



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

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Presenters:

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Lisa Harnisch - Marion and Polk Early Learning Hub

Jennifer Richter - Yamhill Community Care Organization, Yamhill Early Learning Hub

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



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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.

1

Children arrive more ready for kindergarten

2

Families are stable and attached

3

Services are coordinated and aligned

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

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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



hub inc.
MARION & POLK EARLY LEARNING HUB

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



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
 - Early Intervention
 - Early Learning

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.

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



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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

Coordinated Care Organizations:

- 1) Willamette Valley Community Health
- 2) Yamhill Coordinated Care Organizations

Early Intervention Contractor
Serving All 3 Counties:
Willamette Education Service District

Early Learning Hubs

- 1) Marion and Polk Early Learning Hub
- 2) Yamhill Early Learning Hub

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

<p>1) CCOs (WVCH, YCCO)</p> <ul style="list-style-type: none"> • Medical Director • Metrics Staff • Practice Support Staff • Mental Health Director • Staff that oversee services for children • Liaison to Early Learning Hubs • OHA Innovator Agent 	<p>2) Primary Care</p> <ul style="list-style-type: none"> • Practices that see large number of children and are doing developmental screening • Practice staff engaged included: <ul style="list-style-type: none"> ✓ Physician ✓ Care Coordinator ✓ Referral Coordinator ✓ Practice Manager 	<p>3) EI & Education</p> <ul style="list-style-type: none"> • EI/ECSE Program Coordinator • EI Referral Intake Coordinator • School District Representative 	<p>4) Early Learning Hub (Yamhill Early Learning Hub, Marion and Polk Early Learning Hub)</p> <ul style="list-style-type: none"> • Director or Executive Director • Community Engagement Staff • Staff involved in efforts around developmental screening 	<p>5) Home Visiting and Head Start/Early Head Start</p> <ul style="list-style-type: none"> • Centralized home visiting referral programs • Public Health/ CaCoon/ BabiesFirst • Healthy Families • Other community services that provide home visiting • Early Head Start and Head Start 	<p>6) Child Care and Parenting Supports</p> <ul style="list-style-type: none"> • Childcare Resource and Referral Center • Childcare Centers conducting screening • Oregon Parenting Education Collaborative entities
<p>7) Infant and Early Childhood Mental Health</p> <ul style="list-style-type: none"> • 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?

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**

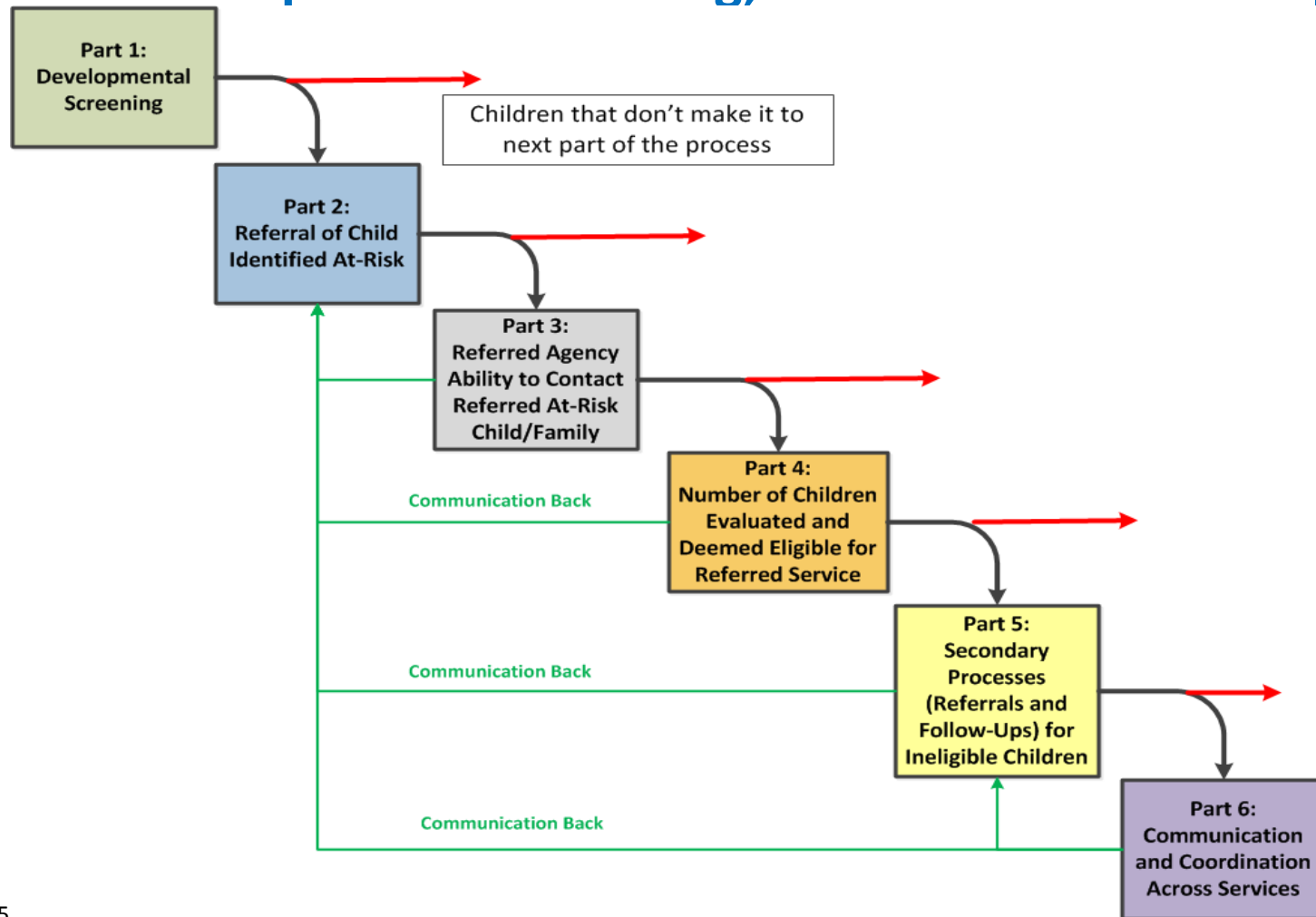
Community-Based Improvement Effort

- 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



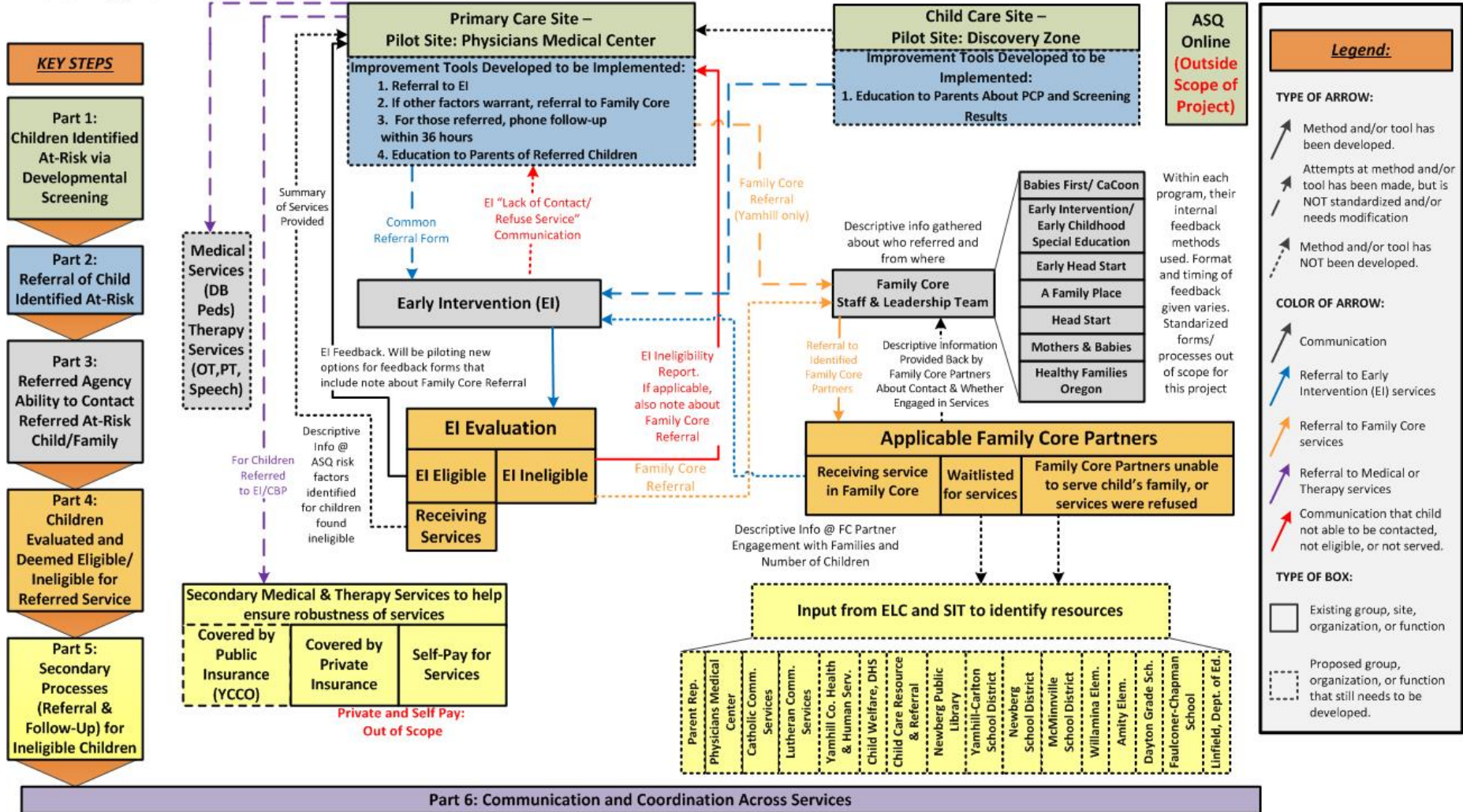
Qualitative Data: Stakeholder Interviews

- 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

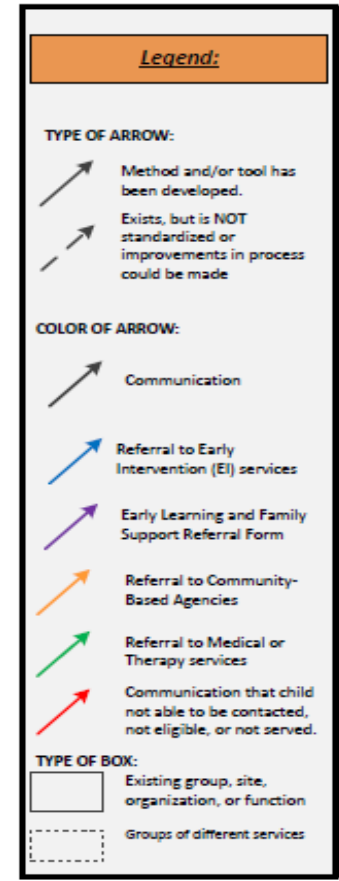
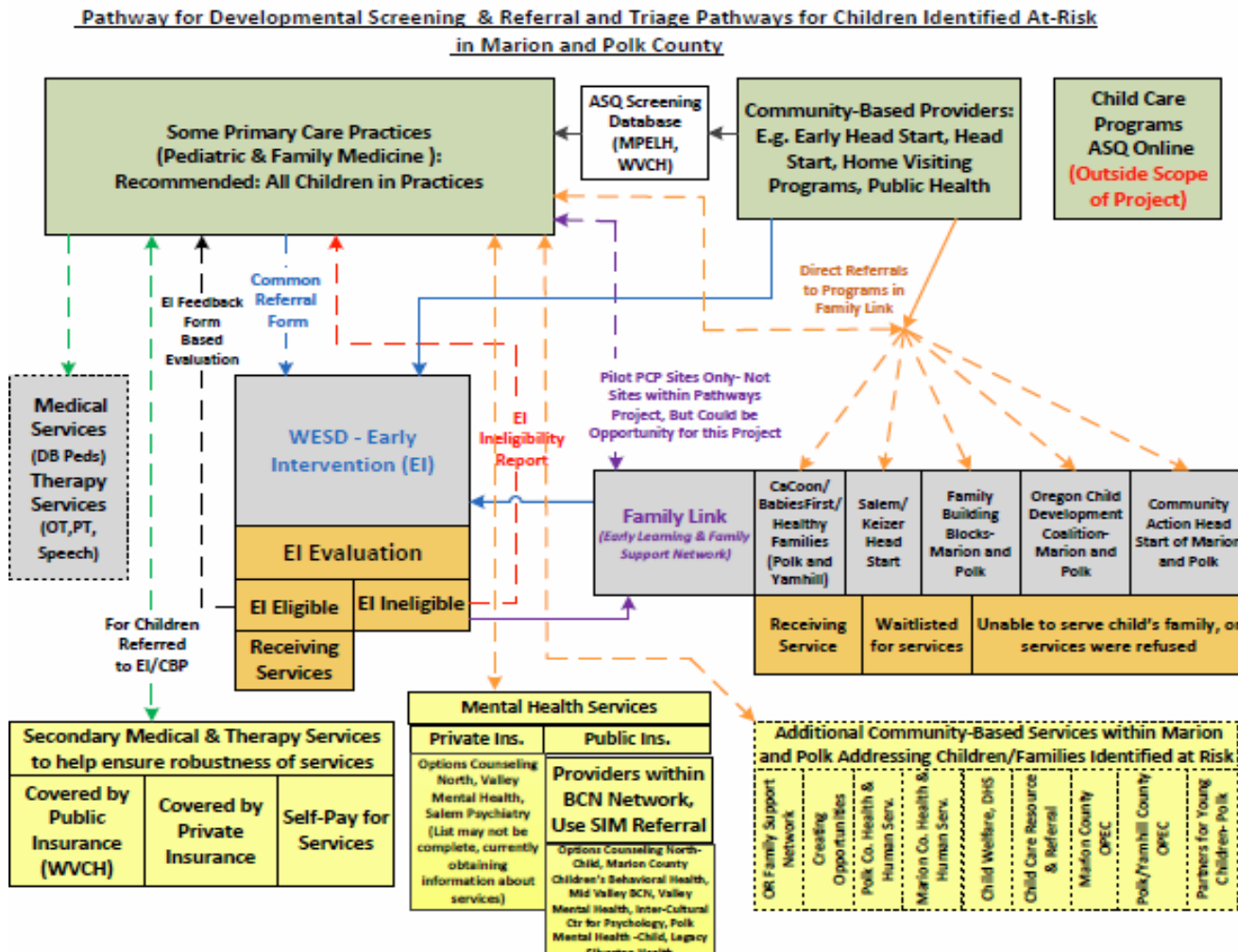
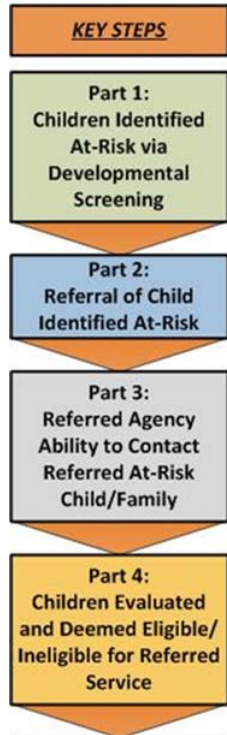
Community Asset Mapping and Pathway Identification in Yamhill County

