Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-risk Receive Best Match Follow-Up

Community-Based Quality Improvement Efforts Led by the ***Oregon Pediatric Improvement Partnership***

Colleen Reuland, MS
Director, Oregon Pediatric Improvement Partnership (OPIP)

State Interagency Coordinating Council
January 24, 2020
Oregon Department of Education

AGENDA

- **Background and context** on the focus on follow-up to developmental screening
- Overview of the **Pathways from Screening to Services** project regions
- Highlight of the **key components of the projects** and overarching findings
- Review of the **areas of focus for improvement efforts**
- Spotlight of **specific pathways of focus** as illustrative examples:
  - Primary care
  - Early Intervention
  - Behavioral health
    - Integrated behavioral health
    - Specialty mental health, dyadic treatments
- Looking forward

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.*

Momentum Around Follow-Up to Developmental Screening in Oregon

Within Health Care:

- Metrics & Scoring
  - As developmental screening rates meet benchmark rates, interest in a metric focused on follow-up to developmental screening
- Health Plan Quality Metrics
  - Interest in follow-up to developmental screening metric being developed and proposed, Endorsed Health Aspects of Kindergarten Readiness 4-part metrics
- Health Aspects of Kindergarten Readiness
  - Follow-up to developmental screening a part of the four-part metric strategy

*Within **Early Learning*** - Follow-up and receipt of services earlier is aligned with Early Learning Hub Goals:

- Children ready for kindergarten
- Families are attached and stable
- Services are coordinated & aligned

Data in OPIP Oregon-Based Projects Show that Most Children Screened in Primary Care Setting Do Not Receive Follow-Up

Follow-Up

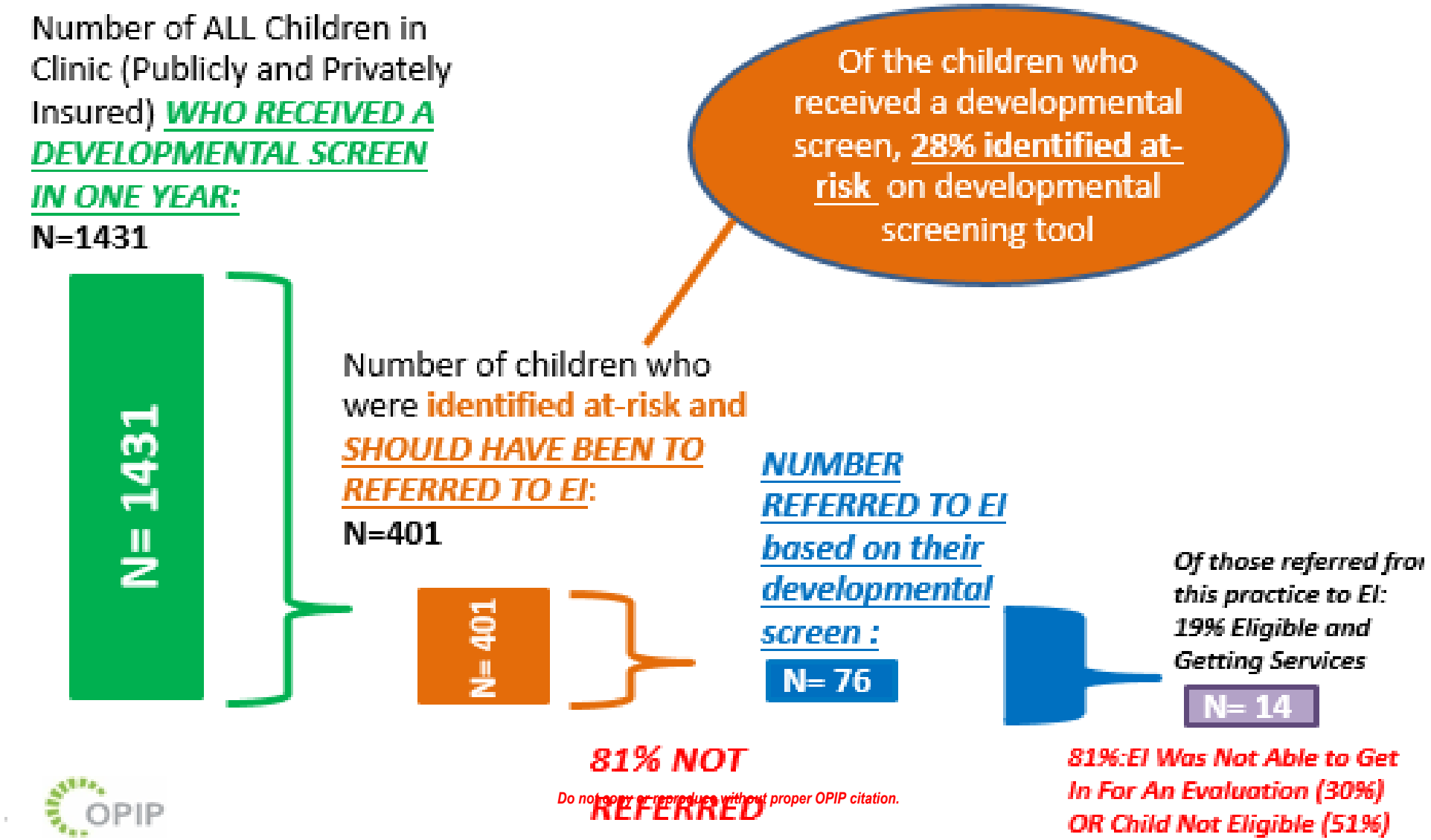
– **2011:** Across **8 Medicaid Managed Care Organizations**, only 40% of children received some level of follow-up

– **2015-2019 with Pathways from Screening to Services Projects:** Rates of follow-up range from 7-60%. A majority of practice-level rates are between 15-23%

If Referred, Lack of Connection to Services. Example for EI Referrals

- Of at-risk children referred to EI:
  - **2 in 5 children** (40%) referred by PCP to EI not able to be evaluated
    - Of those evaluated, 62% were found to be eligible for services, meaning **38% were ineligible for services**
      - ❖ Rates lower for referrals from Primary Care Providers (PCP)

An Applied Example from a Past OPIP Project and Pilot Site in Salem



Community & Population-Based Improvement Efforts focus on Across Sector Follow-Up

- **Multiple regions in the state**
  - Yamhill (Funding: Oregon Health Authority)
  - Yamhill, Marion and Polk (Willamette Education Service District)
  - Clatsop, Columbia, Tillamook (Funding – Columbia Pacific Coordinated Care Organization & Northwest Early Learning Hub)
  - Deschutes, Crook, and Jefferson (Funding- Early Learning Hub of Central Oregon, Central Oregon Health Council)
  - New funding from Ford Family Foundation could include a component of this work in rural counties in southern Oregon
- **Training and support to practices statewide via previous transformation center contract**

Community & Population-Based Improvement Efforts focus on Across Sector Follow-Up

1. **Community-level Stakeholder Engagement Across Eight Sectors, Including Parent Advisors:**
   - **Cross-sector engagement, qualitative interviews**
   - **Baseline data collection across sectors (CCO, Primary Care Practice, Early Intervention)**
   - Asset mapping of services that can provide follow-up to developmental screening, identifications of gaps
   - Community-level prioritization of pathways to focus improvement effort
   - Pilot site commitment and engagement

2. **Pilots to improve** the number of children who receive follow-up and coordination of care. Included in this is development of tools and strategies to improve follow-up AND implementation support

Key partners in implementing these pilots:

A. **Primary Care Providers***
B. **Early Intervention***
C. Behavioral health (Internal, Specialty Mental Health)
D. Applicable Home Visiting
E. Other Early Learning Resources

* *In every community.*

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

1) CCOs (WVCH, YCCO)

