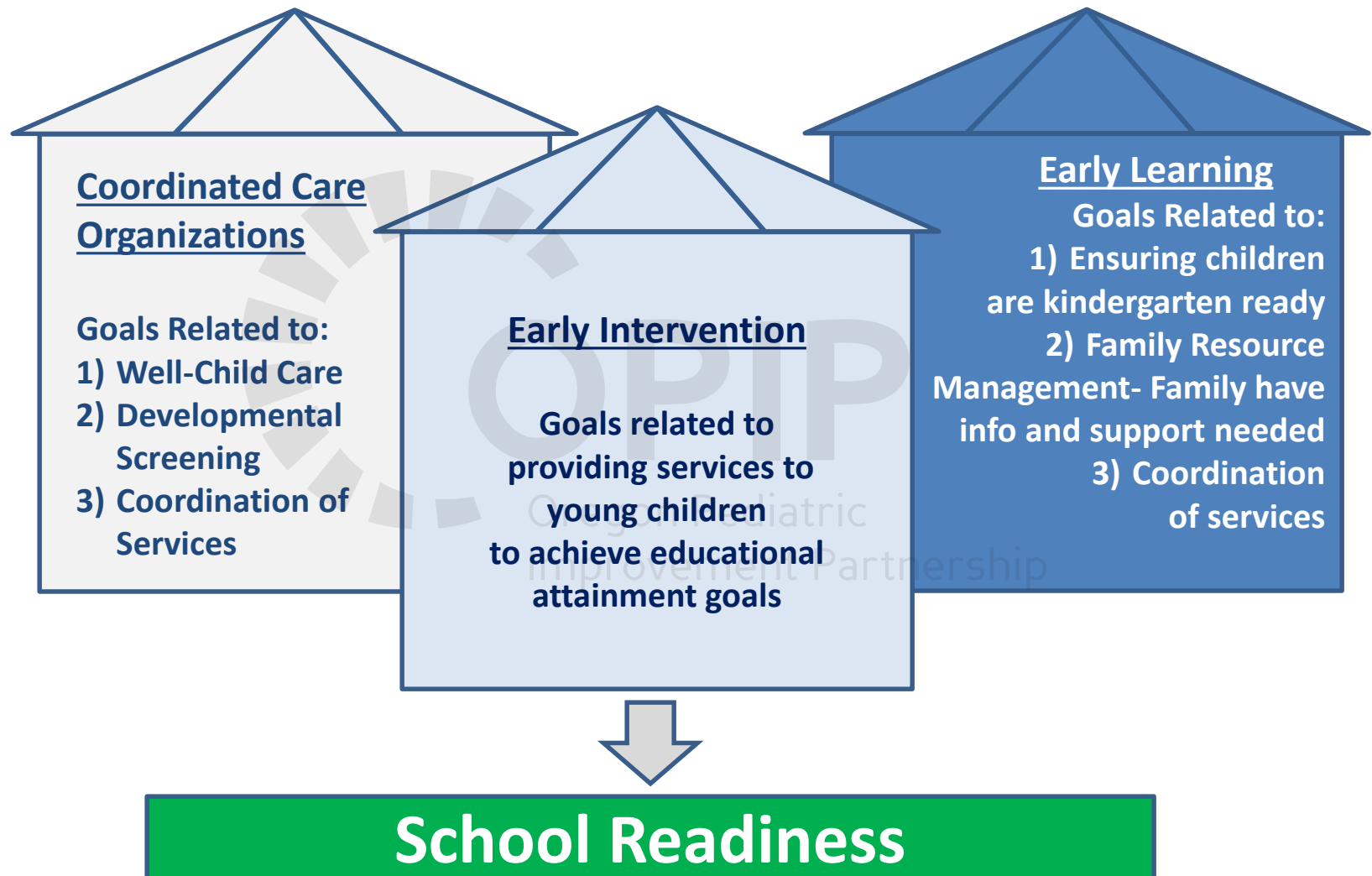
- Identify children **at-risk** for developmental, social and/or behavioral delays
- For those children identified, **provide developmental promotion, refer to services** that can further evaluate and **address delays**
  - Many of these services can address delays in a way that ensures most children have a smooth transition to school
  - Follow-up services live within a variety of settings. For example:
    - Health Care
    - Early Intervention
    - Early Learning

### **Children Identified “At-Risk” on Developmental Screening**

*These are children that 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)<sup>3</sup>. Therefore the children of focus are those identified “at-risk” for delays based on the ASQ domain level findings.*

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



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# Presentation Spotlights 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

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

1. Stakeholder **Engagement** and **Community-Level Prioritization**
2. **Use of Data** on WHERE children are falling out of the pathway from screening to services
3. **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

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# Stakeholder Engagement: Current Systems and Processes Related to Follow-Up to Developmental Screening

- Engaged over 60 stakeholders, **across six sectors**, in the three communities who are either doing developmental screening and/or who provide follow-up services to screening
- 1. Individual interviews and engagement**
- 2. Periodic group-level stakeholder meetings to provide updates and obtain community-level input and guidance**
  - Leveraged shared table and relationships they have created within Early Learning Hubs (Yamhill Early Learning Hub & Marion and Polk Early Learning Hub)
- 3. Parent Advisors and Parent Advisory Groups**
  - Individual Parent Advisors – 3 Parents
  - Parent Advisory Groups
    - Marion and Polk Early Learning Hub
    - Parent Advisory Group within the participating Primary Care Practices

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# Community Asset Mapping and Pathway: Example from Marion and Polk County