Version 12/7/16

Yamhill Referral and Triage Map to Improve Pathways from Developmental Screening to Services



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 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

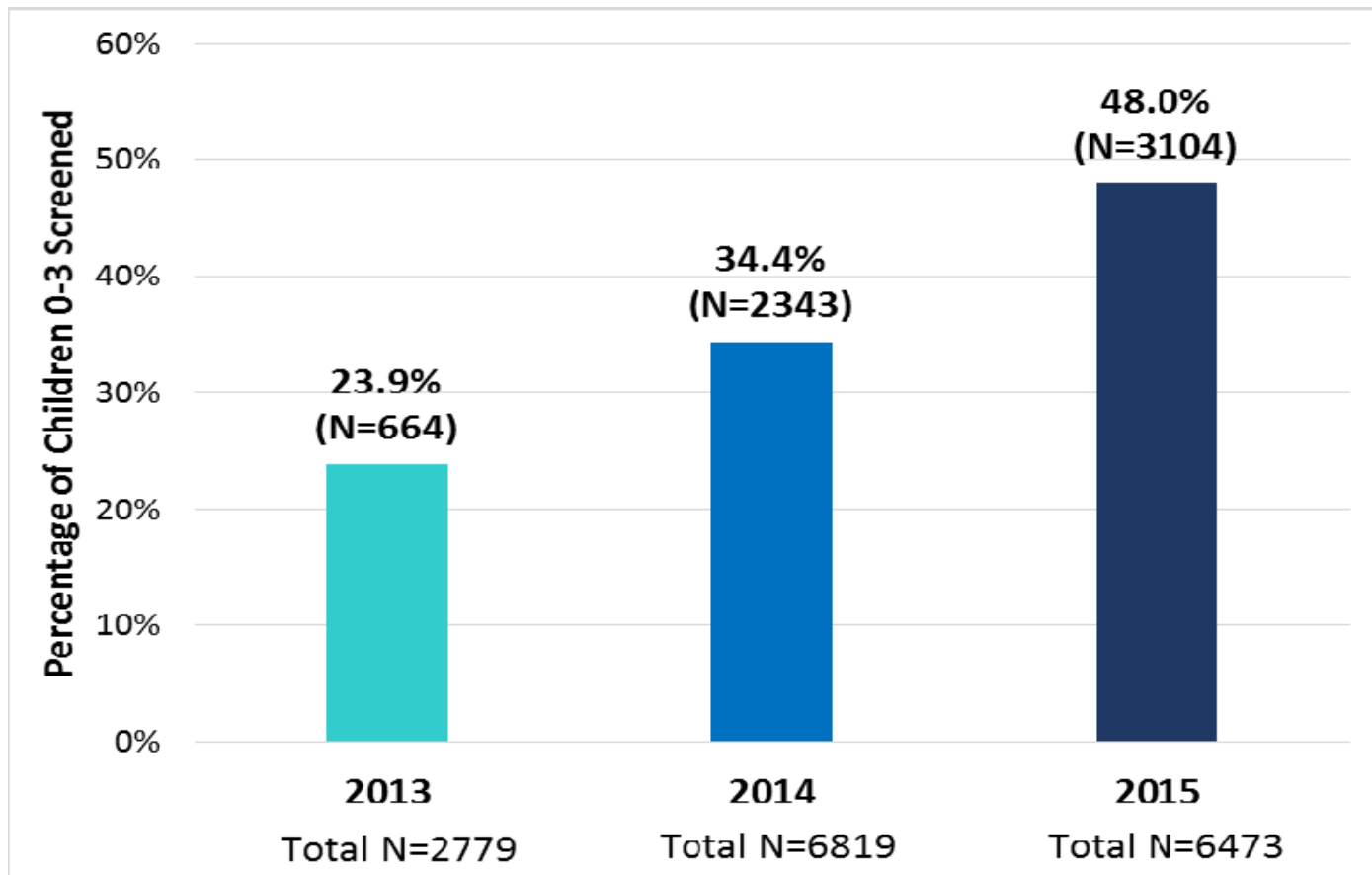
#4: Better communication between multiple entities working with the same family is necessary and appreciated

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

Quantitative Data Collected to Inform Baseline & Evaluation Data

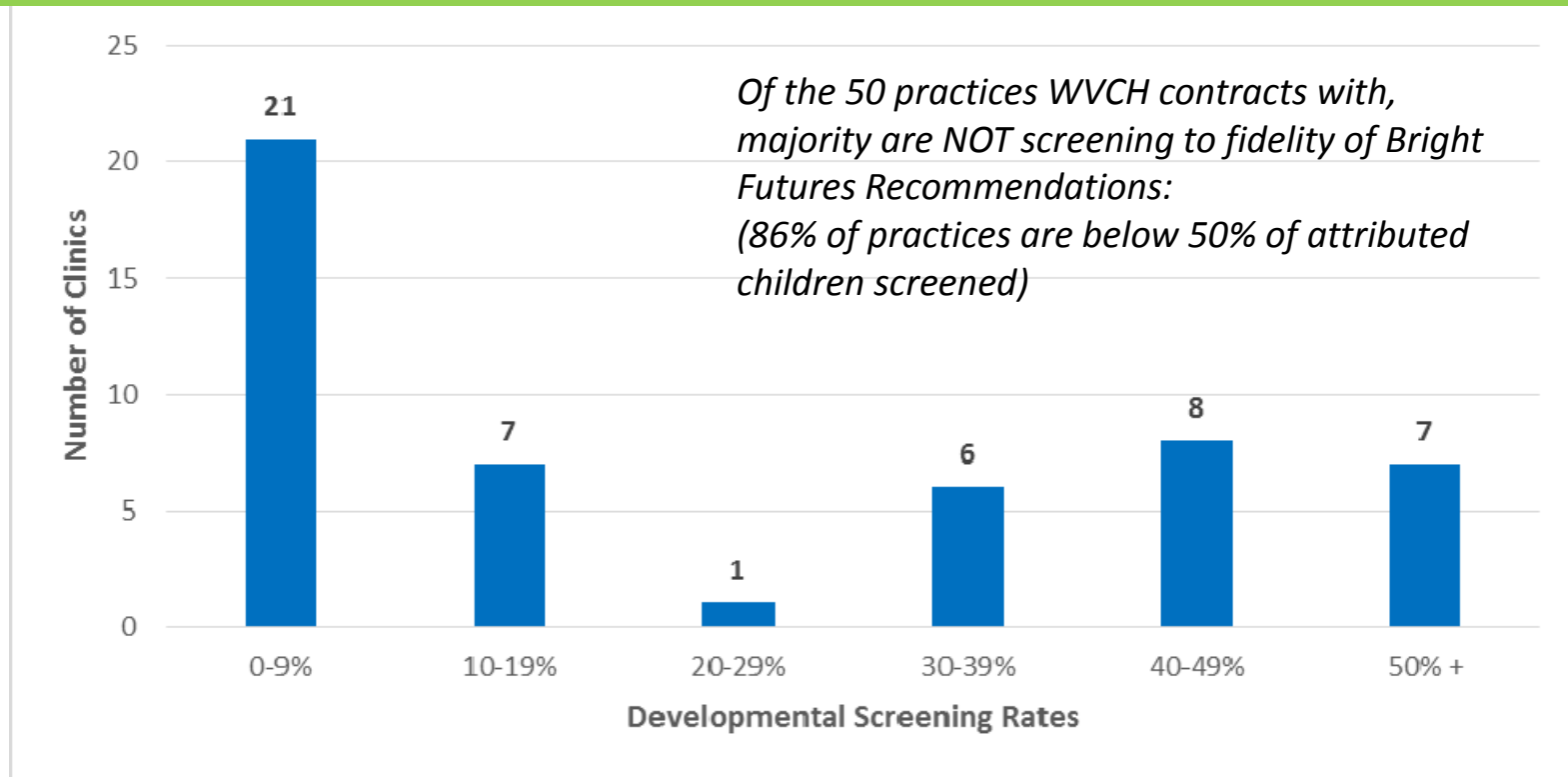
Focus of Metrics			
	CCO Data Based on Claims (Health System for Publicly Insured)	Primary Care Practice Data: Based on EMR	Early Intervention Data: Based on Data in ECWeb, Manual Review
Developmental Screening	X	X	
Of those screened in Primary Care:			
# at-risk , Types of Risk		X	
Referrals		X	X
Provision 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

Primary Care Practice Data

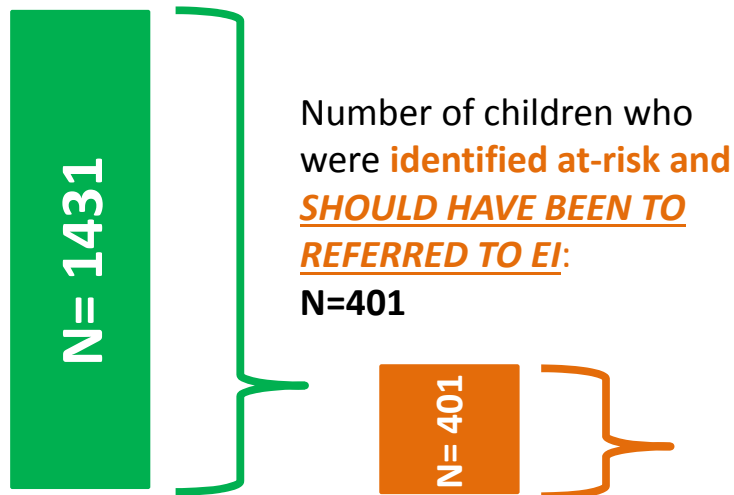
Highlight of Findings:

- 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%
 - Meaning 65-80% of children identified at-risk not referred to Early Intervention