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

2) Primary Care

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

3) EI & Education

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

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

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

5) Home Visiting and Head Start/Early Head Start

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

6) Child Care and Parenting Supports

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

7) Infant and Early Childhood Mental Health

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

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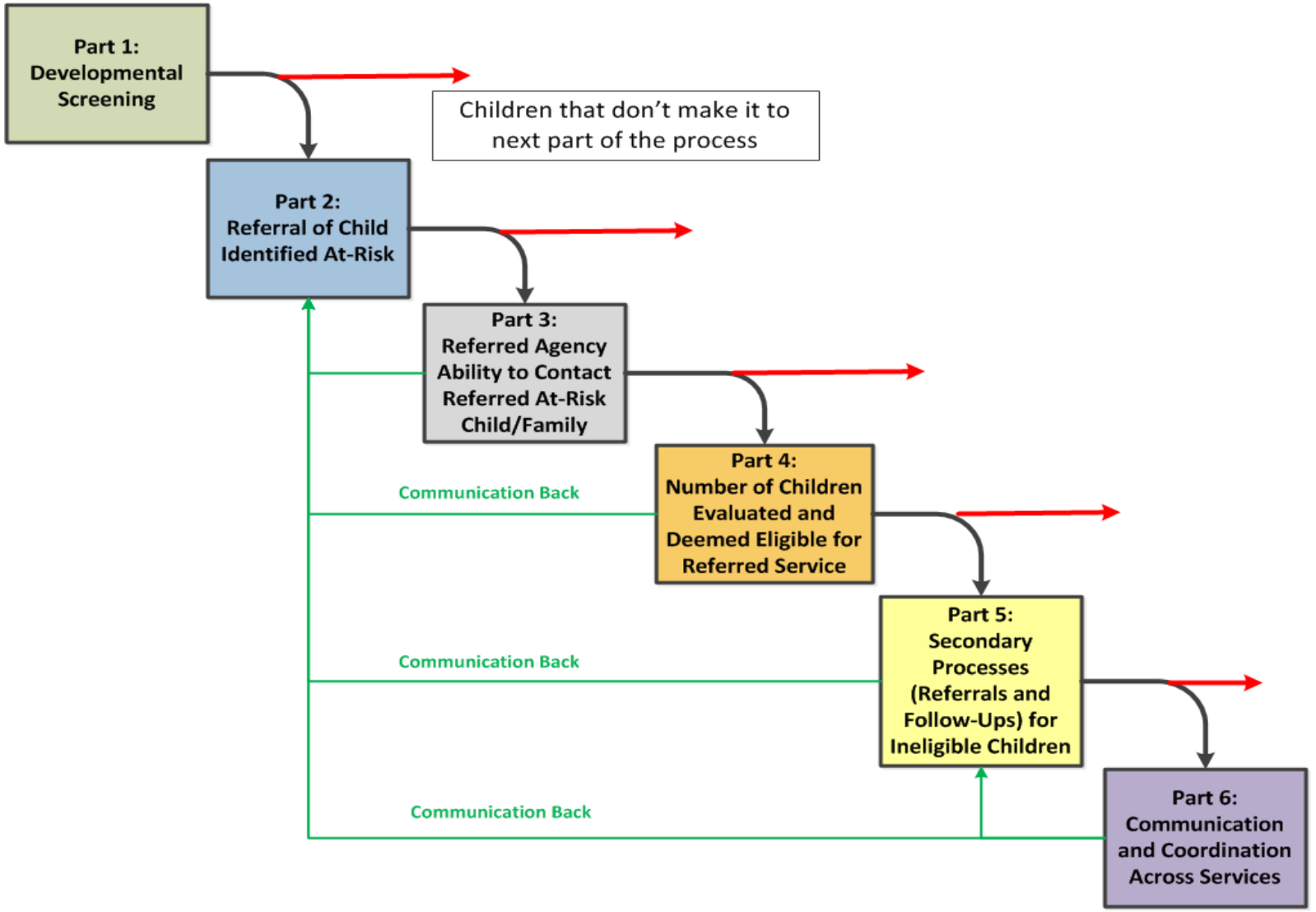
Key Building Blocks of the Pathways for Developmental Screening, Referral and Follow-Up



Community Asset Mapping and Pathway: Central Oregon

PATHWAYS FOR DEVELOPMENTAL SCREENING OF CHILDREN 0-3 & REFERRAL FOR CHILDREN IDENTIFIED AT-RISK IN DESCHUTES, JEFFERSON & CROOK COUNTIES

KEY STEPS

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

Primary Practices Conducting Screening at Rec. Periodicity (Based on PacicSource Claims) :
1. COPA - Pilot Site (D J,C,W)
2. Mosaic- Pilot Site (D,J,C,W)

There appear to be **5 additional clinics that are screening to fidelity** based on PacificSource Claims

Primary Practices Who Appear Not to be Screening to Recommendation (Based on PacificSource Claims) :

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Community-Based Providers Screening Children 0-3:
1. Home Visiting Programs serving young children *(Healthy Families, Nurse Family Partnership, BabiesFirst!, CaCoon)*
2. Early Head Start
3. Select Childcare Providers

Other:

Healthy Beginnings

Within Pilot Primary Care Sites (MOSAIC, COPA) Asset Map will be Updated Once Two Additional Pilot Sites are Onboarded

Part 2a: Within Primary Care Pilots Developmental Supports to Address Delays Identified By Entity Who Screened

Developmental Promotion
- ASQ Learning Activities
- UofO Online ASQ
- CDC Act Early Materials
- Vroom

Internal Behavioral Health
Within Mosaic Medical (Pilot Site)
- 2 LCSW/LMFT who provide care to 0-3

Co-Located Behavioral Health (St. Charles)
Within COPA (Pilot Site)
- 3 LCSW (One at each site)
- 2 PsyD/PhD providers (1 day in clinic/person)

Part 2b: Referral to Agency to Address Delays Identified

Developmental Evaluation*
1. PEDAL Clinic
2. OHSU- CDRC
3. Providence

OT/PT/Speech
1. St. Charles Rehab
2. Redmond Speech & Language
3. Treehouse Therapies
4. Bend Speech Express
5. Bend Speech/Language
6. Sonos Neurotherapies
7. Skidmore Speech/Lang.

EI/ECSE (all)

High Desert ESD

Family Support Services

(CaCoon and Babies First!)

Behavioral Health

BestCare, Brightways Counseling Group, Cherie Skillings, Deschutes County Mental Health, Forever Family Therapy, IHS Warm Springs, Now and Zen Parenting, Rimrock Trails, Starfish Counseling, The Child Center, Treehouse Therapies

(For more information see compendium on Behavioral Health Assets in Central Oregon)

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Part 3: Additional Family Supports that Address Child Development and Promotion

Family Resource Center Parenting Hub (all counties)

Family Support Network

MountainStar Relief Nursery Bend (D), Madras (J), LaPine (D)

Library Story Hours & Parent Groups

Childcare Resources/Inclusion Project

Specific to Autism and Related Disorders:

Center for Autism & Related Disorders (CARD) (D)

Central Oregon Child Center (for Autism specifically)

Healthy Beginnings (new parent support models, potential to do ASQ-SE and other follow-up screens)

Specific to Children Who Meet Eligibility Criterion:

Early Head Start

Head Start

Youth Villages Intercept

Program For Which Children Need to be Enrolled Prenatally or in the First 90 Days of Life, Could be a Support Families Already Enrolled

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Perinatal Care Continuum (All Counties)

VERSION 12/18/19

LEGEND

COLOR CODING BY SERVICE TYPE WITHIN Part 2A and 2B

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Family Support Services: CaCoon/Babies First!

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- **Internal behavioral health within primary care**
- **Mental Health – Referral is for an assessment:**
  - **-- Child Psychotherapy**
  - **-- Parent and Child Interaction Therapy**

** Enhanced services planned (Timing TBD)

***Interviews to be completed

[ ] Referral to evaluation, not necessarily services

*Located outside the community

D = Deschutes, **J**=Jefferson **C**=Crook County, **W**=Conf. Tribes of Warm Springs

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Community Asset Mapping and Pathway: Central Oregon

VERSION 10/31/19 **Part 2b – Expanded View: Referral to Agency to Address Delays Identified for Children 0-3**

	Devel. Evaluation	OT/PT/Speech	EI	Family Support Services (CaCoon, Babies First!)	*Behavioral Health*
Deschutes	X	X	X	X	X
Jefferson			X	X	X
Crook			X	X	X
Conf. Tribes of Warm Springs			X		X
Outside Community	OHSU CDRC Providence				