## KEY STEPS

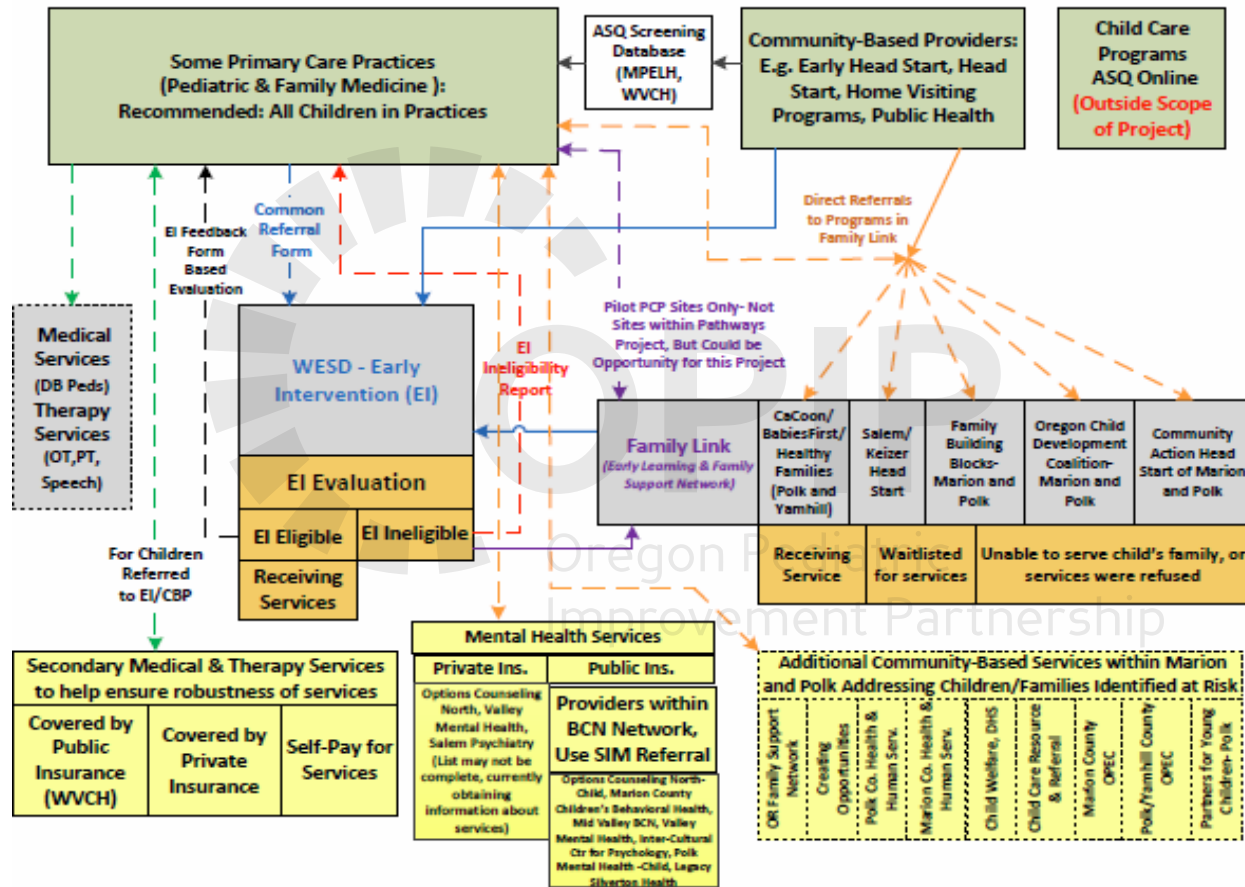
Part 1:  
Children Identified  
At-Risk via  
Developmental  
Screening

Part 2:  
Referral of Child  
Identified At-Risk

Part 3:  
Referred Agency  
Ability to Contact  
Referred At-Risk  
Child/Family

Part 4:  
Children Evaluated  
and Deemed Eligible/  
Ineligible for Referred  
Service

## Pathway for Developmental Screening & Referral and Triage Pathways for Children Identified At-Risk in Marion and Polk County



## Legend:

### TYPE OF ARROW:

- Method and/or tool has been developed.
- Exists, but is NOT standardized or improvements in process could be made

### COLOR OF ARROW:

- Communication
- Referral to Early Intervention (EI) services
- Early Learning and Family Support Referral Form
- Referral to Community-Based Agencies
- Referral to Medical or Therapy services
- Communication that child not able to be contacted, not eligible, or not served.