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



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

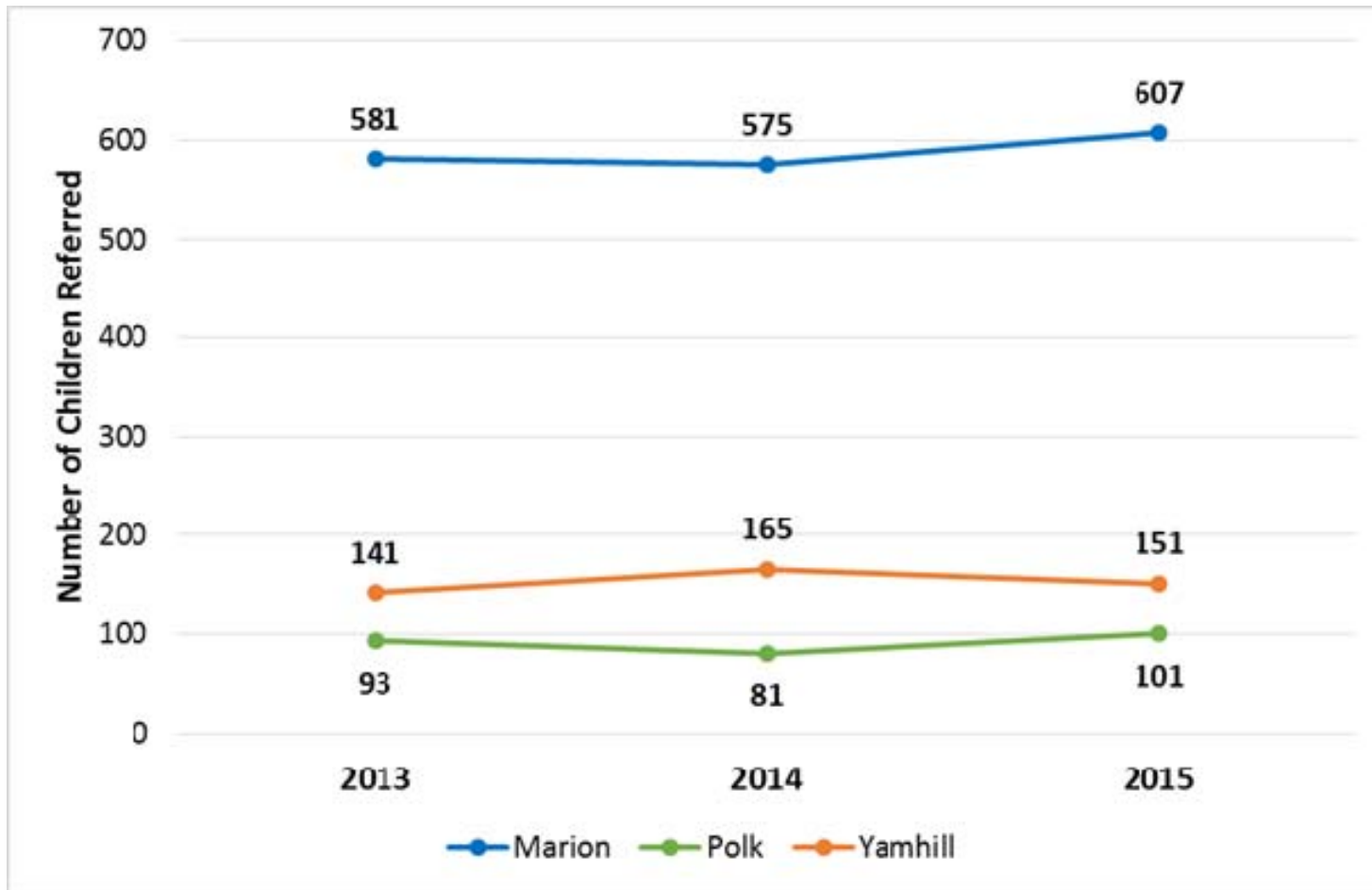
#1: Indication of Follow-Up to Developmental Screening

- Child find rates
- Numbers of referrals
- Number of referrals able to be contacted AND evaluated
- Outcome of referrals (Eligible, Ineligible)

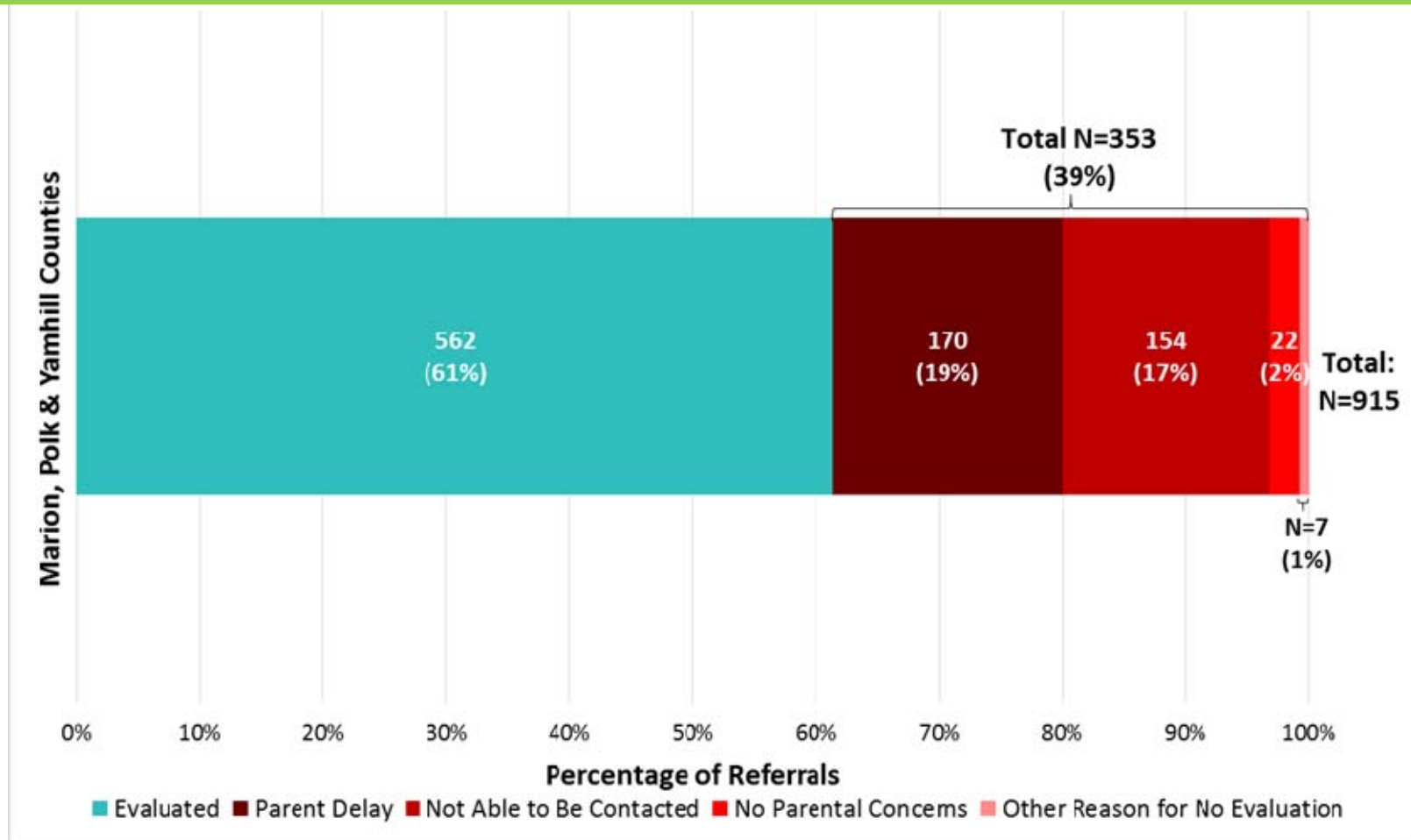
#2: Data to Inform Processes for At-Risk, But EI Ineligible Children

- Evaluation outcome results by referral and child characteristics

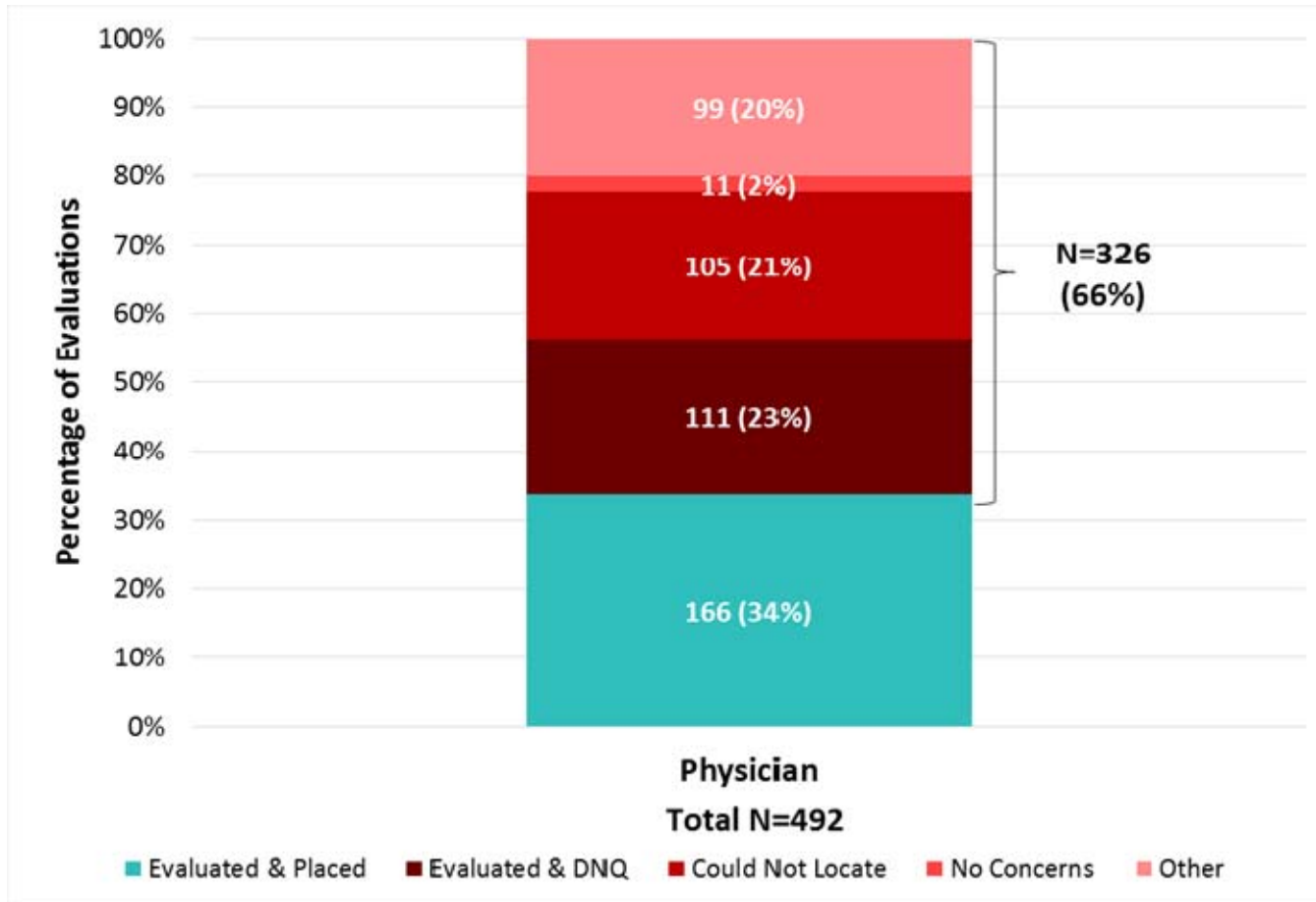
Number of CHILDREN referred to Early Intervention



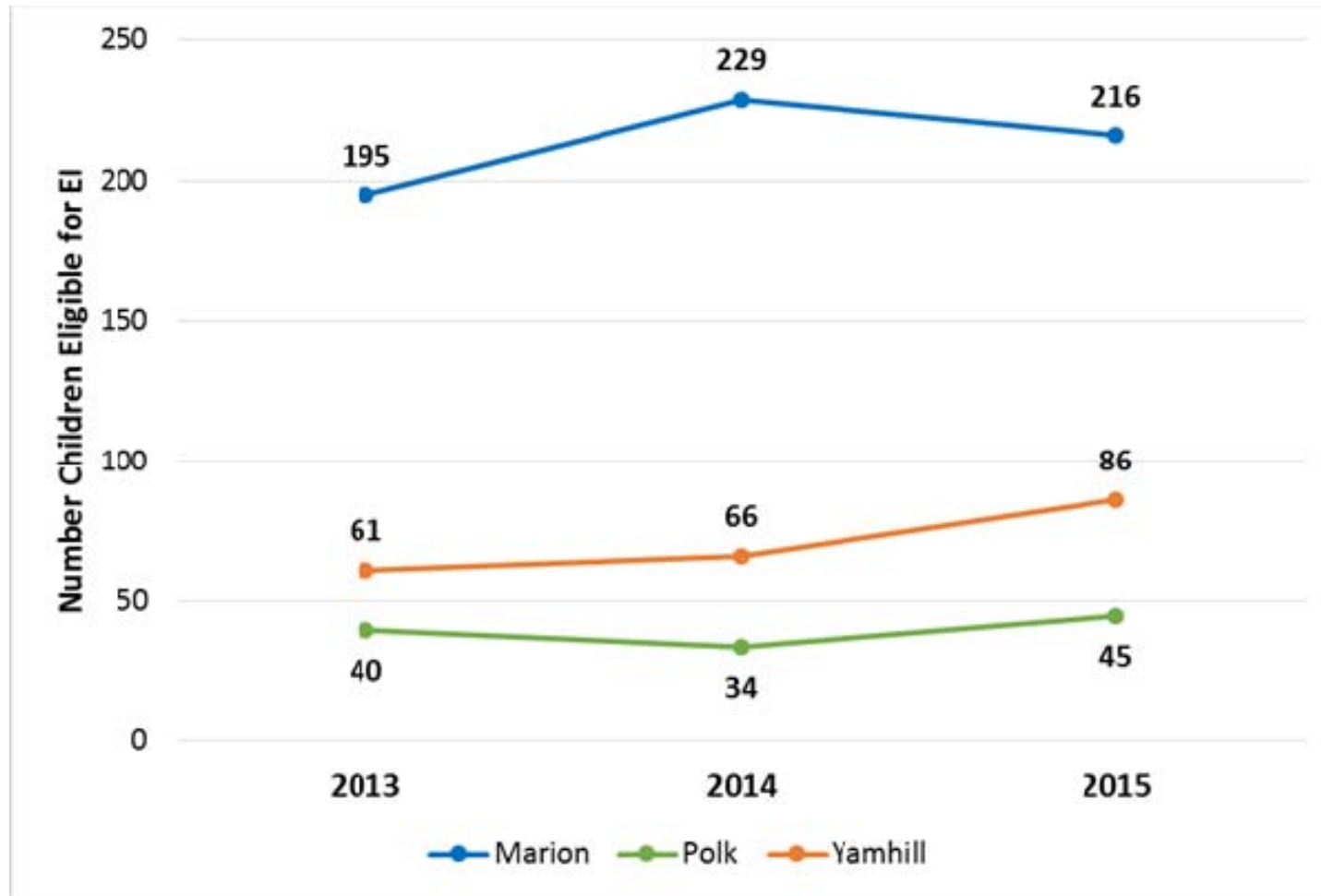
2015 WESD EI Referral Outcomes in Marion, Polk, & Yamhill Counties