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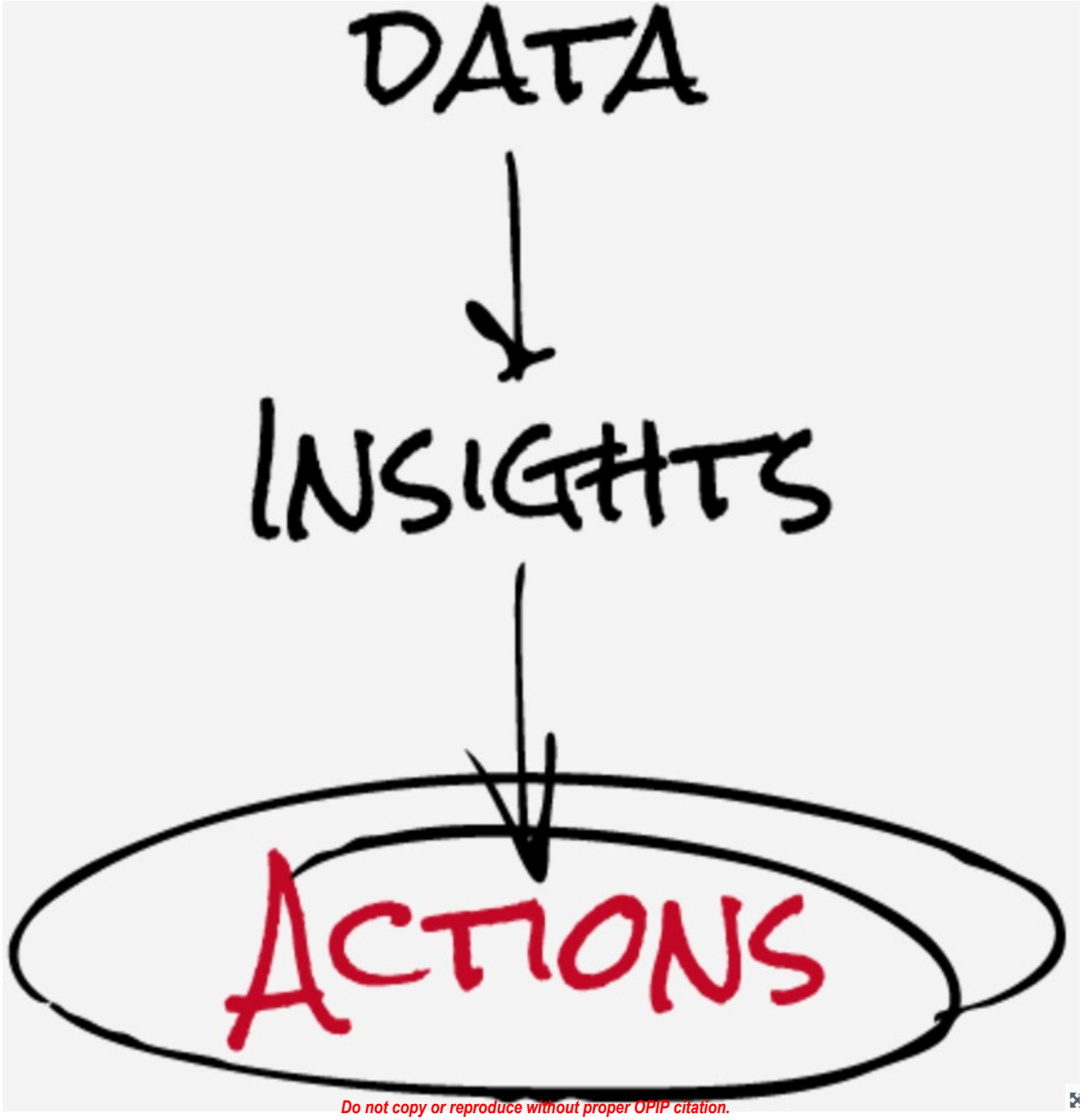
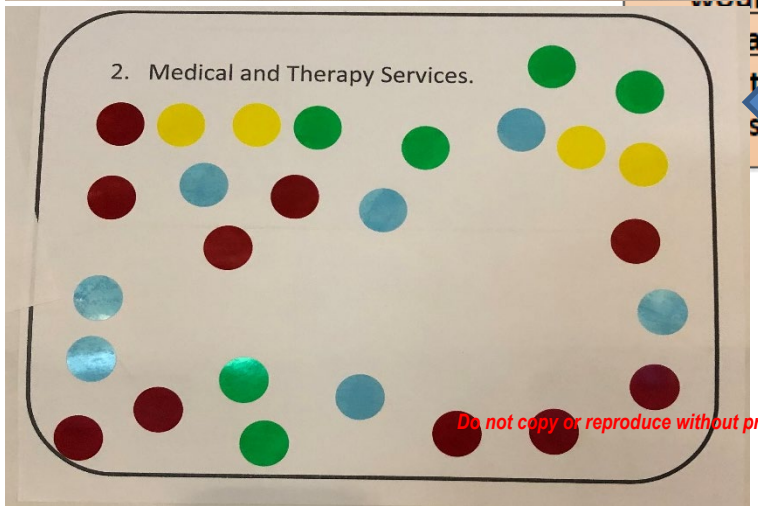


Community Votes and Community Priority Guide Improvement Areas of Focus

- Convene community level stakeholders and confirm community-level priorities about areas of focus
- Review the asset maps and prioritize **which pathways to focus**

Example from Central Oregon: Options Considered

OPTION 1:	OPTION		OPTION 4:
Funding for existing pilots site for existing pathways	Funding for existing pilots site for existing pathways	Funding for existing pilots site for existing pathways	Funding for existing pilots site for existing pathways
		pilot sites and focus to address egional/racial isparities	Add in pilot sites and targeted focus to address the regional/racial disparities
		for rvices that uld enhancing ays th limited	A targeted focus on funding for services that would enhancing pathways with limited capacity or that don't exist to fidelity
			Targeted Developmental Supports for Children High Social Complexity (Alignment with Priority Populations in CCO 2.0/ Governors Budget)



Priorities Areas Identified for WHERE to Focus Improvement Pilots: Illustrative Examples from Three Sectors

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**
   - Example I will share: Internal behavioral health and specialty mental health, dyadic services has been a priority in most regions

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Improvement Tools and Processes Developed and/or Identified

Pilot Primary Care Site

1) Community Asset Map of Applicable Follow-Up Resources
2) Tools to developmental promotion for all at-risk children
3) Tools to follow-up to developmental screening supported by:
   a) **Develop** a follow-up medical decision tree, including secondary follow-up, anchored to: i) ASQ scores, ii) Child and family factors, iii) Resources within the community
   b) **Develop** parent education sheet to support shared decision making, care coordination support strategies
4) Tools to Refer to EI, Ways to Use Communication Received Back

Early Intervention

1) Enhance communication and coordination for children referred & not evaluated
2) Communication about evaluation results
   - For Ineligible Children: Communication Back to PCP to Inform Secondary Steps; If Applicable, Referral to Early Learning supports, Pilots of referral to Early Learning.
   - For Eligible Children: Communication about EI services being provided to inform secondary steps

3) Referral Pathways to Mental Health

Central Oregon Asset Map

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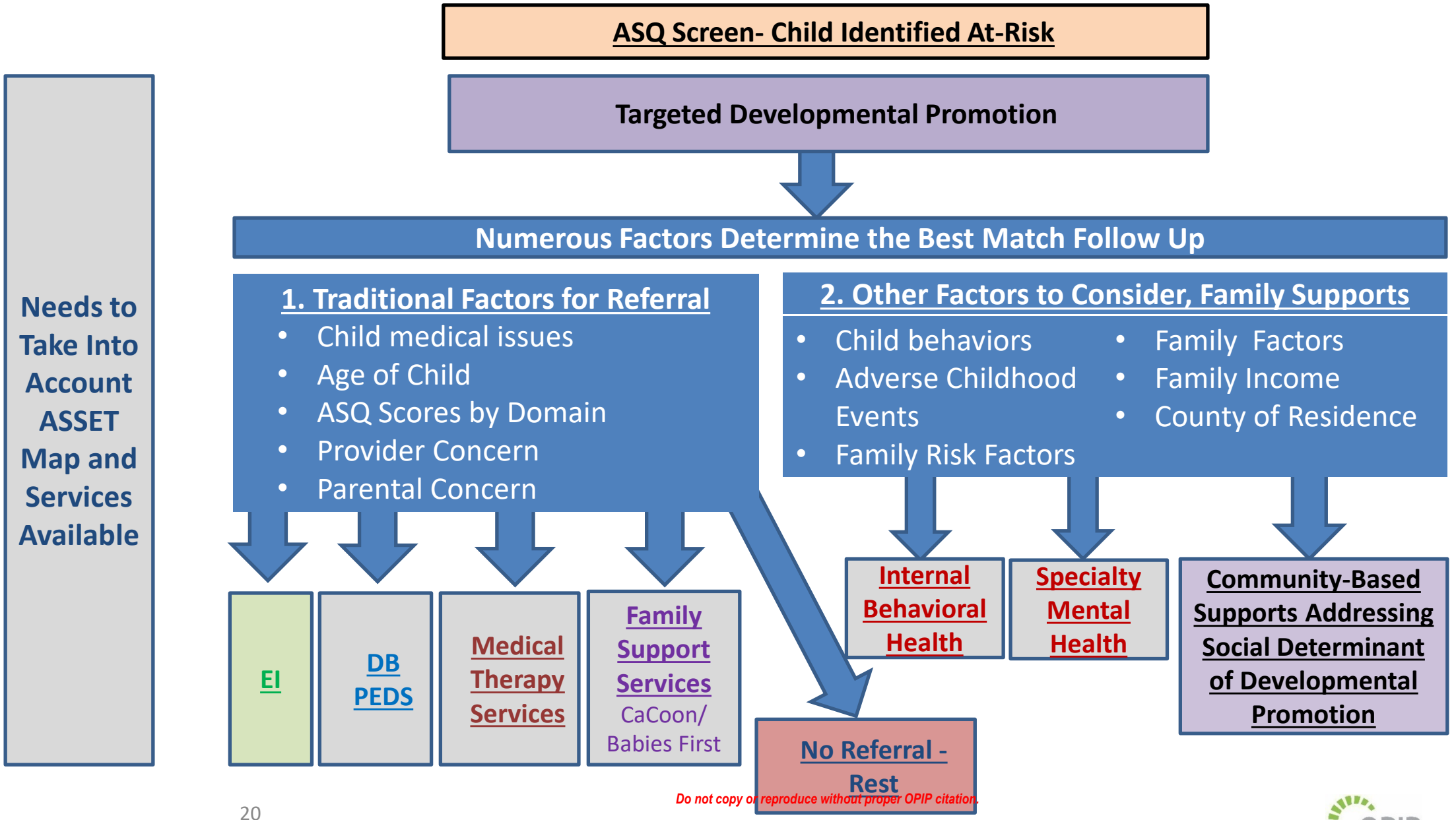
Follow-Up to Screening Decision Tree: Determining the "Best Match" Follow-up Services You Could *Provide*, and *Refer* the Child/Family To