### TYPE OF BOX:

- Existing group, site, organization, or function
- Groups of different services

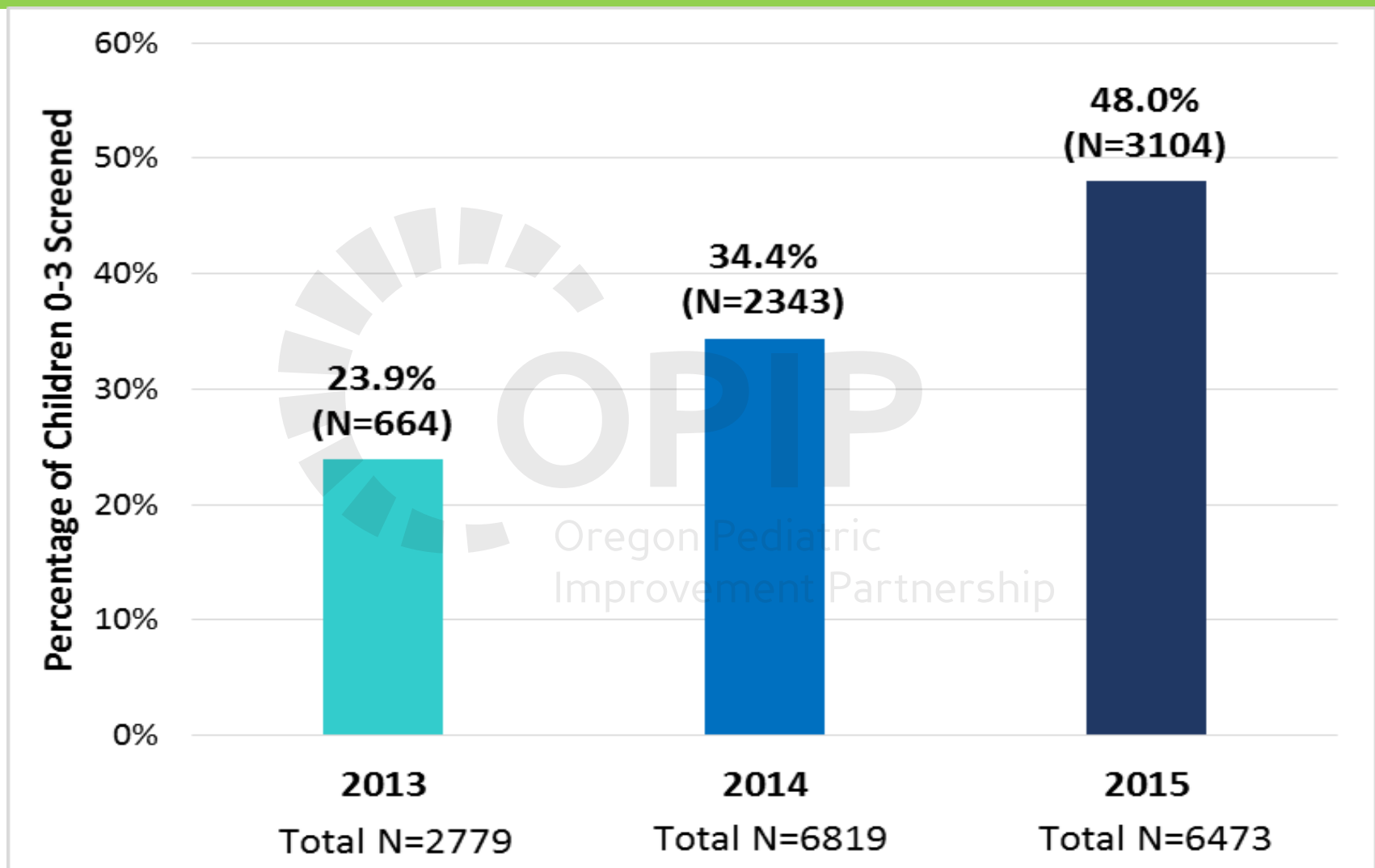
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# Examination and Use of Data About Developmental Screening and Follow-Up for Children 0-3 to Understand Current Processes and Needs

- **CCO-level data about developmental screening**
  - Total number of children screened
  - Screening rates by practices to which children 0-3 are assigned
  - Examining data for disparities by race ethnicity
- **Pilot Primary Care Practice-level data**
  - Of developmental screens conducted, how many identify a child at-risk for delays
  - Of developmental screens where child identified at-risk for delays, follow-up steps documented
- **Early Intervention data**
  - Referrals
  - Evaluation Results
  - Examining data for disparities by race ethnicity

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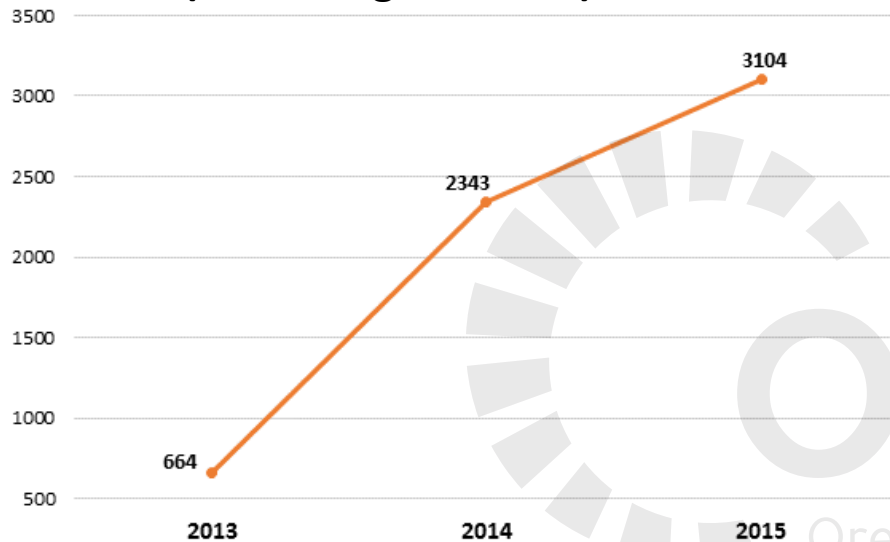
# Developmental Screening Rates in the First Three Years of Life for Publicly Insured Children in Willamette Valley Community Health (WVCH): As Tracked by 96110 Claims Submitted