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



Number of CHILDREN Receiving EI Services



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

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 Parenting Classes)

Questions about Qualitative & Quantitative Data

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

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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

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anchored to:
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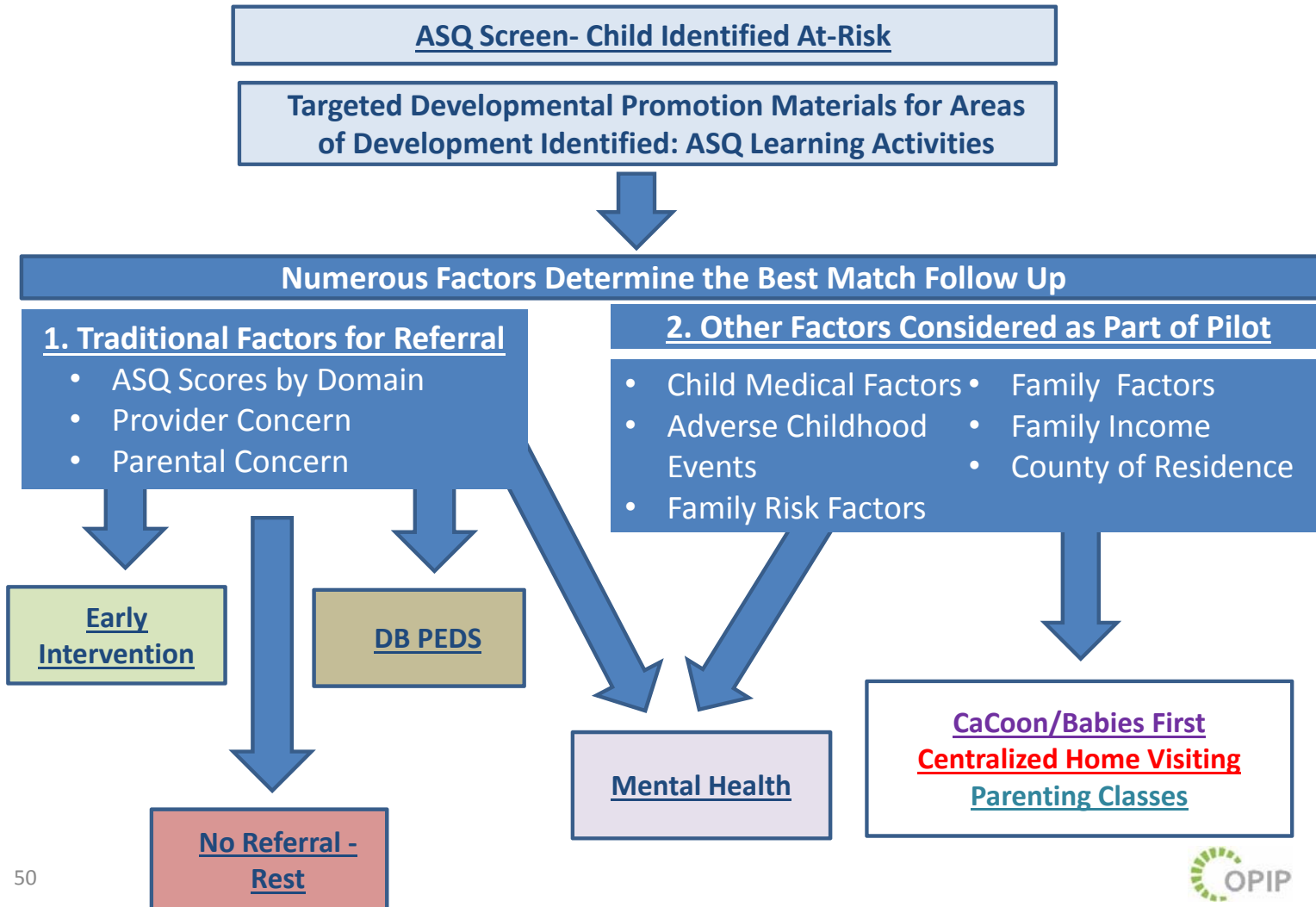


Development of Decision Support Tools for Primary Care Providers to Identify Best Match Services in Community

- 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

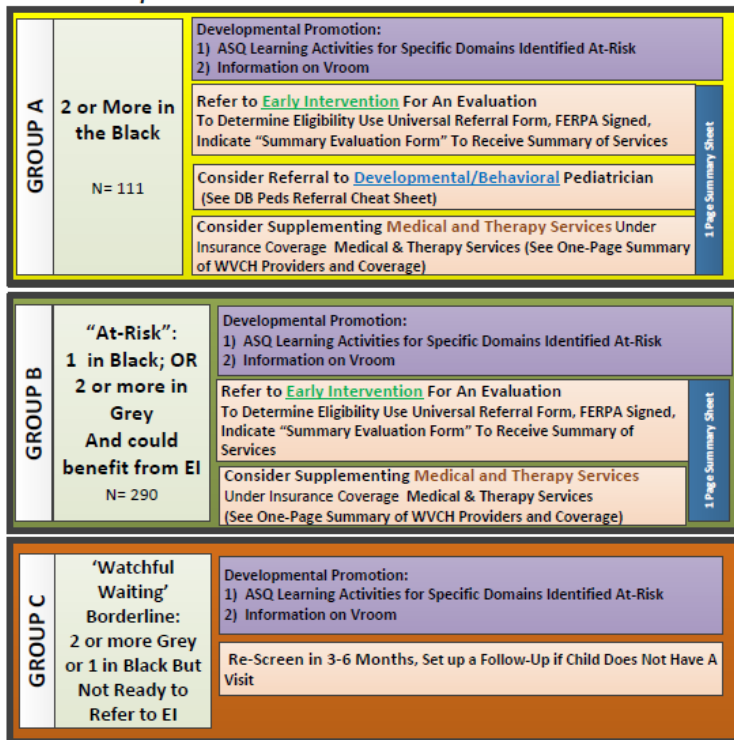


Pathways for Follow-Up to Development Screening for Children 0-3 in Marion and Polk County

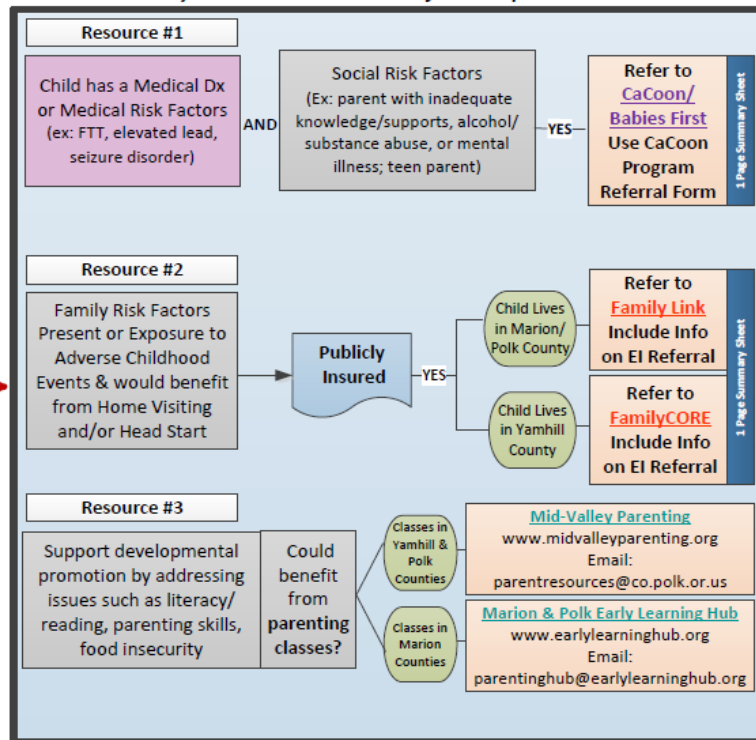
Figure 1.0: Decision Tree - Pilot to Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks



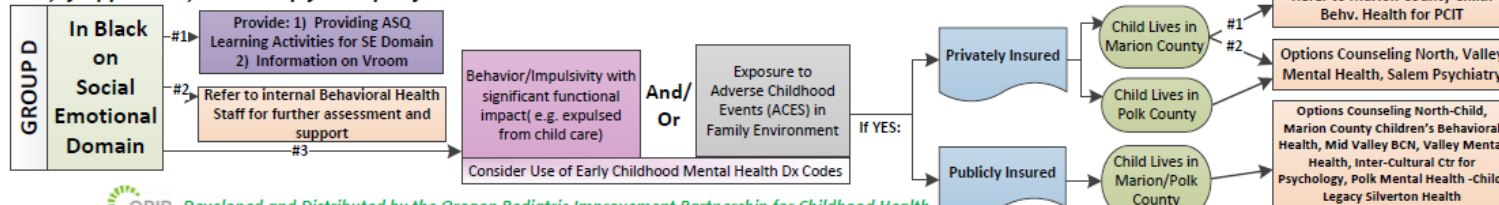
Follow-Up Based on Total Score Across Domains:

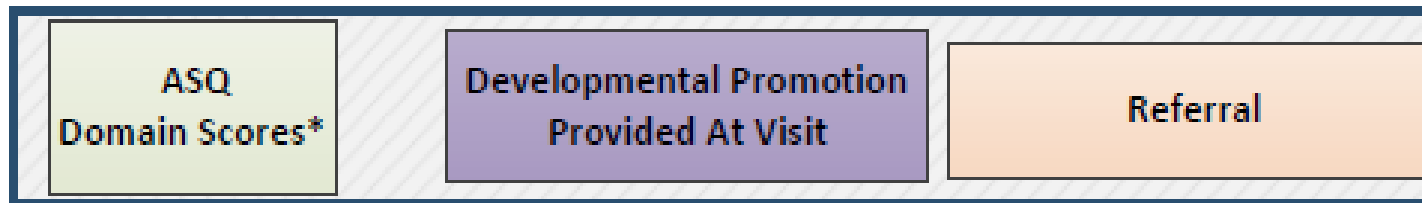


Three Community Resources To Consider for Groups A-D



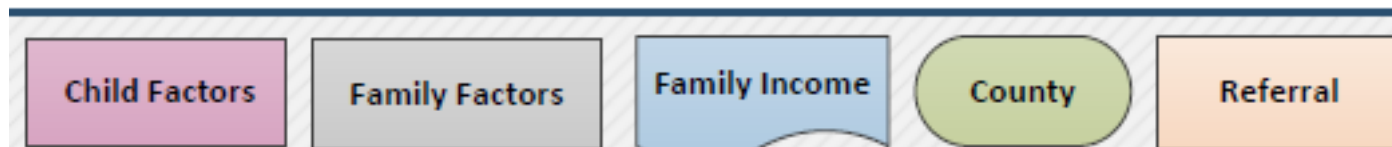
And, If Applicable, Follow-Up for a Specific Domain:





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!

vroom Brain Building Basics

find out more
joinvroom.org

5 things to remember
for building your child's brain

1. Look



Make eye contact so you and your child are looking at each other.

2. Chat



Talk about the things you see, hear and do together, and explain what's happening around you.

3. Follow



Take your child's lead by responding to their sounds and actions, even before they are old enough to talk. When they do start talking, ask follow up questions like "What do you think...?" or "Why did you like that?"

4. Stretch



Make each moment longer by building upon what your child does and says.