It is not as a simple as "at-risk" or not based on the ASQ
(1 in the Black, 2 in the Grey)

- It is not as simple as knowing about the resources, without telling you when it might be best to refer a child to them
- We developed a decision tree to guide follow-up to available resources based on:
  1) Age of the child
  2) ASQ domain scores – number of domains and specific domain results
  3) Parent or provider concern
  4) Child/family risk factors
  5) **Community-Level Resources**

Determining the "Best Match" Follow Up for the Child and Family



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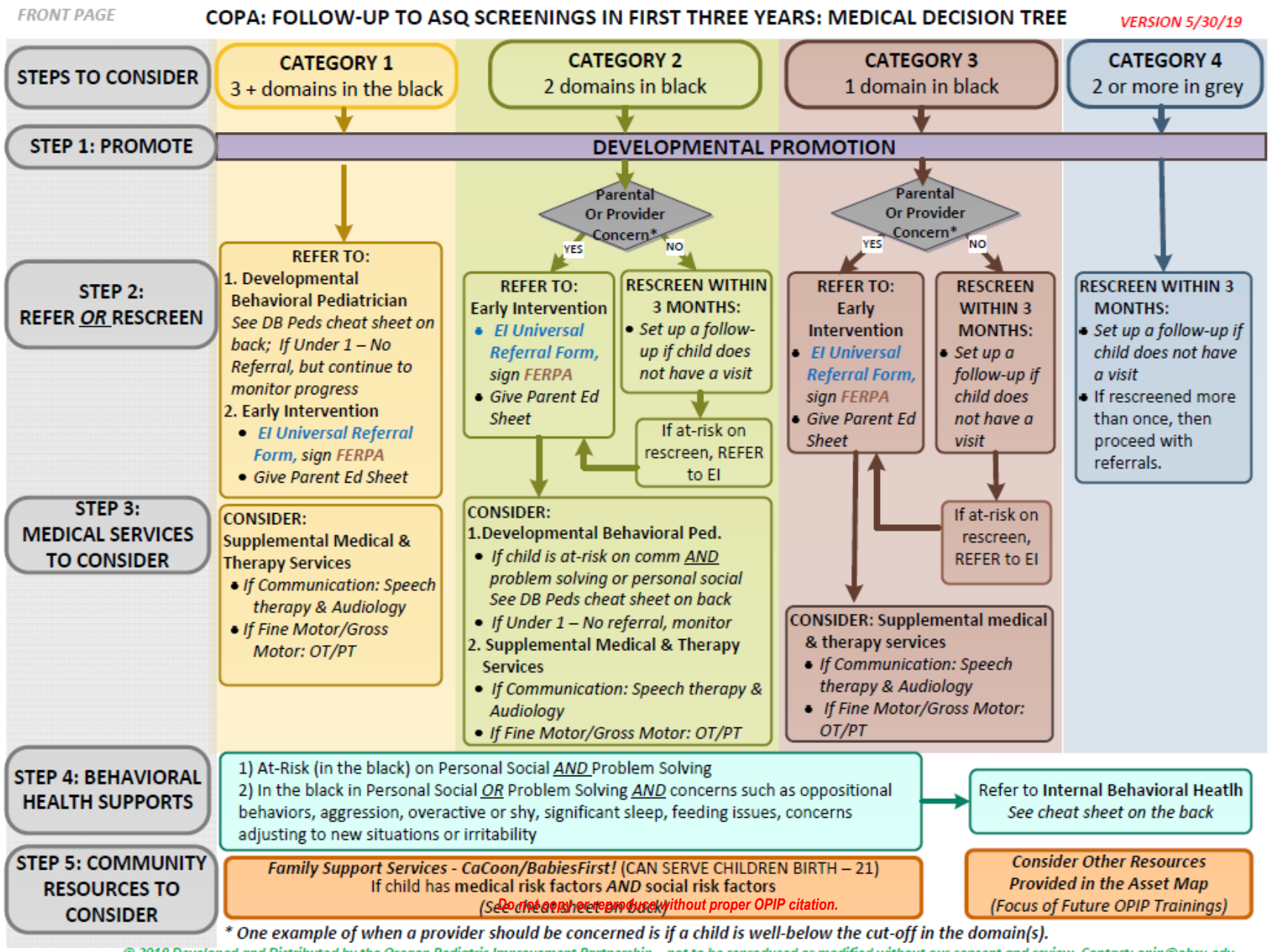
Follow-Up to Screening Decision Tree

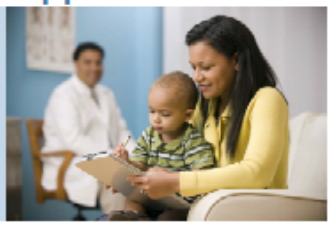


Follow-Up to Screening: How We Can Support Your Child

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, High Desert Education Service District (HDESD) 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:

- HDESD 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.
- Your county's Service Center will schedule your EI evaluation:
  - **Deschutes and Crook Service Centers schedule evaluations** Monday-Friday.
  - **Jefferson schedules evaluations** on Tuesday, Wednesday and Thursdays at 9, 11 or 1

The results from their assessment will be used to determine whether or not EI can provide services for your child.

Contact Information:
HDESD Intake Coordinator
Deschutes/Crook: 541-312-1947
Jefferson: 541-693-5740
www.hdesd.org

☐ Family Support Services

Family Support Services, through programs like CaCoon and Babies First!, use public health nurses to work with your family to support your child's health and development. A 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 these services.

What to expect if your child is referred to Family Support Services:

A nurse will come to you, at a time and place that works and provide services such as:

- Weigh baby or child and screen for normal development
- Provide information and connection to community based resources
- Make sure your child's health team works well together. The team is made up of your family and the professionals involved.

Contact Information:
Deschutes: 541-322-7448
Jefferson: 541-475-4456
Crook: 541-447-5165

https://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm

Medical & Therapy Services

- ☐ **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 the following child development areas: Learning delays, feeding problems, behavior concern, delayed development in speech, motor, or cognitive skills
- ☐ **Pediatric Psychologist:** Specializes in neuropsychological assessment, which are an in-depth assessment of skills and abilities in areas as attention, problem solving, language, behaviors and self-regulation.
- ☐ **Autism Specialist:** Specializes in providing a diagnosis and treatment plan for children with symptoms of Autism

Within COPA:
Behavioral Health Specialist who can help your family with:
- Health and family coaching
- Child development support
- Social and emotional support

Why did you sign a consent form?