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

# If follow-up to developmental screening is occurring, shouldn't the slope of the lines should be similar?

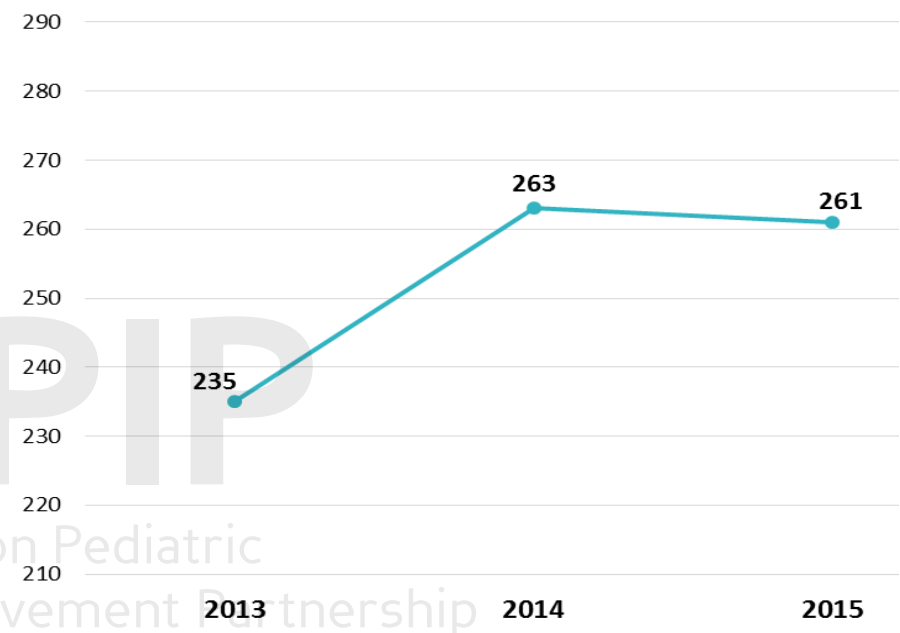
Number of Children 0-3yrs Screened  
(According to 96110) in WVCH



**2013 vs. 2015:**

**Total Improvement:  
79% (N=2440 Children)**

Number of Children Found Eligible To Receive  
EI Services in **Marion** & **Polk** Counties



**2013 vs. 2015:**

**Total Improvement: 10% (N=26 Children)**  
**Marion: 10% (N=21) Polk: 11% (N=5)**

# An Applied Example- Primary Care Pilot Site

Number of SCREENS Conducted in the Practice in One Year:  
N= 1431

In Marion & Polk Counties during this time period, 747 referrals were made to WESD. If just this practice were to refer ALL identified children- the total referrals to WESD could have been about 44% higher- or about 1072

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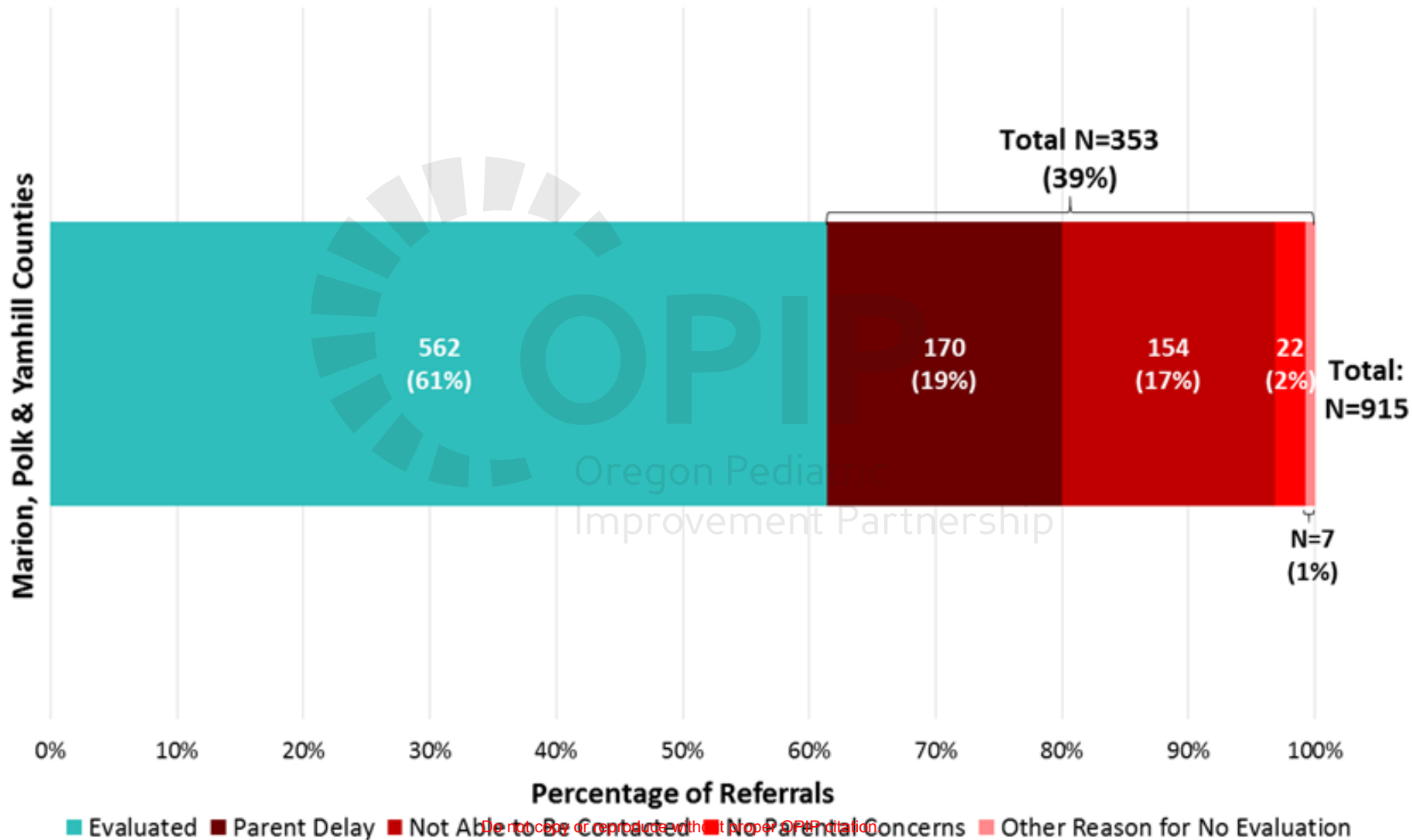
# Qualitative Findings:

## Why Are Children NOT Referred for Follow-Up Services

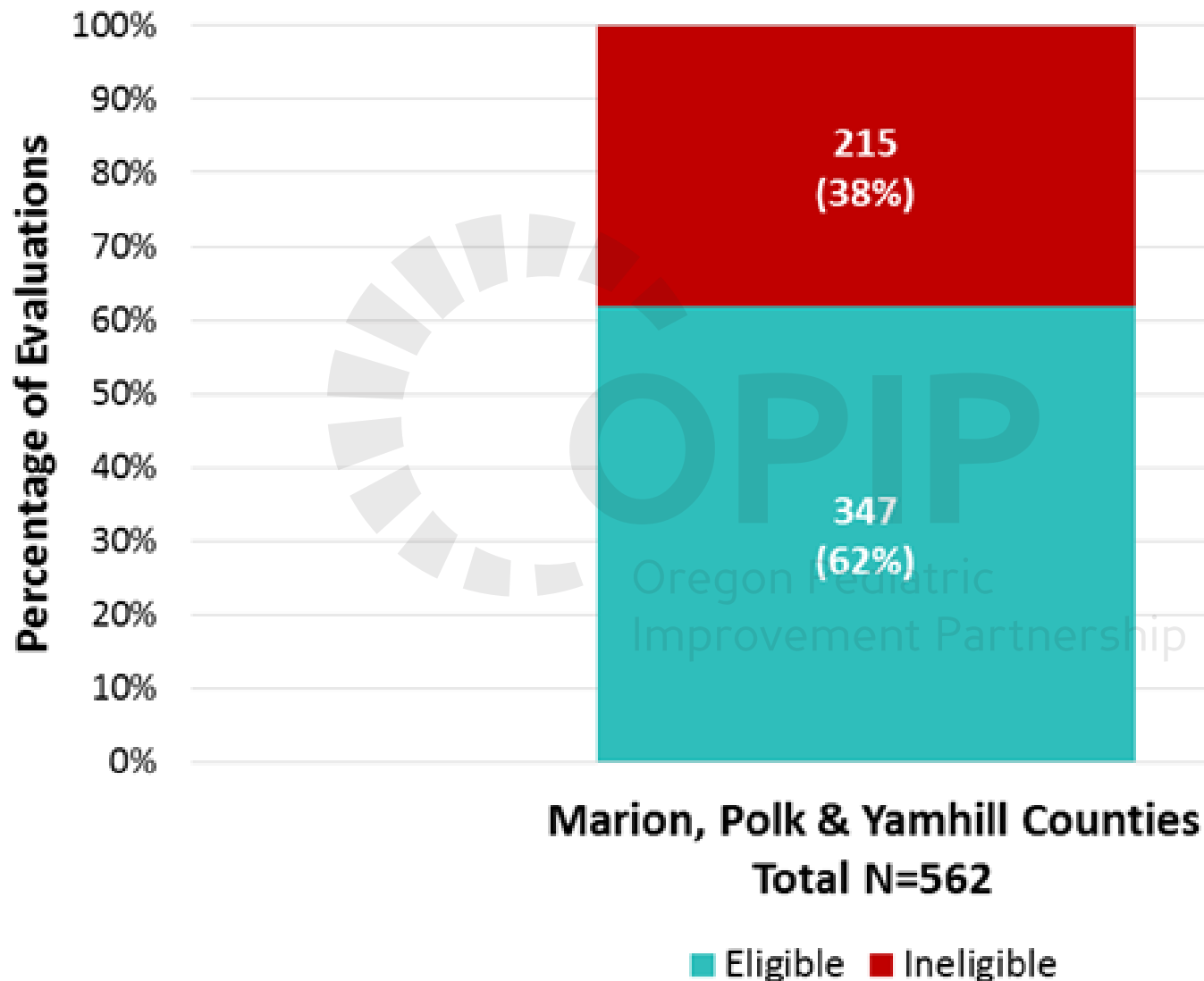
- **Follow-up to screening in primary care**
  - Confusion and lack of awareness within primary care about difference between recommendations for when to refer to EI vs EI Eligibility
    - Perception that many children referred will not be eligible
  - Need for referral criteria that take into account 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 to refer to them
  - Parent push back on referrals, cultural variations
- **Need for parent supports**
  - Developmental promotion that could in occur in the home
  - Education about referrals when provided
  - Parent support in navigation

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# 2015 WESD EI Referral Outcomes in Marion, Polk & Yamhill County: 2 in Five Children Referred Not Evaluated