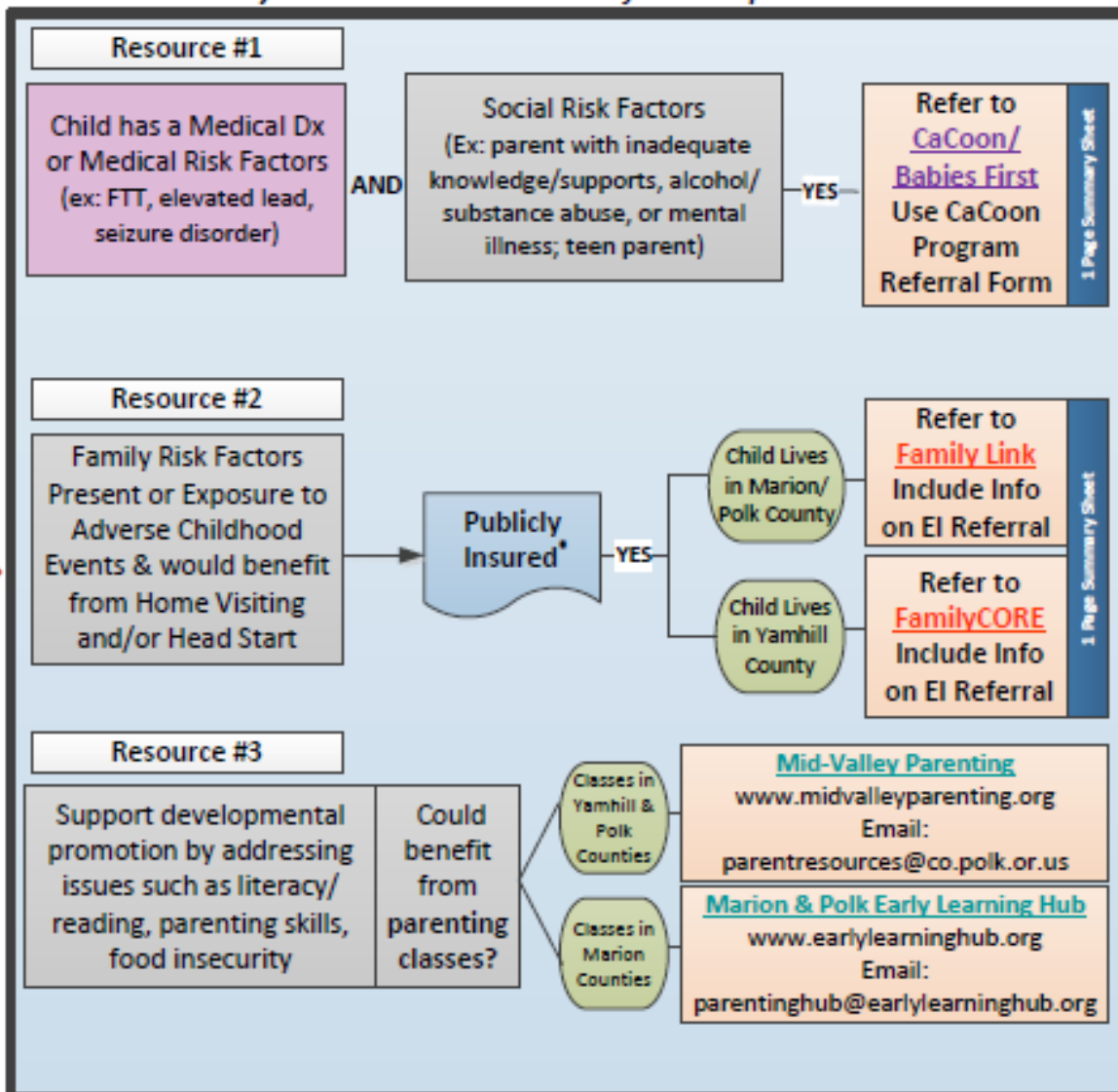
5. Take Turns



With sounds, words, faces and actions, go back and forth to create a conversation or a game.

OPIIP

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: Yvette Guevara
Referral Coordinator
503-590-7431 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 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 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).



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

1 | Page

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

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

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

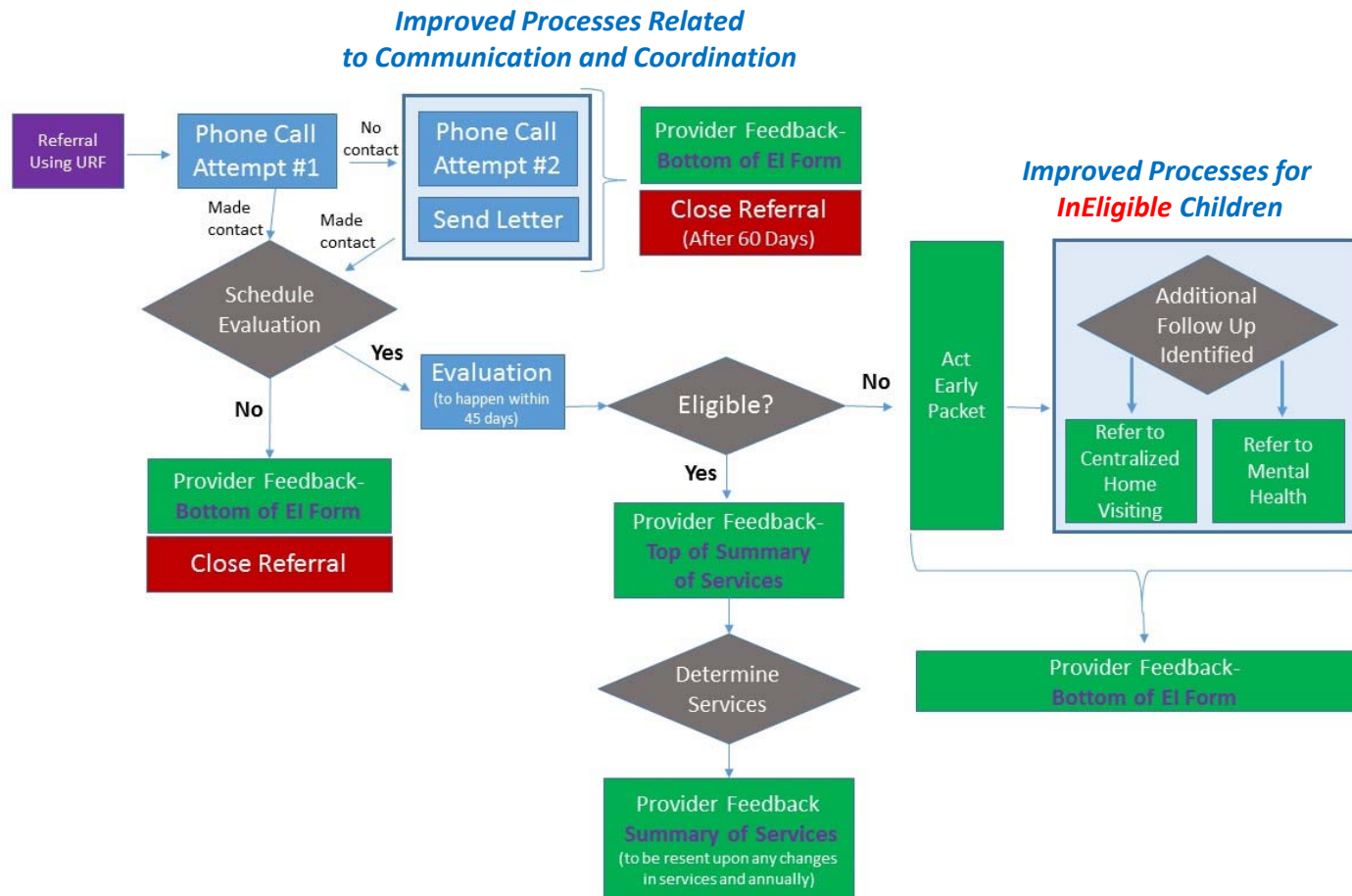
Implement new processes focused on:

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



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

GREEN- new process implemented



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/ECSE 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/di/outreach/ocys/ehp/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

EVEECSE 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: _____

EVEECSE County Contact/Phone: _____ Notes: _____

Attachments as requested above: _____

Unable to contact parent Unable to complete evaluation EVEECSE will close referral on ____/____/____

*The EVEECSE 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 RESULTS TO REFERRING PROVIDER

EVEECSE Services: please complete this portion, attach requested information, and return to the referral source above.

Family contacted on 07 / ____ / ____ The child was evaluated on ____ / ____ / ____ and was found to be:

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

EVEECSE 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 EVEECSE will close referral on 9 / 1 / 16 due to NO CONTACT

EVEECSE Referral Form may be duplicated and downloaded at: <http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/dev-screening-and-referrals.cfm>

RECEIVED

Form Rev. 10/22/2013

OCT 11 2016

BY: AM

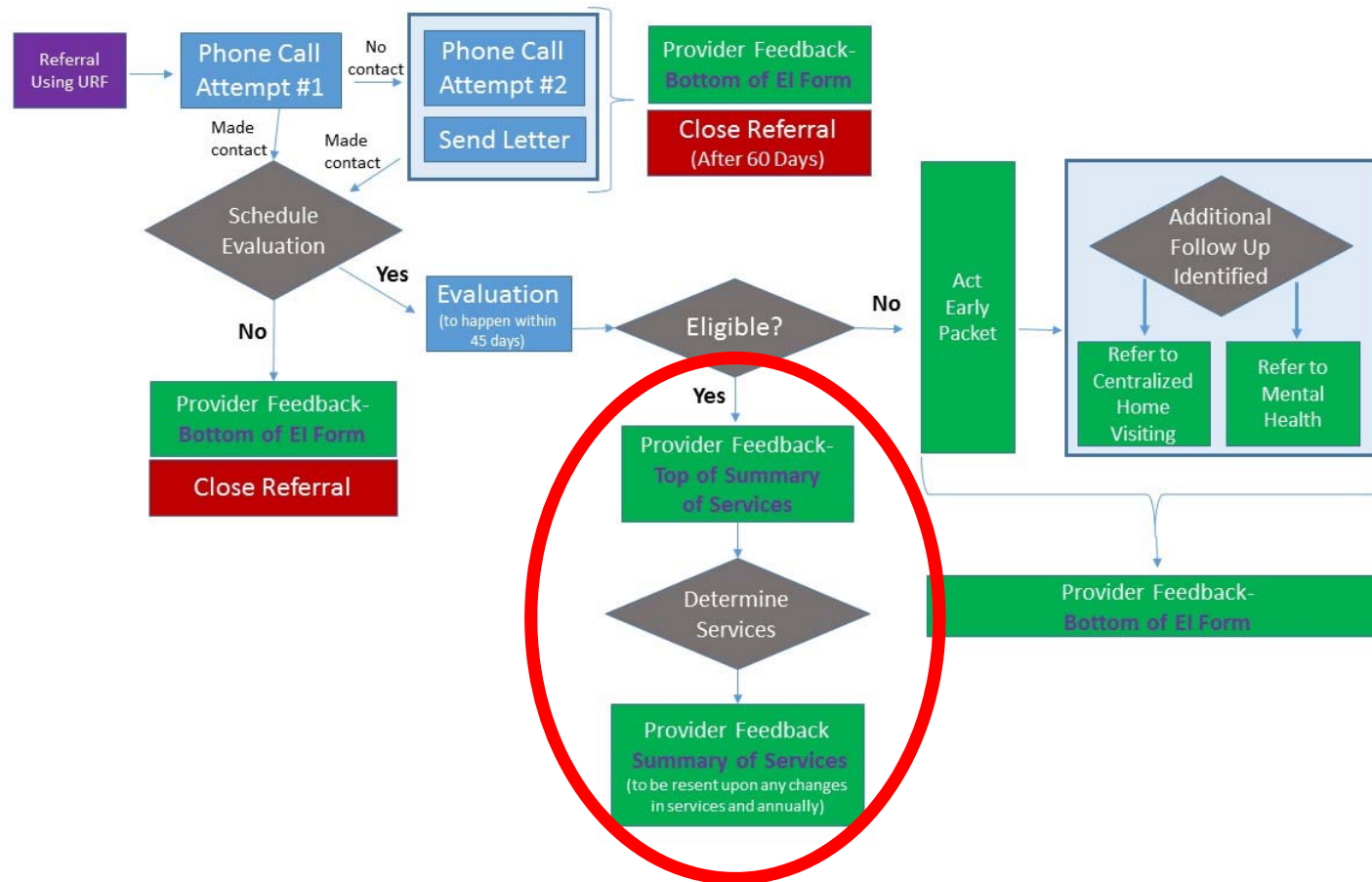
8/12 vm 8/20 vm

 9/1 Letter


W 13


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

GREEN- new process implemented



One-Page Summary of Services





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 patient _____ 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

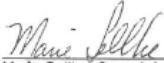
A new Individual Family Service Plan (IFSP) was developed for _____ on 11/16/16. These services will be reviewed again no later than 05/15/17.