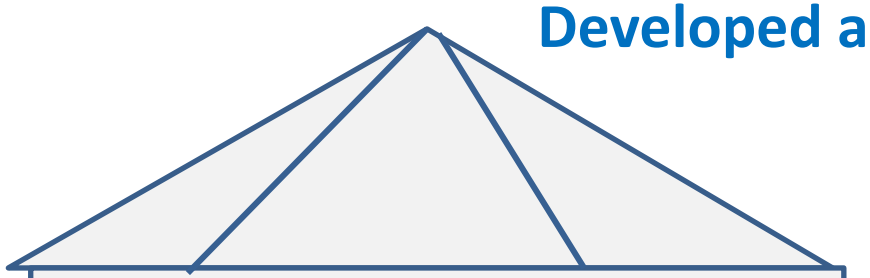
As your child's primary care provider, we want to be informed about the care your child receives so that we can provide the best care possible. The consent you signed allows the programs to share information back to us. Different programs have different consent requirements, which is why you may need to sign multiple forms.

Any Questions?

At COPA, we are here to support you and your child. If you have questions about this process or if you haven't heard from the agency you were referred in two weeks please call us! **541-389-6313**

Shared Decision Making Tool To Explain Referrals

Improvement Tools and Processes Developed and/or Identified



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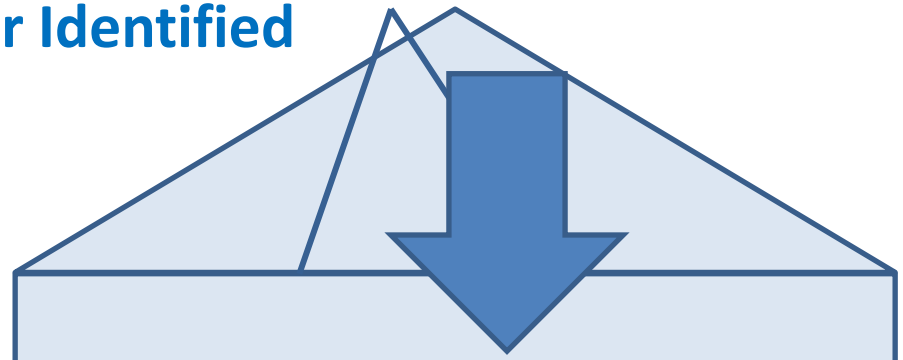

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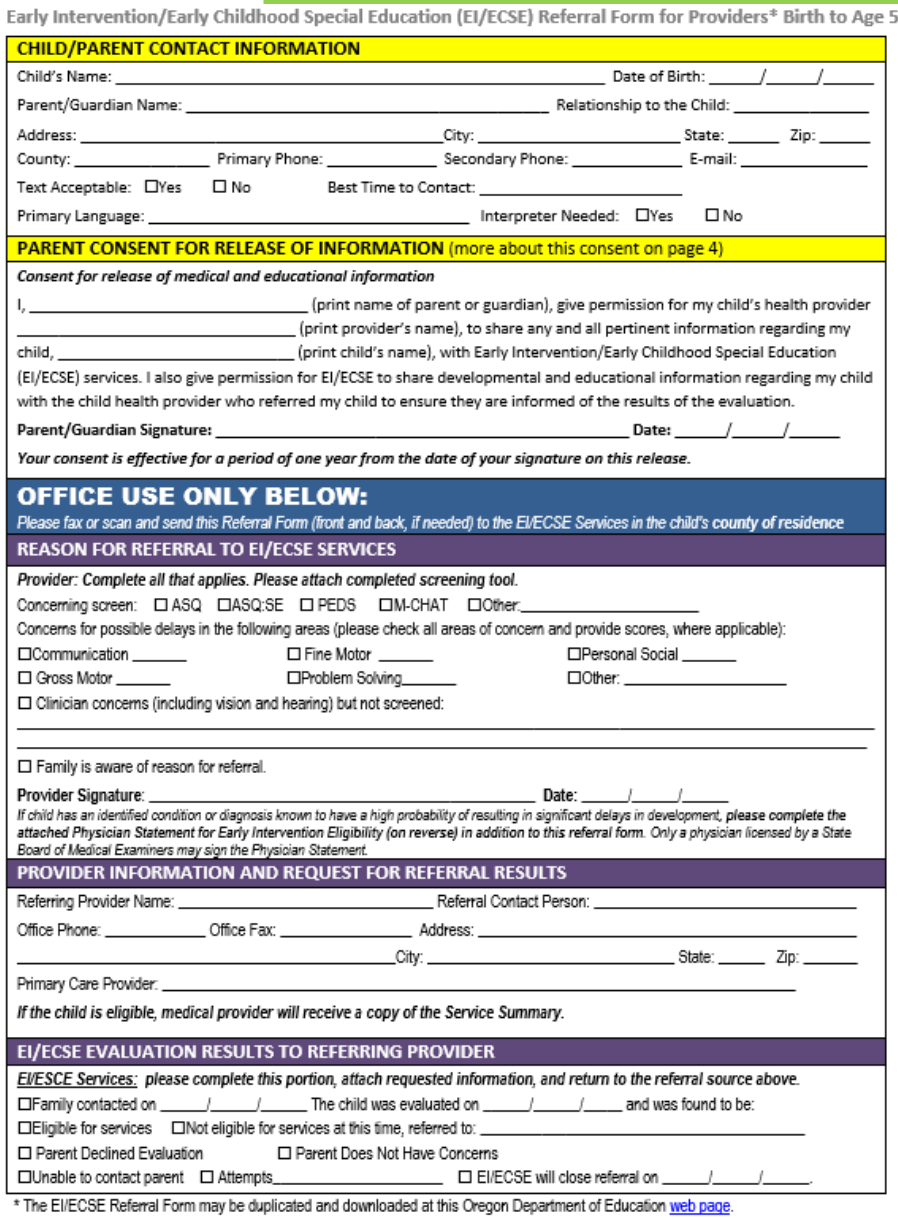
3) Referral Pathways to Mental Health

Early Intervention Universal Referral Form (URF)



Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers* Birth to Age 5

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: _____

Text Acceptable: ☐Yes ☐ No Best Time to Contact: _____

Primary Language: _____ Interpreter Needed: ☐Yes ☐ No

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 ☐M-CHAT ☐Other:_____

Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

☐Communication _____ ☐ Fine Motor _____ ☐Personal Social _____

☐ Gross Motor _____ ☐Problem Solving_____ ☐Other: _____

☐ Clinician concerns (including vision and hearing) but not screened:

_____

_____

☐ Family is aware of reason for referral.

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

*If child has an identified condition or diagnosis known to have a high probability of resulting in significant delays in development, **please complete the attached Physician Statement for Early Intervention Eligibility (on reverse) in addition to this referral form.** Only a physician licensed by a State Board of Medical Examiners may sign the Physician Statement.*

PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS

Referring Provider Name: _____ Referral Contact Person: _____

Office Phone: _____ Office Fax: _____ Address: _____

_____ City: _____ State: _____ Zip: _____

Primary Care Provider: _____

If the child is eligible, medical provider will receive a copy of the Service Summary.

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

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

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

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

☐ Parent Declined Evaluation ☐ Parent Does Not Have Concerns

☐Unable to contact parent ☐ Attempts_____ ☐ EI/ECSE will close referral on _____/_____/_____.