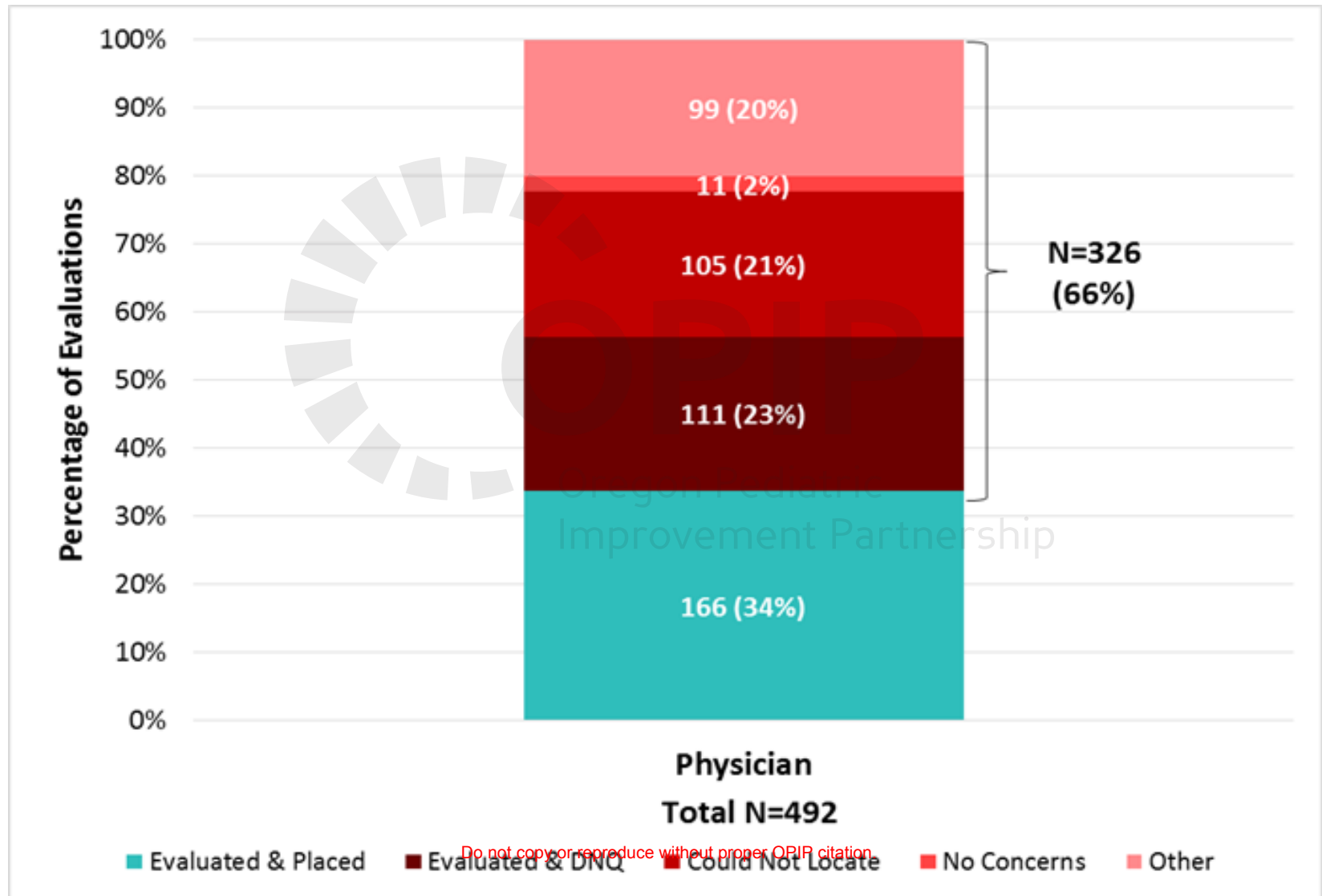
# Of Children Able to be Evaluated, 2 in 5 NOT Eligible: 2015 Outcomes of WESD EI Evaluation in Marion, Polk & Yamhill County



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# Outcomes of Evaluation For WESD Referrals from Physicians: Marion, Polk and Yamhill County- 2015

## Nearly 7 out 10 Not Receiving Services



# Community-Based Improvement Opportunity: Pilot Sites Implementing Efforts to Improve Follow-up to Developmental Screening

## PILOT PRIMARY CARE SITES:

Enhance follow-up  
for children  
identified that  
include medical, EI,  
and early learning;  
Supports for  
Families

Early Intervention (EI):  
Enhance quality of  
referrals,  
coordination and  
communication with  
the entity that  
referred the child;  
Follow-up steps for  
EI ineligible

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Early Learning  
pilots of referrals &  
connections

- Centralized home visiting referral
- Parenting classes within the OPECs
- Developmental Promotion materials (e.g. VROOM)