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

Services Provided by:	Frequency	Current Provider
<input type="checkbox"/> Early Intervention Specialist	_____	_____
<input type="checkbox"/> Occupational Therapist	_____	_____
<input type="checkbox"/> Physical Therapist	_____	_____
<input checked="" type="checkbox"/> Speech Language Pathologist	1x/2 weeks; 45 minutes	Marie Sellke
<input checked="" type="checkbox"/> 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 Sellke 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 Sellke, 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



If you have concerns about your child's development please contact:
Marion, Polk & Yamhill Counties
Toll Free Number (888)560-4666
sandra.gibson@wesd.org



Willamette
EDUCATION SERVICE DISTRICT

Learn the Signs. Act Early.

www.cdc.gov/milestones
1-800-CDC-INFO



Adapted from CARING FOR YOUR BABY AND YOUNG CHILD: BIRTH TO AGE 5, Fifth Edition, edited by Steven Shelov and Tanya Remer Altmann © 1991, 1993, 1998, 2004, 2009 by the American Academy of Pediatrics and BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS, Third Edition, edited by Joseph Hagan, Jr., Judith S. Shaw, and Paula M. Duncan, 2006, Elk Grove Village, IL: American Academy of Pediatrics.
Special acknowledgements to Susan P. Berger, PhD; Jenny Burt, PhD; Margaret Greco, MD; Katie Green, MPH, CHES; Georgina Peacock, MD, MPH; Lara Robinson, PhD, MPH; Camille Smith, MS, EdS; Julia Whitney, BS; and Rebecca Wolf, MA.

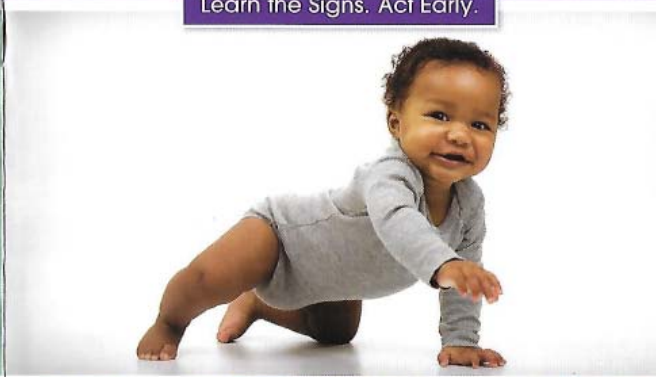
Department of Health and Human Services
Centers for Disease Control and Prevention



Centers for Disease Control and Prevention
www.cdc.gov/milestones
1-800-CDC-INFO

Milestone Moments


Learn the Signs. Act Early.





You can follow your child's development by watching how he or she plays, learns, speaks, and acts.
Look inside for milestones to watch for in your child and how you can help your child learn and grow.

Department of Health and Human Services
Centers for Disease Control and Prevention



Centers for Disease Control and Prevention
www.cdc.gov/milestones
1-800-CDC-INFO

220786

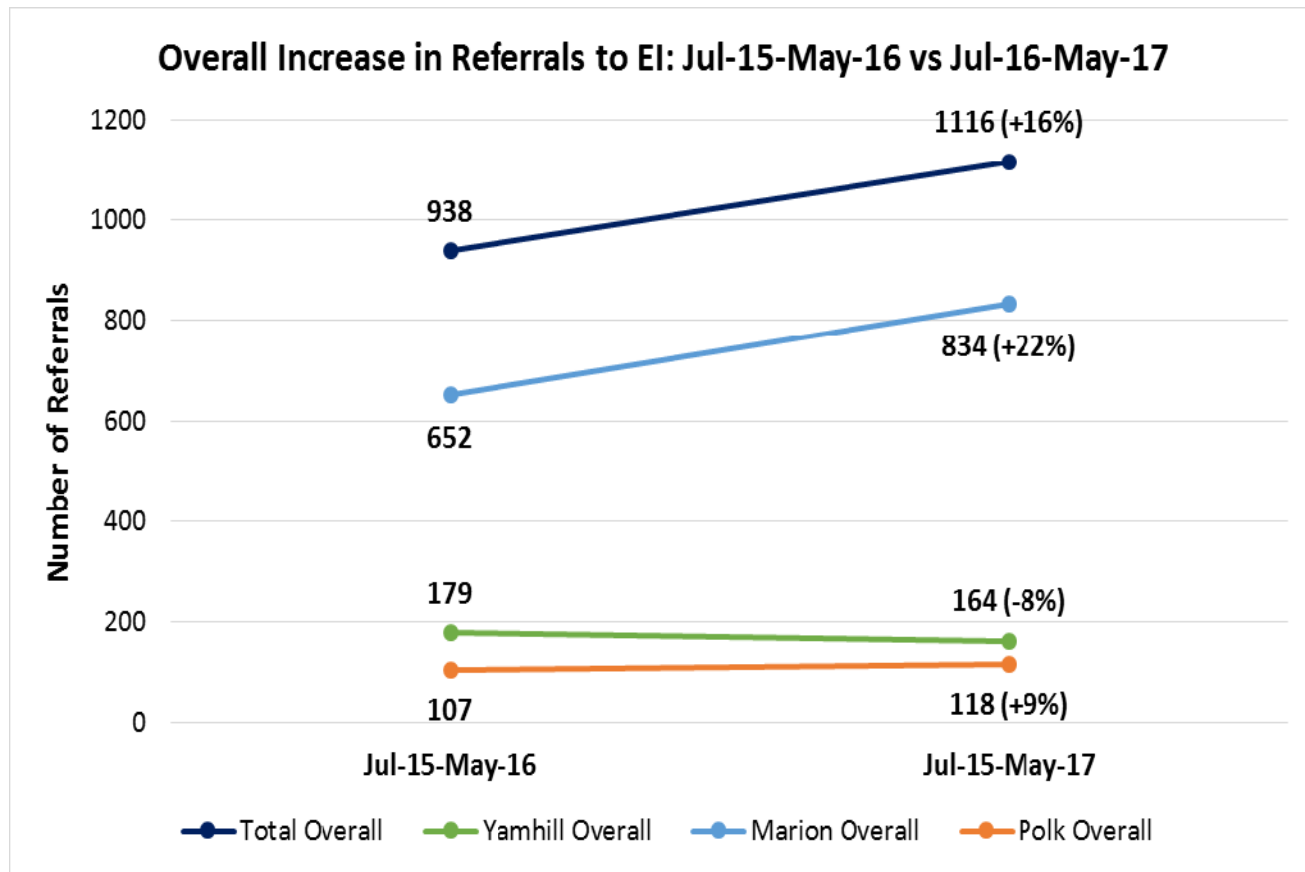
Successes in WESD Efforts

- 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

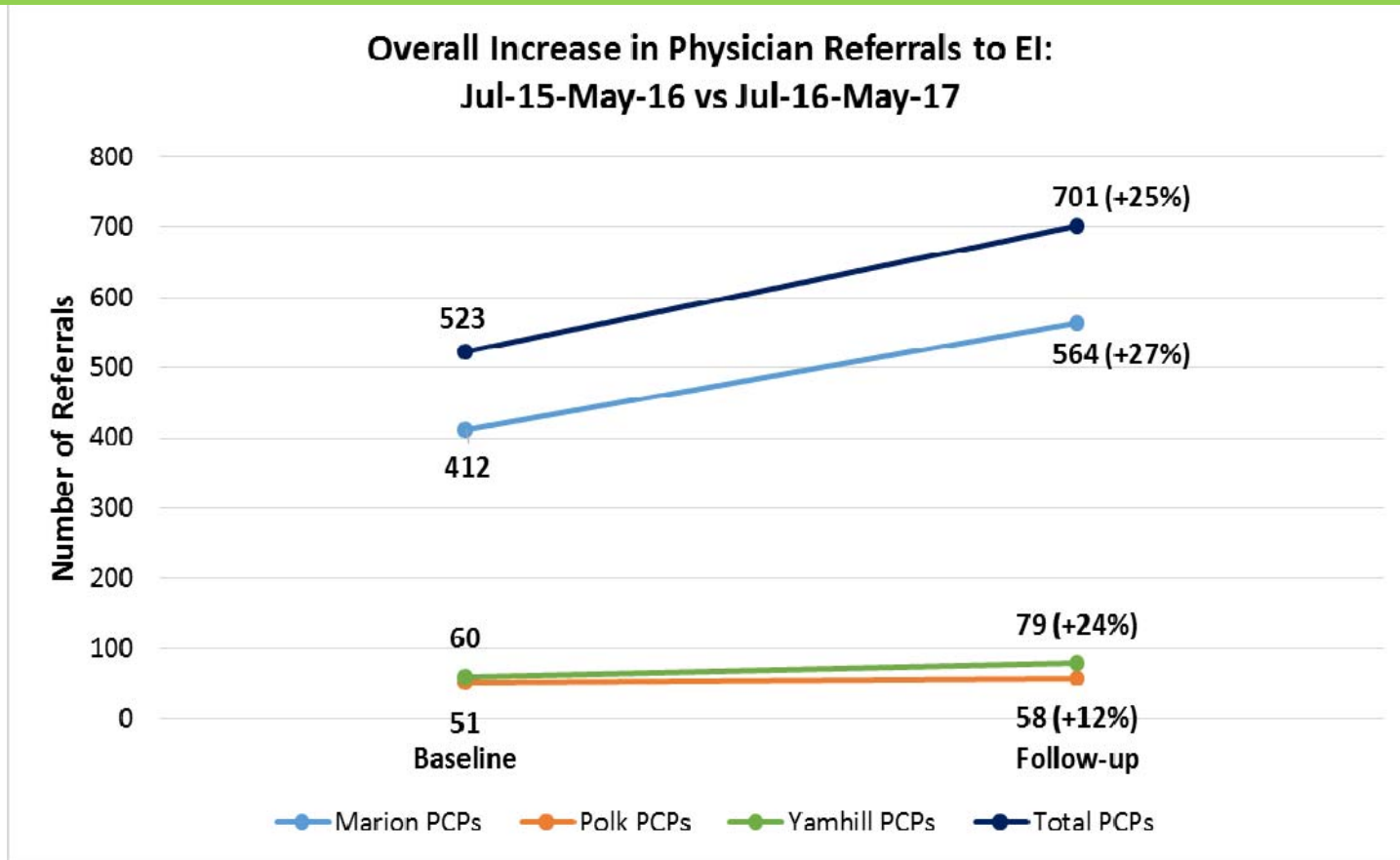
From Our Perspective: **Barriers** to Our Efforts

- **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
 - Need for services to address moderately delayed given impact
- **Difference between children identified by the ASQ vs. EI Eligibility and impact on referral, impacts referrals to WESD**

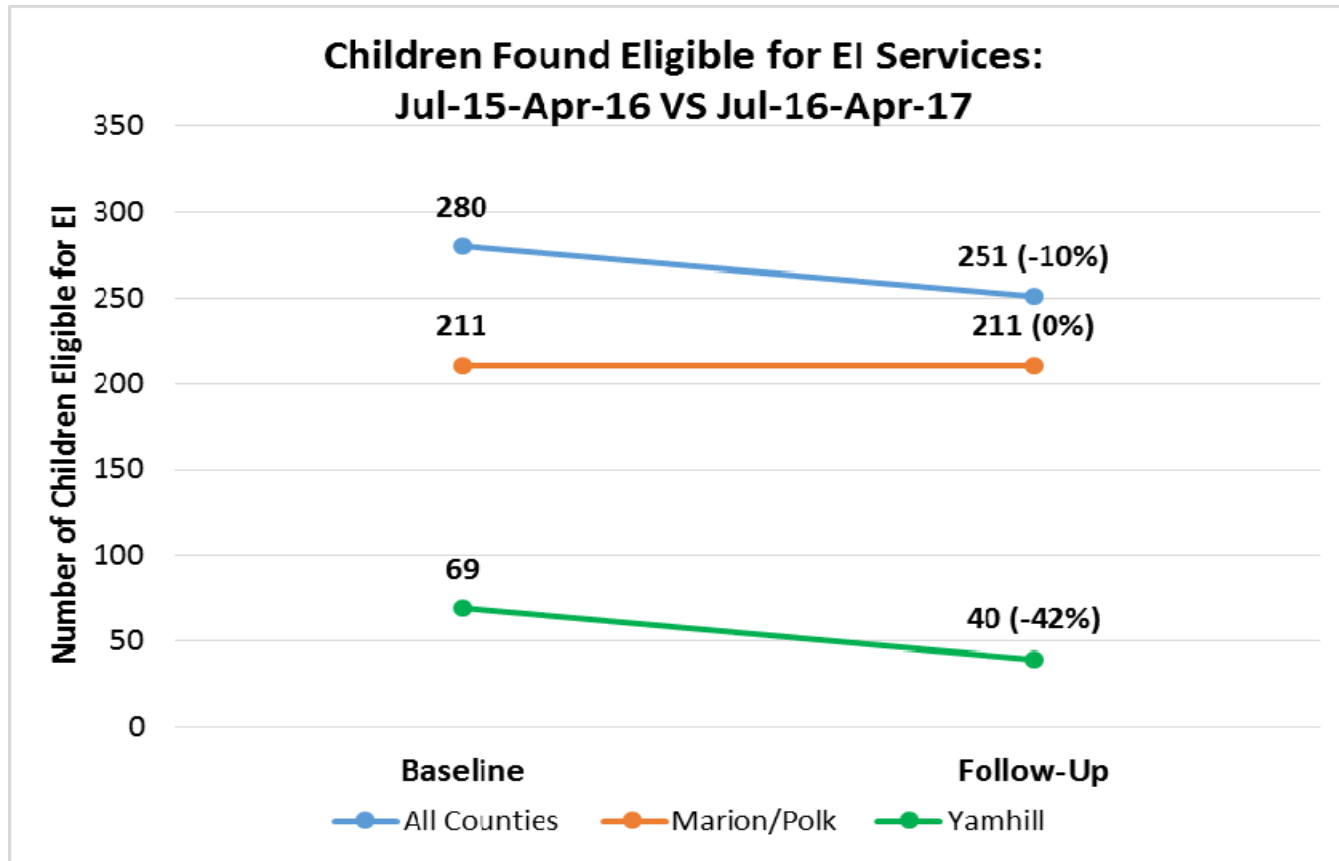
Over Course of Project: Increase in Referrals to Early Intervention