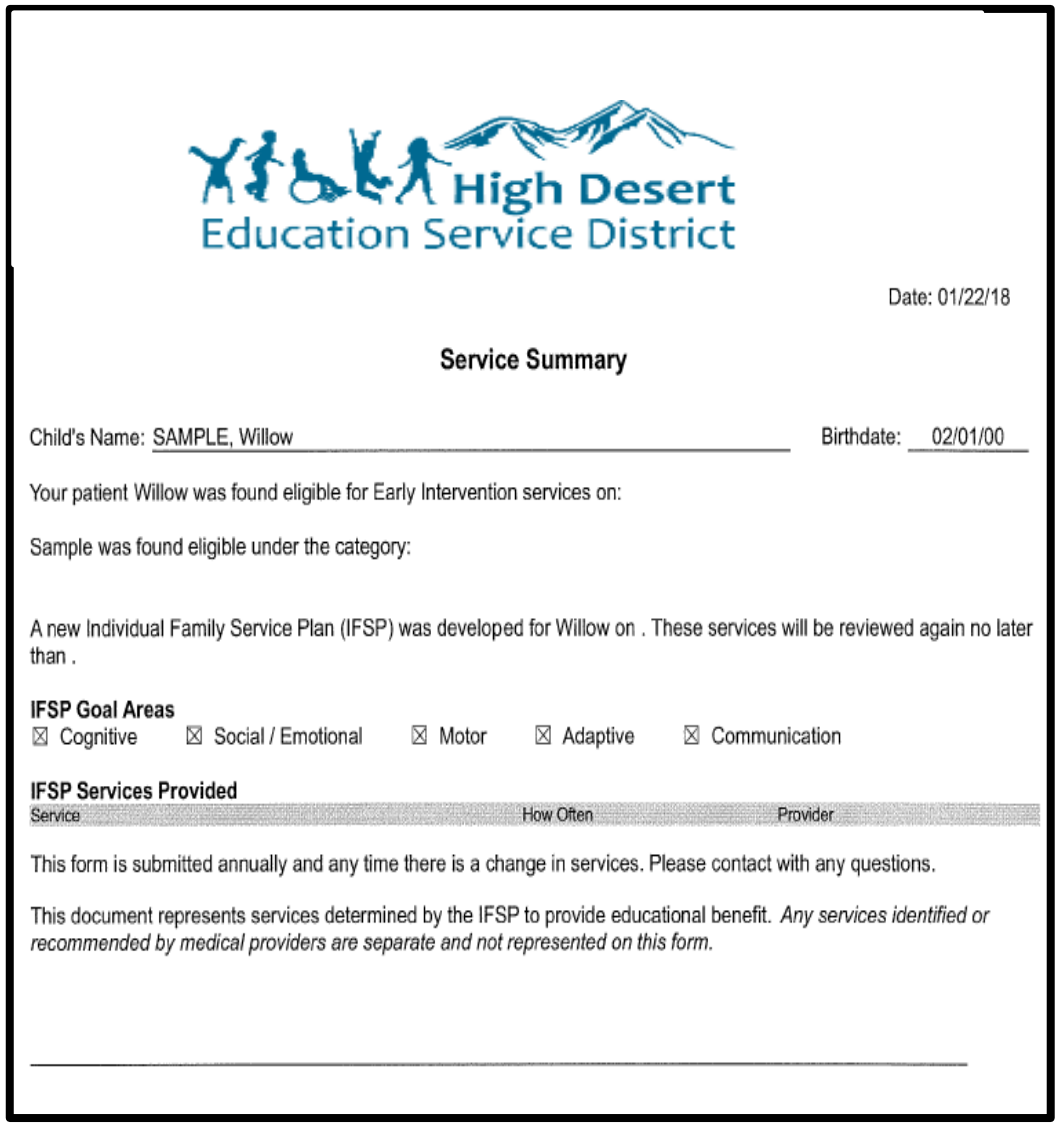
* The EI/ECSE Referral Form may be duplicated and downloaded at this Oregon Department of Education web page.

Training on the updated form and the functions of the update form to:

1. Help facilitate improved communication between EI/ECSE and the referred family
2. Streamline Communication between referring providers and EI/ECSE
3. Support enhanced <u>timely</u> communication so that PCPs can assist with outreach and engagement of families
4. Inform follow-up steps for EI ineligible and EI eligible

Completing it to fidelity enhances communication and coordination.

Use of Summary Service for Eligible: Service Summary Overview



High Desert Education Service District

Date: 01/22/18

Service Summary

Child's Name: SAMPLE, Willow Birthdate: 02/01/00

Your patient Willow was found eligible for Early Intervention services on:

Sample was found eligible under the category:

A new Individual Family Service Plan (IFSP) was developed for Willow on . These services will be reviewed again no later than .

IFSP Goal Areas

☒ Cognitive ☒ Social / Emotional ☒ Motor ☒ Adaptive ☒ Communication

IFSP Services Provided

Service	How Often	Provider

This form is submitted annually and any time there is a change in services. Please contact 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.*

Send the Service Summary to referring providers for children who are found **ELIGIBLE** and whenever changes are made to the services provided (annually)

Part of the focus of the next year will be around the *IMPLEMENTATION* of how to 'catch' and 'use' this information

Central Oregon Improvement Pilots

A) Improve Follow-Up in Primary Care Practice Pilot Sites conducting developmental screening

- Two committed site (COPA, MOSAIC) who have been expecting implementation support
- Recruit two additional sites

B) Improve Follow-Up in Early Intervention:

- Component of the PCP pilots is best match referrals to EI, enhanced care coordination for referrals
- Enhance coordination and communication with the entity that referred the child **and PCP use of that information**
- Follow-up steps for EI ineligible, Potential secondary referral pathways

C) Improve Follow-Up to Priority Areas Identified by the community

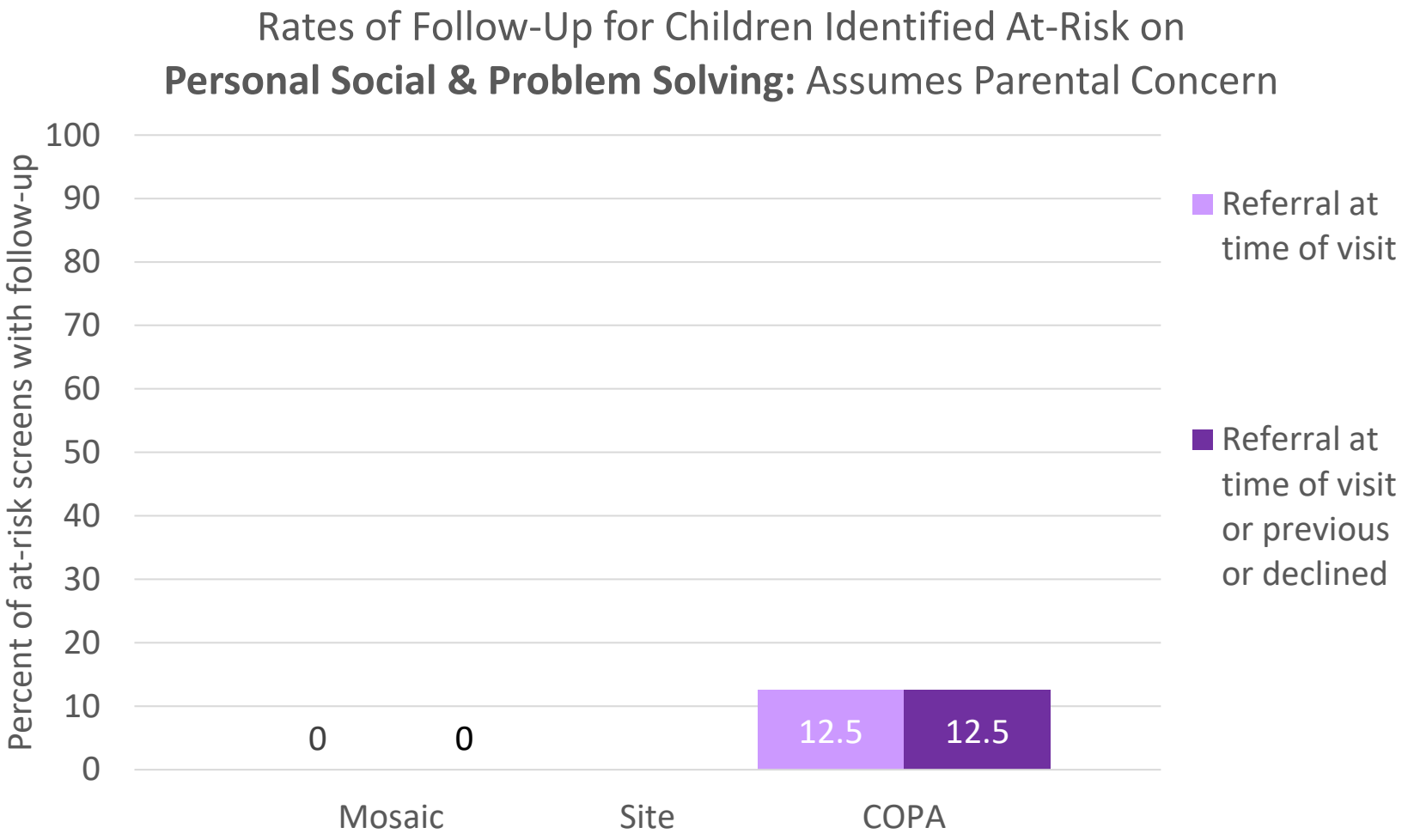
1. Addressing children with **social-emotional delays** (integrated behavioral health, specialty mental health)
2. Pathways to medical and therapy services

D) Proactive Developmental Promotion & Preventive Behavioral Health for High-Risk Children

- Children with socially complex families (Health complexity data)

** Across these efforts **ensure equity lens** and that intentionally addresses areas of disparities

Central Oregon Improvement Pilots



Mosaic Data Source: Provided by Mosaic Data Team, November 2018. Data for screens (According to EMR Flowsheet) between 7/1/17 - 6/30/18 for children under three years. N=0 for both bar 1 and bar 2.
COPA Data Source: Provided by COPA Data Team, November 2018. Data for screens (According to EMR) between 7/1/17 - 6/30/18 for children under three years. N=4 for both bar 1 and bar 2.