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

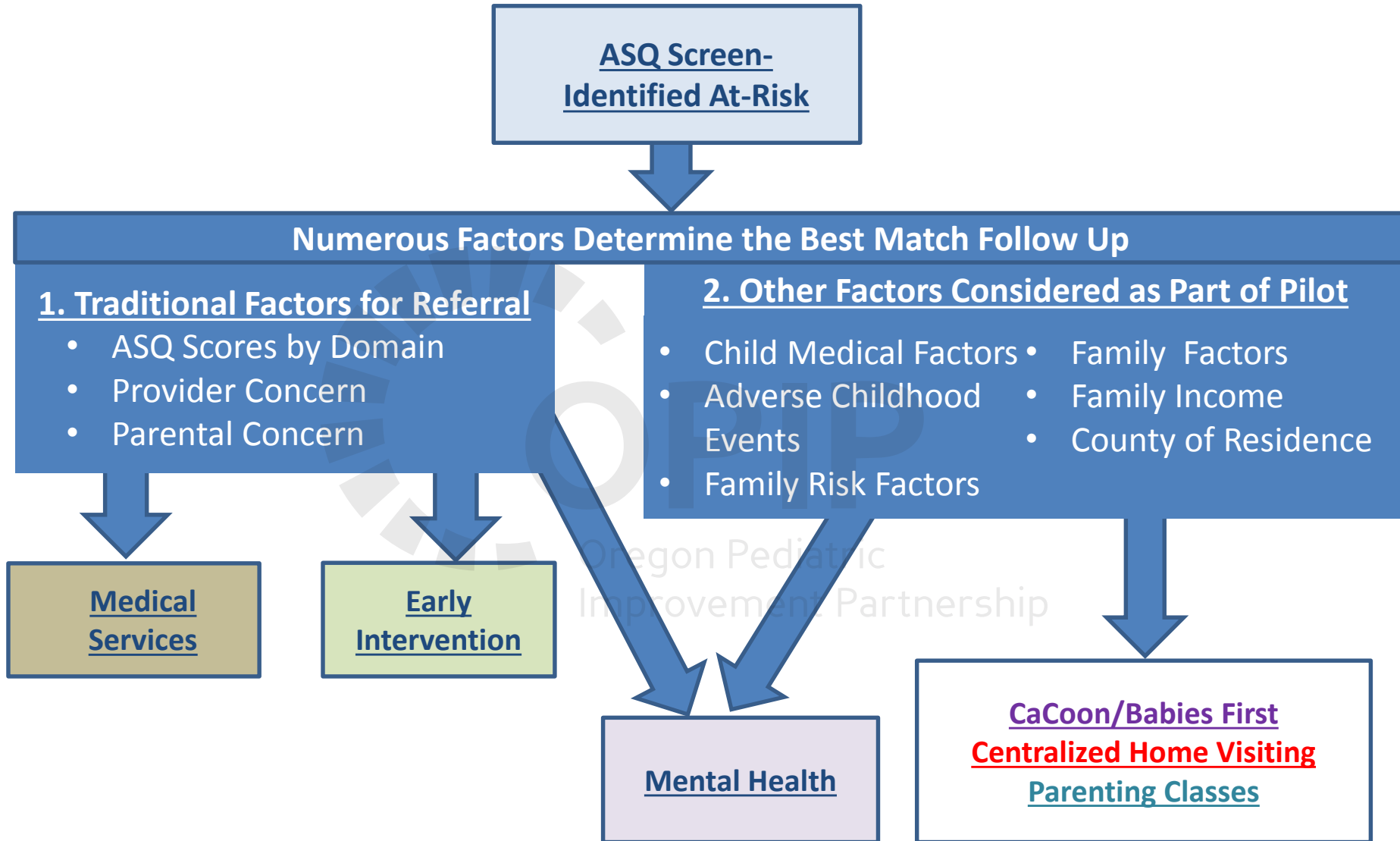
Based on data and community engagement, **six priority referrals** were identified and collaborative partnerships established.

Create 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**

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



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## 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: Ivette 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 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

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*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

# Preliminary Findings from Pilot Sites

1. Enhanced collaboration and coordination across primary care, early intervention, and early learning
2. Tools and resources have been effective in a more family-centered approach and referrals to services
  - Filled a need for specific and community-based information about WHICH kids to refer and HOW
  - More children referred to EI → More children not eligible for EI
    - A significant number of children identified on ASQ will be evaluated and not eligible for Early Intervention
  - Examining population identification rates and capacity of the systems to which they referring
    - Home visiting
    - Mental health services specific to early childhood mental health
3. Disparity in services available to privately insured or children/families that don't meet the priority criterion for home visiting

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## **Hearing from the Front Line:**

# **How this Project is Connecting Front-Line Health Care with the Early Learning System**

**Suzanne Dinsmore, MD**

**Child Health Associates of Salem (CHAoS)**



# Focus of Our Improvement Efforts Within Childhood Health Associates of Salem

1. Examined our practice-level data and the need for improvement, provision of our data to inform the community-level conversations
2. Implementing OPIP's Pilot Medical Decision Referral Algorithm
  - Incorporates ASQ, child and family risk factors
  - Includes community based resources we did and did not know about
  - Pilot with FamilyLink (Centralized home visiting referral)
3. Refined Process for EI Referrals to Get More Child Evaluated
  - Family supports (phone follow-up)
  - Process for using communication back from EI
    - ✓ Child not able to be evaluated
    - ✓ Child not eligible
    - ✓ Child eligible, but on what
4. Parent Support – Using the Education Sheet
  - Value of it to facilitate shared decision making with families
  - Value of it from information management



## Powerful Partnership of Primary Care & Early Learning to Improve Health & Educational Outcomes

### Primary care sees young children 11 times in the first three years of life for well-child care alone

- Unique opportunity to partner with parents and connect, literature shows we are a trusted source of information
- Unique opportunity to gather data to inform discussions about capacity
  - Data is already showing the need far exceeds the capacity
  - Longterm ROI on services provided to young children
  - We are now identifying the kids, but there are not sufficient resources to address what we are identifying
- That said, we see public and privately insured
  - Disparity in services available for privately insured, income though does not support out of pocket expenses
- Opportunity to locate public health services in office for parents reluctant to have come to their home