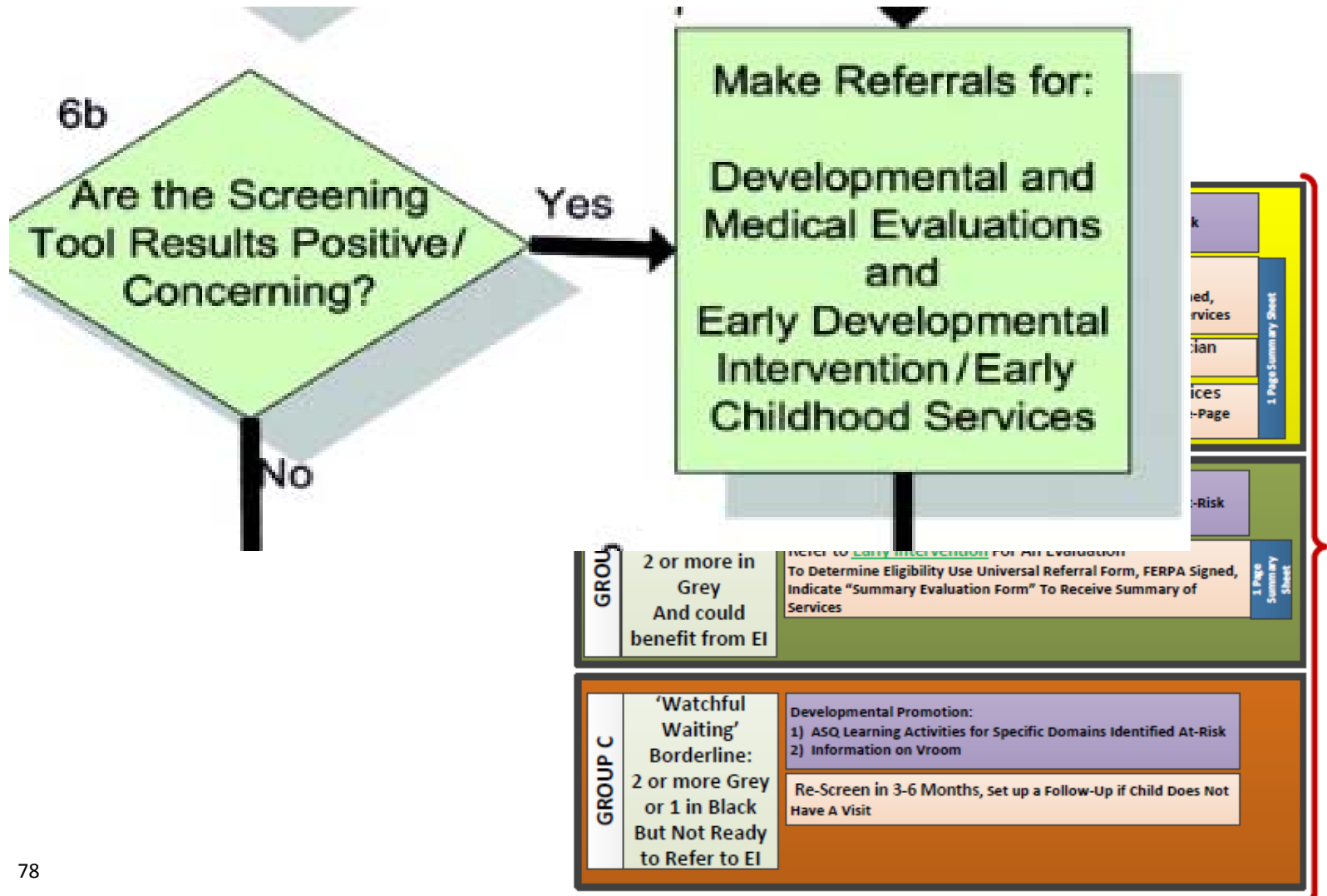
Over Course of Project: Increase in Physician Referrals to EI Largely Driven by Pilot Sites



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



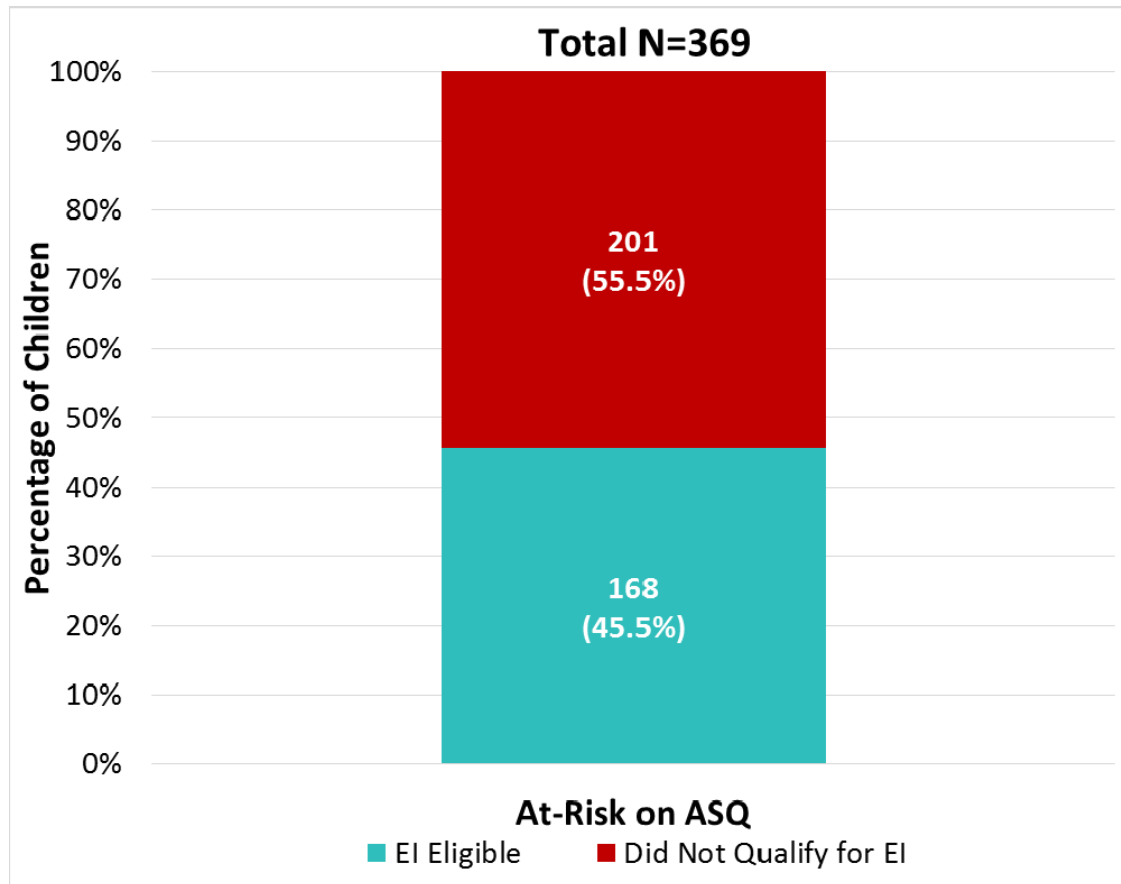
Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. Council on Children with Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for 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**

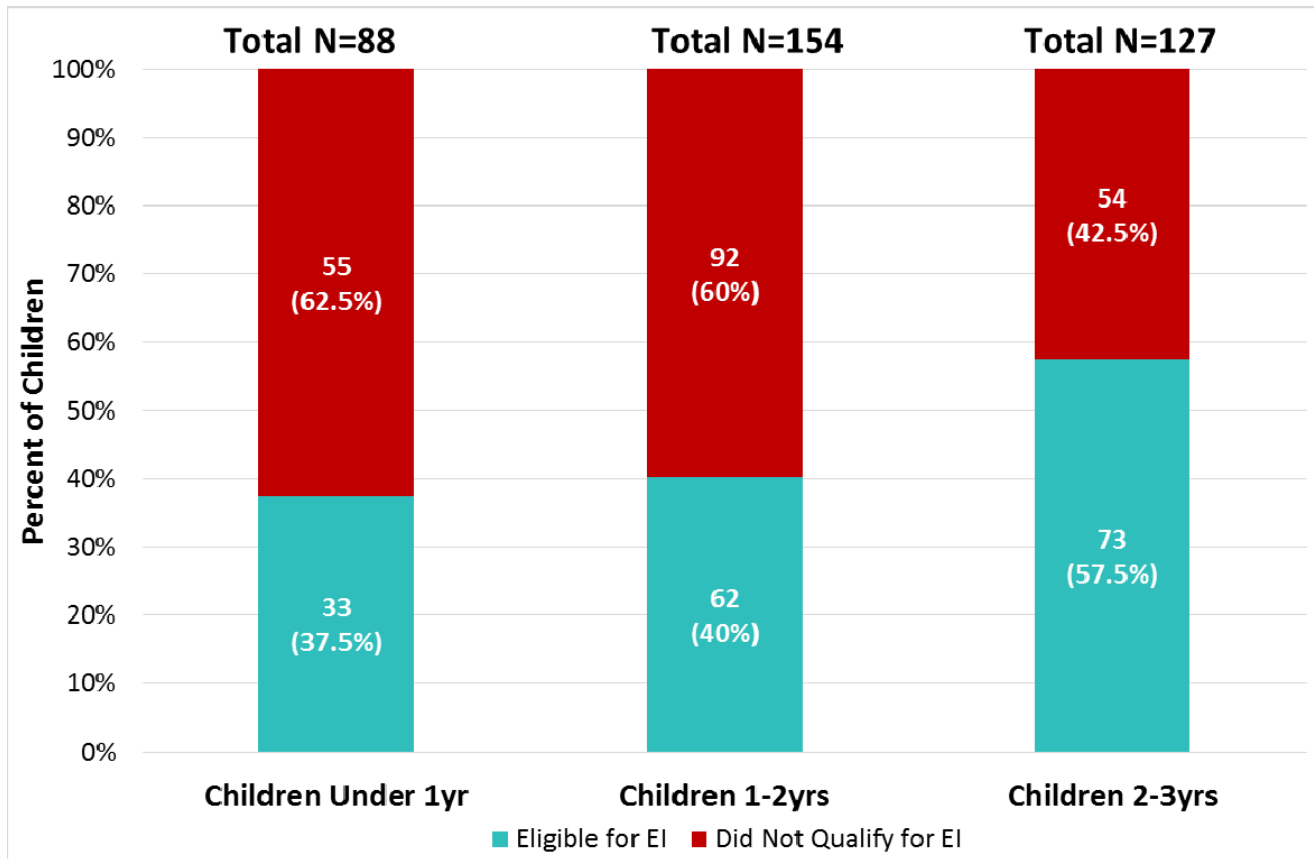
Children Identified as At-Risk on ASQ by Referring Provider & EI Eligibility