Improvement Work Focused on Pathways for Children with Social-Emotional Delays

1. Within Pilot Primary Care Sites, **Improve identification and internal follow-up with their integrated behavioral health**
   - Train them on factors that are indicators of delays to social-emotional health
   - Train them on services they can provider internally, pathways to external services
2. **Identify behavioral health providers that serve 0-5**
   - Update asset map provided in Phase I, apply an Equity Lens
   - Address community concern about the current lack of providers or lack of capacity within existing providers, facilitate community-level conversation on gap in availability of services
3. **If there is capacity and opportunity, pilot improvement referrals from pilot primary care sites to external behavioral health providers.**
   - Ensure that these pilots include tools and workflows for improved communication and coordination across service providers
     - Two-way communication with resources to which families are referred.
     - Need for better and standardized processes (agreements, tools, workflows)

Focus on Addressing Young Children with Social-Emotional Delays in Primary Care Sites

Within Pilot Primary Care Sites:

- Need for **training medical decision tree specific to social-emotional delays** and what are best match supports.
- Need for **training on what behavioral health services are for young children,** concern about whether there are people to refer to
- Need for **better and standardized processes** (work flows & tracking) around best match promotion and referrals (who, what, where, how) aligned with community-level assets
- Need for **specific strategies integrated behavioral health** can use with young children with social-emotional delays
- Need for **educational materials for parents** of children identified that encourage and facilitate shared decision making
- Need for **tools and strategies to engage families** in accessing the referrals

1/22/20 Training of Primary Care Practices Integrated Behavioral Health

1. Overview of Pathways from Screening to Services Project At-Large, Topic Specific Focus of the Training Today
2. Overview OPIP's Medical Decision Tree and Children 0-3 who have been trained to be referred to the pilot primary care site behavioral health staff
3. Overview of social-emotional development and why the indicators are flags of potential delays.
4. Overview of follow-up steps you may consider:

Services You Provide:

a. Secondary assessments and clinical decision making framework:

1) Conceptual framework for determining risk
2) Available assessment strategies
3) Profiles of risk

b. Intervention strategies for impacting early childhood social-emotional delays:

1) Low-intensity intervention resources
2) Research-based primary care therapies
3) Adapting evidence-based therapies

c. Billing Strategies

Referrals to External Mental Health Agencies

a. Overview of children that should be referred
b. Currently available external mental health providers
c. Strategies to engage families in referrals

Specific Community-Level Feedback for Phase 2 Activities Focused on Pathways for Children with Social-Emotional Delays

1. **Within Pilot Primary Care Sites, Improve identification and internal follow-up**
2. **Identify behavioral health providers that serve 0-5**
   - Update asset map provided in Phase I, apply an Equity Lens
   - Address community concern about the current lack of providers or lack of capacity within existing providers, facilitate community-level conversation on gap in availability of services
3. **If there is capacity and opportunity, pilot improvement referrals from pilot primary care sites to external behavioral health providers.**
   - **Ensure that these pilots include tools and workflows for improved communication and coordination across service providers**
     - Desire for better **two-way communication** with resources to which families are referred.
     - Need for **better and standardized processes** (agreements, tools, workflows)
     - Need for **timely communication** between service providers, including whether the family made it to the referral, services provided (assessment results, service type and frequency)

Behavioral Health Services for 0-5: What Exists Now

- **Identified services** across the region.
  - Anchored to delays identified on the ASQ and dyadic behavioral health services for young children
  - Identified WHO can see children 0-3
  - Identified the specific modalities provided by the service providers given they impact who and what are best match services
- Understand **capacity of services**
- Apply an understanding of the current services with an **equity lens**:
  - ✓Region
  - ✓Race –Ethnicity
  - ✓Tribal Designation
  - ✓Languages spoken

OPIP Examination of Behavioral Health Services for 0-5:Factors Considered

- **Type of social-emotional delays or factors the service targets**
  - If the goal is to get kids in to the right "best match" services, what are the best services for specific factors the pilot sites and project will focus on
- **Delivery method**
  - Dyadic or group
  - Can be factor in consider options for spread or location of services
  - Can be factor in consider parent engagement
- **Scientific Rating - Evidence Base for Various Modalities:**

- **Summarized services by those that are a level 1-3, but per community feedback documenting other services and openness to exploring services that may have less that Scientific Rating of 3 AND that community finds value**

Framework Used for Assessing Modalities Focused on Population Focus for this Project

Therapy/Program Name	Delivery Method[1]	Age of Child	Rating
SERVICES TARGETED TO CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS			
Parent Child Interaction Therapy (PCIT)* ** PCIT is also an effective program for children with known trauma history*	Dyadic	1-7	1
Generation-PMTO	Dyadic, Family & Group	2-18	1
Triple P (Positive Parenting Program)	Group	0-12	2
Theraplay	Dyadic	0-18	3
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)			
Collaborative Problem Solving	Family, Individual	3-21	2
Play Therapy	Family, Individual	3-12	3
Helping the Non-compliant Child	Dyadic	3-8	3
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY			
Child Parent Psychotherapy (CPP)	Dyadic	0-5	2
Eye Movement Desensitization and Reprocessing (EMDR)	Individual	2-17	1**
Attachment Regulation and Competency (ARC)	Dyadic, Family, Individual	0-21	Not rated
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED CHILDREN UNDER 3)			
Trauma Focused CBT	Dyadic	3-18	1
SERVICES TARGETED TO CHILDREN WITH AT-RISK PARENTS/ FAMILIES			
Family Check-Up	Dyadic	2-17	1
Attachment and Biobehavioral Catch-up (ABC)	Dyadic	0-2	1
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED CHILDREN UNDER 3)			
Incredible Years* ** Incredible Years is also good for children with disruptive behavior problems*	Group	4-8	1

Modalities Available in Central Oregon

SERVICES TARGETED TO CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS		
Parent Child Interaction Therapy (PCIT) ** PCIT is also an effective program for children with known trauma history*	Brightways, Cherie Skillings, Deschutes County, Starfish Counseling	10
Generation-PMTO		0
Triple P (Positive Parenting Program)		0
Theraplay	Treehouse Therapies	1
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)		
Collaborative Problem Solving	Forever Family Therapy	4
Play Therapy	Deschutes County, Jefferson County Best Care, Starfish Counseling, Life Source	15
Helping the Non-compliant Child		0
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY		
Child Parent Psychotherapy (CPP)	Cherie Skillings	1
Eye Movement Desensitization and Reprocessing (EMDR)	Deschutes County, Starfish Counseling	14
Attachment Regulation and Competency (ARC)	Deschutes County	1
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)		
Trauma Focused CBT	Jefferson County BestCare, Treehouse Therapies, Rimrock Trails, Deschutes County, Brightways, Forever Family Therapy, Life Source Therapy	19**
SERVICES TARGETED TO CHILDREN WITH AT-RISK PARENTS/ FAMILIES		
Family Check-Up		0
Attachment and Biobehavioral Catch-up (ABC)		0
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)		
Incredible Years ** Incredible Years is also good for children with disruptive behavior problems*	Deschutes County	1
OTHER SERVICES PROVIDED WITHIN THE COMMUNITY:		
Child and Family Marriage and Therapist Counseling	Jefferson County Best Care, Cherie Skillings, Deschutes County	16
Other Modalities without evidence base (Dance Therapy, Art Therapy, Equine Therapy, Baby Doll Circles)	Warm Springs*, Treehouse Therapies, Life Source Therapy	2
Youth Villages Intercept Program	Youth Villages	6

*Counts need to be verified in follow, up interviews
** Individuals were trained but not certified

Capacity of Current Providers Who See Young Children in Central Oregon

Draft Version 6.0 December 18, 2019	Current Assessment of Specialty Mental Health Providers Who See Children 0-5 in Central Oregon										
	Deschutes County	Treehouse Therapies	Brightways Counseling	Cherie Skillings	Jefferson County BestCare	Rimrock Trails	Forever Family Therapy	Life Source Therapy	Starfish Counseling	Youth Villages**	Crook County BestCare
Location	6 in Redmond, 6 in Bend, 3 in LaPine	Bend	Redmond	Bend	Madras	Bend & Prineville	Bend	Redmond	Bend	Deschutes, Crook, Jefferson	Prineville
Number of Providers	15	1	2	1	3	2	4	1	1	6	3
Current Case Load (per week)	114*	28	62	24	*	50	40	30	25	24**	*
Capacity to take on New referrals (# of families)	25	5	8	12	20	25	16	Limited, but could be flexible	0	2**	6
Need follow up Interviews with: Now and Zen, IHS Warm Springs, The Child Center											
Do Not see Children 0-5: Lutheran Community Services, Bend											