# Looking Forward

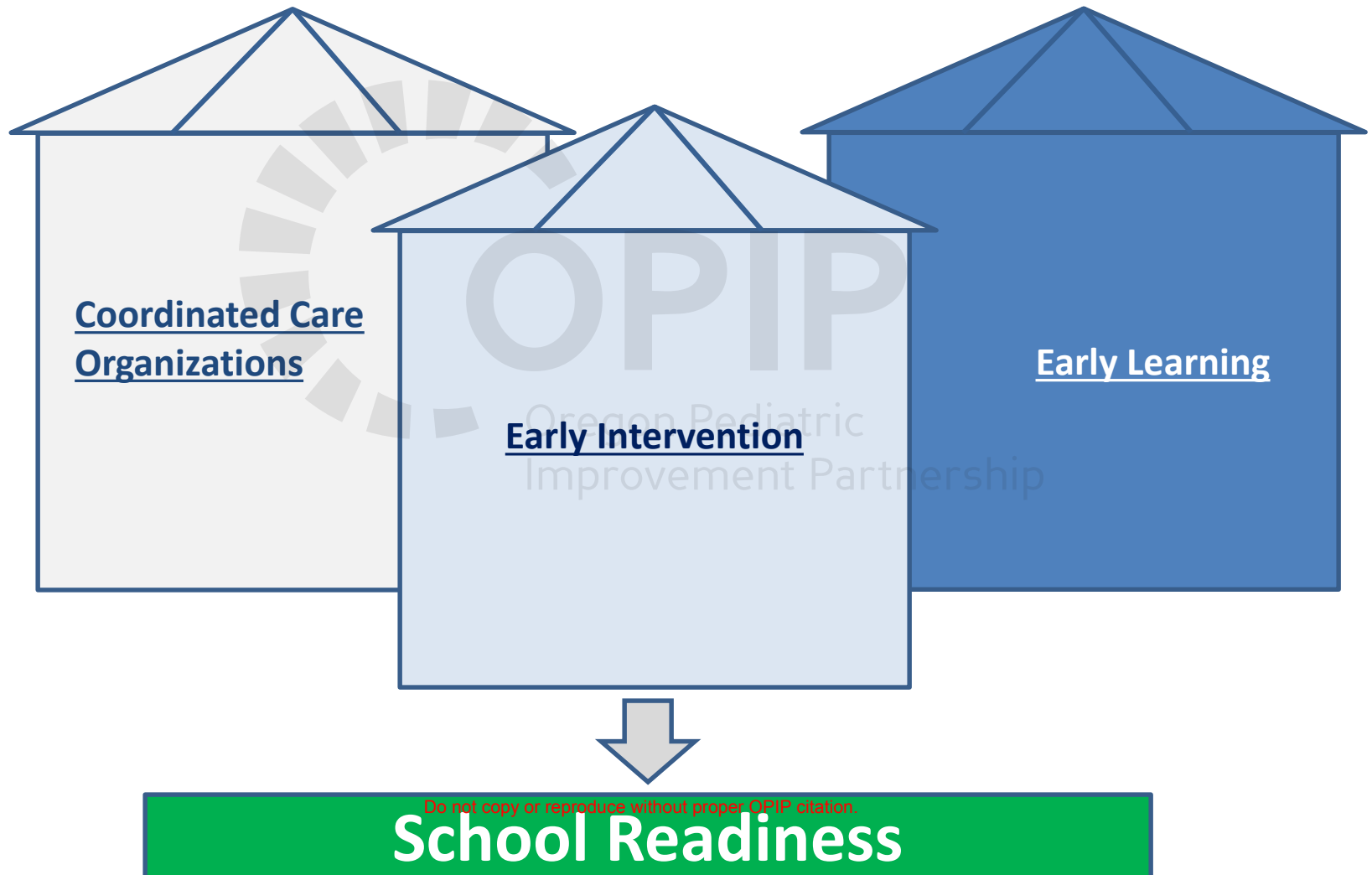


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Fantastic Individual Silos Exist:

Opportunity is to Now Support Coordination Across the Sectors and  
Capacity Funding Within to Serve the Children & Families

We Are Now Identifying In Order to Achieve the Child's Level Outcomes





# Looking Forward: Punchline



- Need to ensure **all young children receive developmental screening**
  - Valid way to identify children who can be served early and have delays addressed with long term positive outcomes in school
  - CCO Benchmark: 60.1%
- Gains in developmental screening **do not** equal improvements in receipt of early service provision to address the delay identified to be ready for school
  - Community-based improvement projects needed that engage multiple sectors including health care, early intervention, and early learning
- Need to address **funding, capacity** for programs for which research has shown that they can effectively address the risks we are identifying to improve health and educational outcomes
  - Developmental pediatrician
  - Early Intervention
  - Home Visiting
  - Mental Health
  - Parenting supports (e.g. Parenting Classes)
- High functioning **Early Learning Hubs are a critical and essential component, but not sufficient** on their own

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# Special Thanks to Our Funders and Amazing Collaborators

- OHA
- WESD
- Parent Advisors
- Partners in Marion, Polk & Yamhill
  - 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
  - Family Link
  - Family CORE
  - Marion County Health Department
  - Polk County Health Department



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# Questions? Door is Always Open

Colleen Reuland:  
[reulandc@ohsu.edu](mailto:reulandc@ohsu.edu)

503-494-0456



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

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## FODDER SLIDES FOR IF QUESTIONS ARE ASKED ABOUT NEXT STEPS



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# Opportunities to Build Off This Improvement Pilot

- 1. Build off tools, methods and processes developed in this project within these communities**
  - Support spread of primary care models to other primary care sites
  - Support the primary care sites NOT doing developmental screening, prioritize sites who care for ethnic groups least likely to be screened
  - Modify tools/strategies for others conducting screening (e.g. childcare providers)
- 2. Support other communities to refine the tools to their own settings**
  - Requires a cross system focus and engagement of the key partners noted: Primary Care, CCOs, EI & Education, Early Learning Hubs, Early Learning System providers
  - Learning collaborative across communities
- 3. Engagement of EI at the State and Local Contractor level on tools and methods**
  - Incorporation of the feedback loops and summary form across EI contractors
  - Examination of ASQ presenting scores and EI Eligibility statewide, Explore methods to be efficient and thoughtful about resources used to evaluate the child

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# Needs Identified in this Project Not Addressed

- 1. Follow-up for children identified at-risk, and likely to not be kindergarten ready, but who unable to be served by existing programs**
  - Privately insured, but can't afford private therapies
  - Children with family risk factors impacting development and readiness (social-emotional regulation), but for whom current funding or priorities force services to deem them ineligible
- 2. Assess and address cultural variations needed to ensure follow-up**
- 3. Models for parent to parent support, parent navigators for this population**