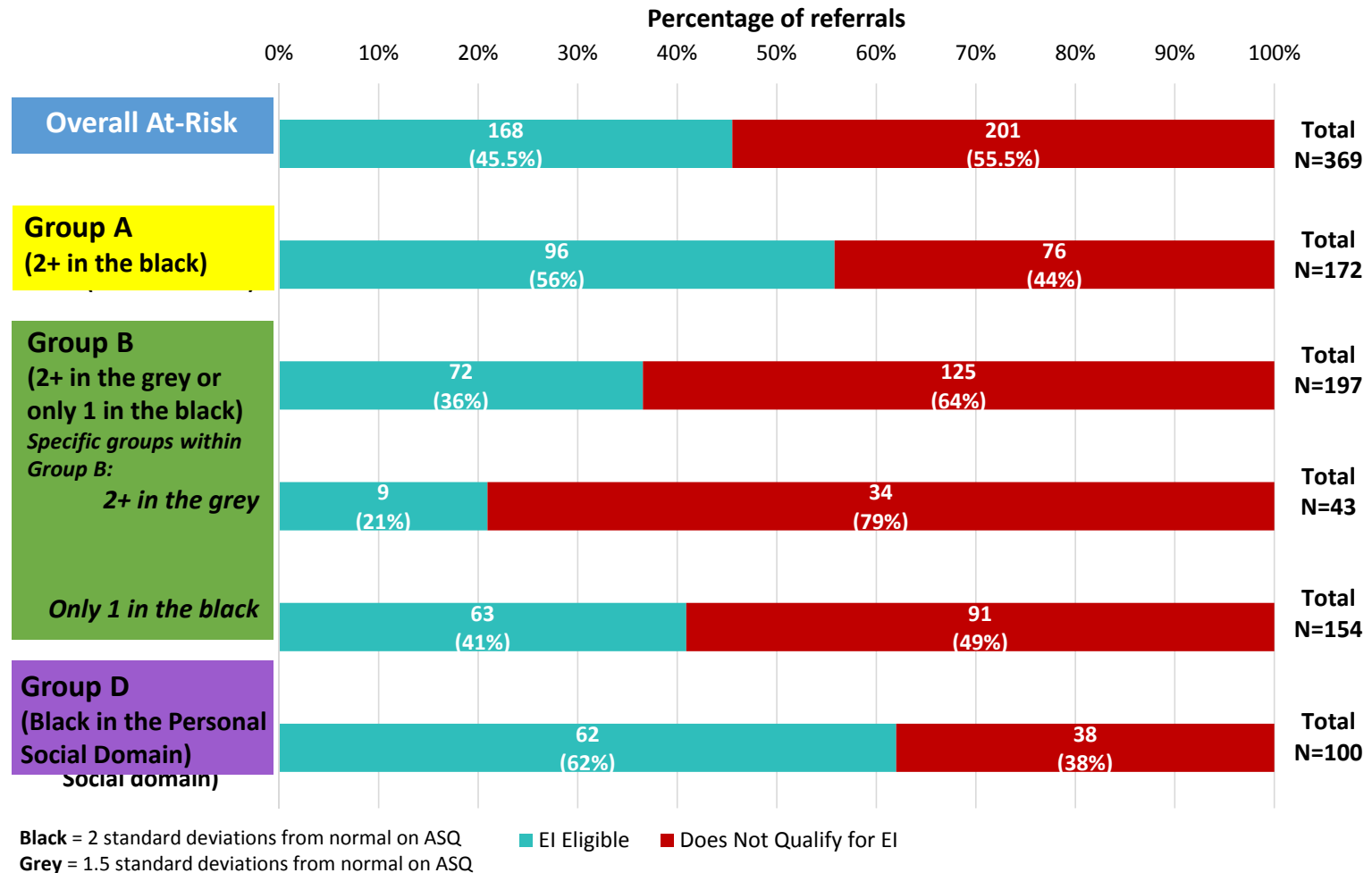
At-Risk on ASQ, Across Five Domains:

- 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



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
 - ✓ Domains identified at risk

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

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

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 Hispanic/Latino Black/African American Native American Other

Please check all that apply

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

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	Early Intervention/Early Childhood Special Education
Babies First	Healthy Families
CaCoon	Maternity Case Management
Early Head Start/Head Start	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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____
Child: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: _____
Parent/Guardian: _____	DOB: _____	Relationship to child: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N	Due date: _____
Parent/Guardian: _____	DOB: _____	Relationship to child: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Address: _____	City: _____	Zip: _____
Cell Phone: _____	Texts? <input type="checkbox"/> Y <input type="checkbox"/> N	Home Phone: _____
Preferred Language: _____		Best Time to Call: _____
Email: _____		
Reason for Referral: Check ALL that Apply		
Child or Children		
<input type="checkbox"/> Lack of Prenatal Care	<input type="checkbox"/> Has Disability	<input type="checkbox"/> Behavior concerns
<input type="checkbox"/> Support with Breastfeeding	<input type="checkbox"/> Born Premature	<input type="checkbox"/> Feeding concerns
<input type="checkbox"/> Support with Infant Care	<input type="checkbox"/> Home Environment concerns	<input type="checkbox"/> Health concerns
<input type="checkbox"/> Drug-Exposed Infant/Pregnancy	<input type="checkbox"/> Development concerns	<input type="checkbox"/> Weight concerns
<input type="checkbox"/> Support with Attachment/Bonding	<input type="checkbox"/> Social/Emotional concerns	
Parent or Guardian		
<input type="checkbox"/> Feels Depressed or Overwhelmed	<input type="checkbox"/> Teen/Young Parent	<input type="checkbox"/> Lack of Food/Clothing/Housing
<input type="checkbox"/> Isolation/Lack of Support	<input type="checkbox"/> First Time Parent	<input type="checkbox"/> Incarceration/ Probation
<input type="checkbox"/> Support with Parenting	<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Low Income
<input type="checkbox"/> Has Disability	<input type="checkbox"/> Alcohol/Drug Use	<input type="checkbox"/> Other: _____
Additional Family Information:		
<input type="checkbox"/> Migrant/Seasonal Work	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Homeless
<input type="checkbox"/> Receives TANF/SSI	<input type="checkbox"/> 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 <u>Yakima Valley Farm Workers Clinic</u> 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:		
<input checked="" type="checkbox"/> Family Building Blocks	<input type="checkbox"/> Oregon Child Development Coalition (OCDC)	
<input type="checkbox"/> Mid-Willamette Valley Community Action Agency	<input type="checkbox"/> Marion County Public Health Department	
<input type="checkbox"/> Polk County Public Health Department	<input type="checkbox"/> Willamette Education Service District (WESD)	
<input type="checkbox"/> Salem-Keizer Head Start	<input type="checkbox"/> Other _____	
Parent/Guardian Signature: _____	Date: _____	

YCCO Support of Family CORE

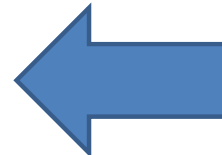
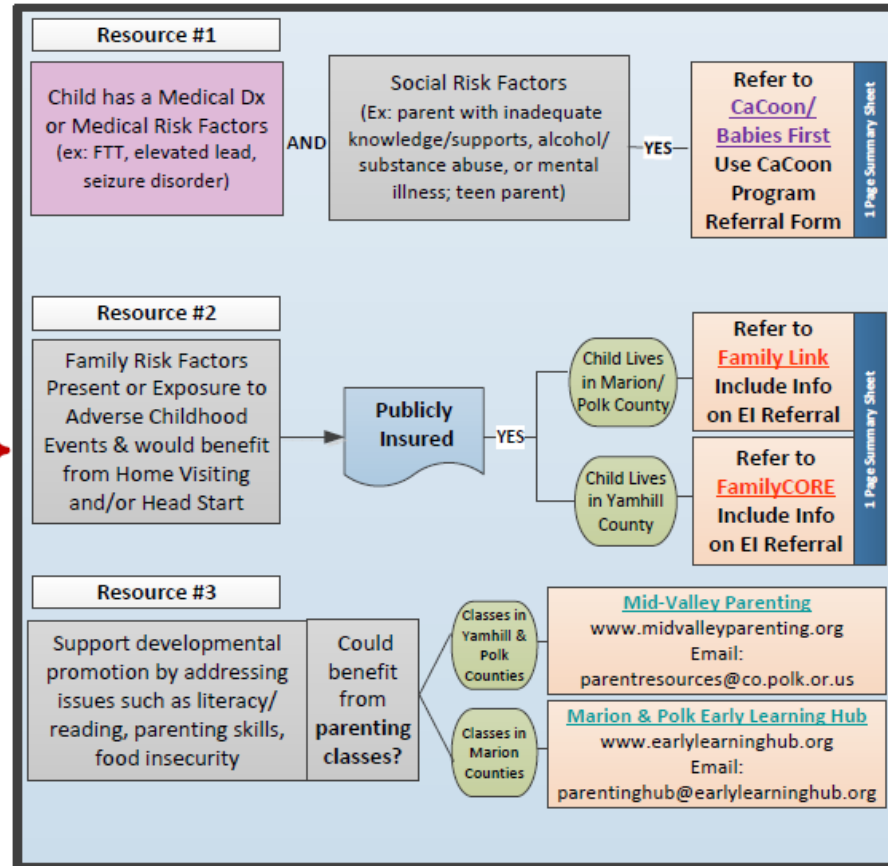
- Family CORE originally housed at Yamhill County Public Health
- As CCO staff capacity increased, Family CORE moved to CCO – BAAs signed October 2016.
- Member Engagement Coordinator continued to support, but Family CORE Leadership Team desired increased focus on home visiting
- Grant & Project Coordinator 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	1 Page Summary Sheet
		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)	
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	1 Page Summary Sheet
		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)	
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	1 Page Summary Sheet
		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



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**

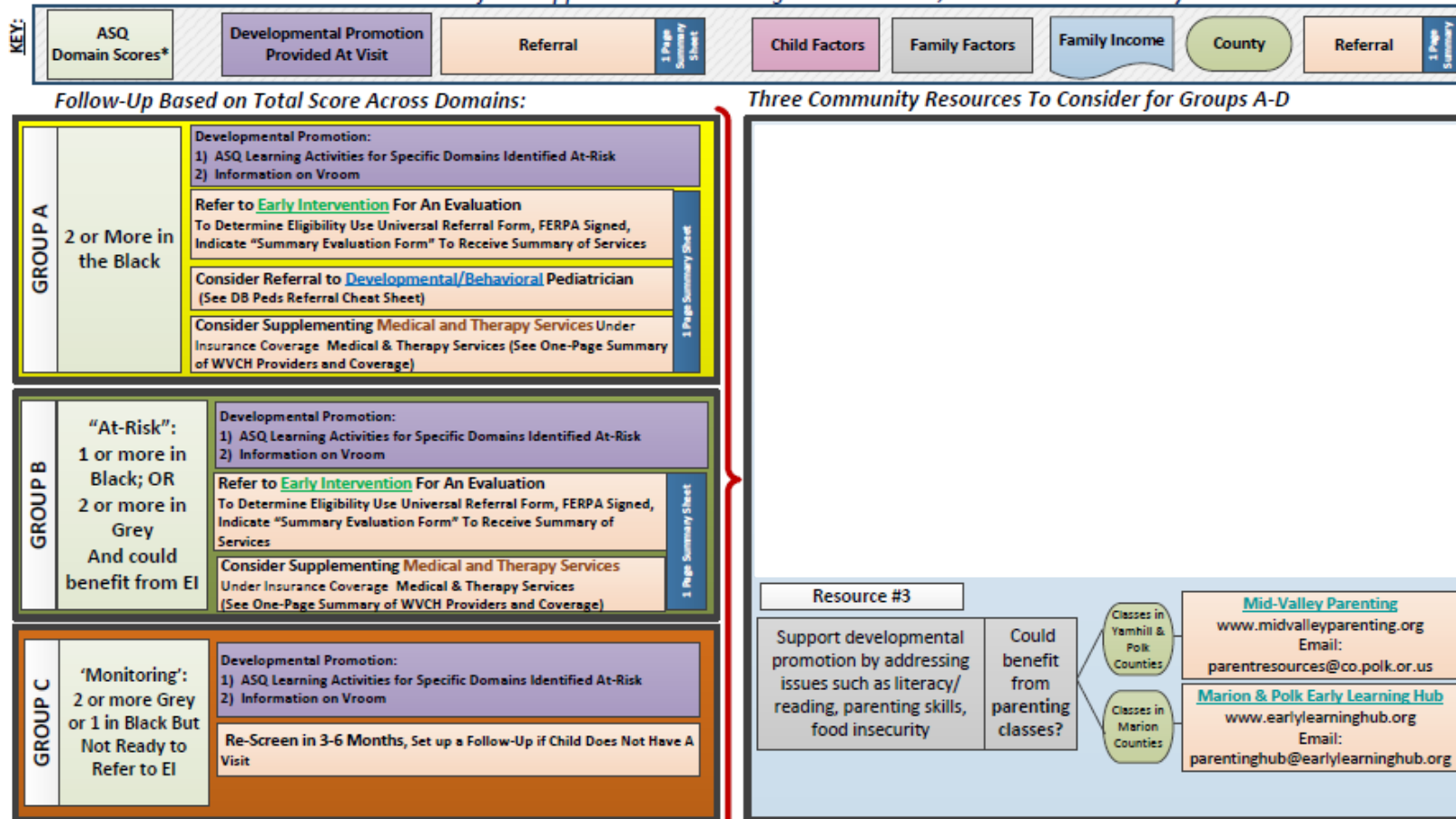
Pilot to Parenting Classes



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



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”

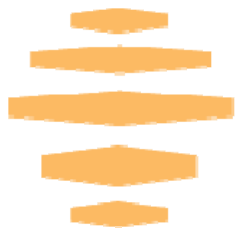
Looking Forward – Sustaining this Work as Early Learning Hubs



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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

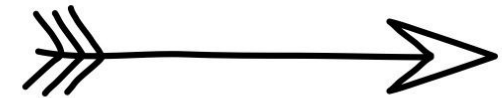


hub inc.
MARION & POLK EARLY LEARNING HUB



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



KEEP MOVING
FORWARD



More Information

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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