*Counts need to be verified

**Youth Villages only takes referrals for children/families that are at risk for out of home placement, and therefore are not a traditional referral pathway for behavioral health services, and will not be included in counts towards capacity in Central Oregon

Applying an Equity Lens

Draft Version 6.0 December 18, 2019	Applying an Equity Lens: Current Assessment of Specialty Mental Health Providers Who See Children 0-5 in Central Oregon										
	Deschutes County	**Treehouse Therapies**	**Brightways Counseling**	**Cherie Skillings**	**Jefferson County BestCare**	**Rimrock Trails**	**Forever Family Therapy**	**Life Source Therapy**	**Starfish Counseling**	**Youth Villages****	**Crook County BestCare**
Location of Therapy											
Deschutes	X	X	X	X		X	X	X	X	X	
Crook						X				X	X
Jefferson					X					X	
Therapy Provider Race, Ethnicity or Tribal Affiliation	14 Identified as White (1 White/Hisp , 1 Hispanic)	Identified as White	Identified as White	Identified as White	Identified as White	Identified as White	3 Identified as White, 1 as African American	Identified as White	Identified as White	1 Japanese-American, 5 Caucasian	Identified as White
Therapy Provider Language Spoken	14 English only, 1 Spanish/ English	English	English	English	English	English	English	English	English	English	2 English, 1 Spanish/ English
Payor	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP Only	OHP/ Private	OHP/ Private	OHP/ Private	OHP/Private	OHP
Need follow up Interviews with: Now and Zen, IHS Warm Springs, The Child Center											
Do Not see Children 0-5: Lutheran Community Services, Bend											
*Counts need to be verified **Youth Villages only takes referrals for children/families that are at risk for out of home placement, and therefore are not a traditional referral pathway for behavioral health services, and will not be included in counts towards capacity in Central Oregon											

Trainings for Primary Care Providers and Integrated Behavioral Health on Engaging Parents in These Referrals

- Important to explain what the referral is and why you are referring them
- Address the stigma of the services
- Address the stigma of the organization
- Support them in the tools
- Use of shared referral form (if agreement obtained) to ensure a “warm” referral
  - Developed a referral form for 0-5 that ensured closed loop communication in NW Oregon
  - If we obtain agreement of Central Oregon providers, will include it in the pilot

Parent Education Sheet to Support Shared Decision Making

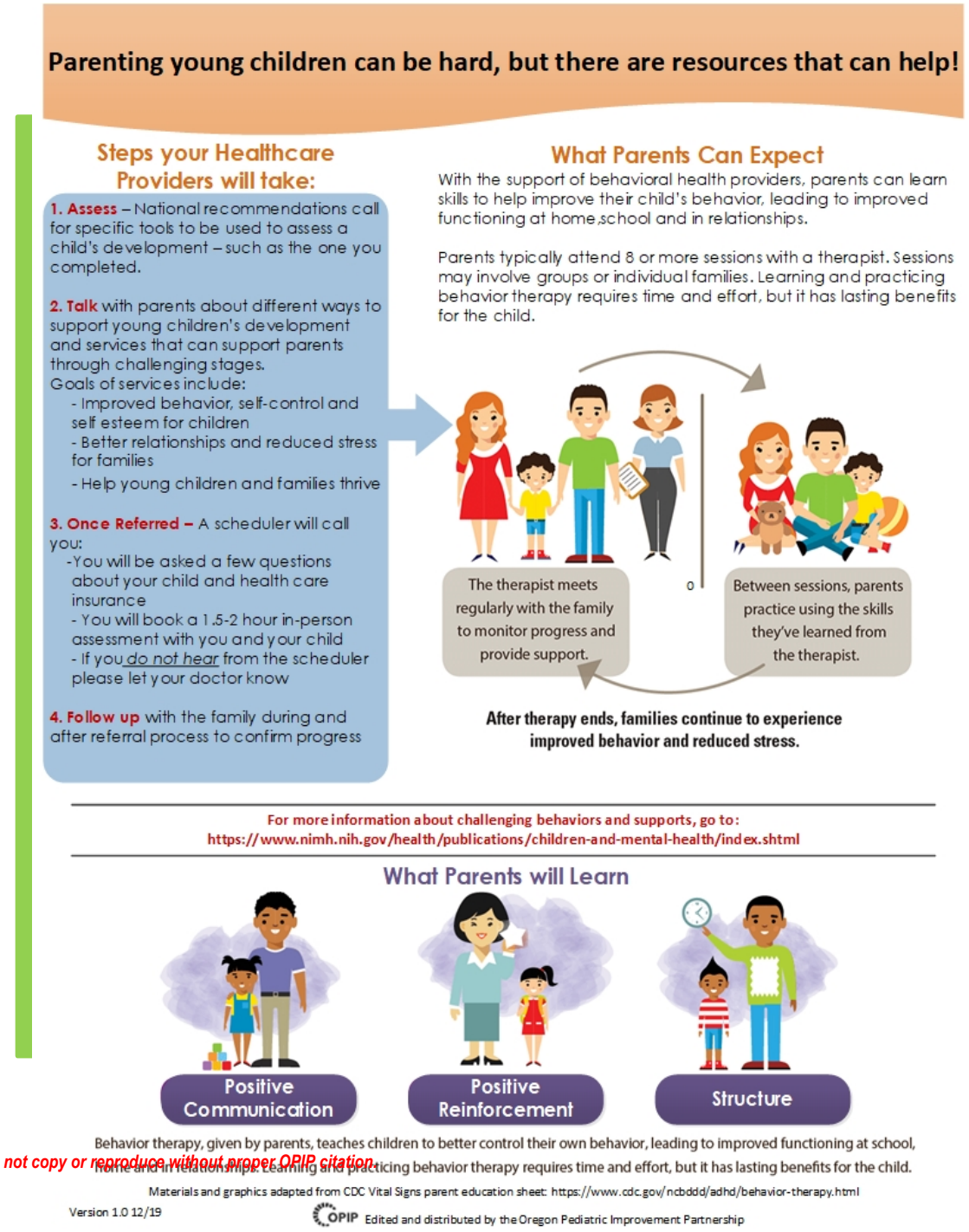
- Developed based on literature and website review
- Phone calls with a number of key leaders in the state and across the county
- Templates derived from CDC

Goal of Education Sheet:

- Provide families a one page resource sheet to refer back to after appointment

Explain:

- Steps your Provider has Taken
- What Parents can Expect
- What Families will Learn



Talking Points about Mental Health Services

What is infant and child mental health?

- **Parenting young children can be hard**, but there are **resources that can help** you get through these tough times and improve challenging behaviors
- It is normal for children to go through **periods of development that are more challenging**, and sometimes children and their families benefit from **learning about strategies** that can help a child learn to better **control their emotions**.

What is Family Attachment Therapy[1]?

- What parents learn:
    - Positive Communication
    - Positive Reinforcement
    - Structure
    - Discipline
- This therapy teaches children to **better control their own behavior**, leading to improved functioning at school, home and in relationships.
- Learning and practicing behavior therapy **requires time and effort**, but has **lasting benefits** for the child.
- Typically attend **8-16 sessions** with a provider and learn strategies to help their child. Sessions may **involve groups or individual families**.
    - Therapist meets regularly with the family to monitor progress and provide support
    - Between sessions, parents practice using the skills they've learned from the provider/therapist
- After therapy ends, families continue to **experience improved behavior and reduced stress**.

Looking Forward

Next Steps

- Continue work in Central Oregon
- Potential work in rural regions with Ford Family Foundation Support
- OPIP role on the Health Aspects of Kindergarten Readiness (HAKR) team to develop two metrics proposed for a CCO incentive metric
  - System-Level metric focused on Social-Emotional Health
  - Follow-Up to Developmental Screening
- Where applicable, incorporate work into **Oregon's Integrated Care for Kids** effort

More Information About Projects Presented Today

Colleen Reuland reulandc@ohsu.edu

OPIP Website

- Section focused on Follow-Up to Developmental Screening:

  https://oregon-pip.org/area-of-focus/follow-up-to-developmental-screening/

Oregon Health Authority – Transformation Center

- https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Dev-Screen-Tech-Assist.aspx