Primary Care Practice Facilitation Summary
Deliverable 1.7 & 2.8 – Successes, Barriers and Implications in Primary Care
May 2021

Background and Context: The *Pathways from Developmental Screening to Services* project is a community-level improvement effort focused on improving the receipt of services for young children identified at-risk for developmental, behavioral and social delays. A component of this work is focused on improving **follow-up to developmental screening in primary care practices**. To support this, the Oregon Pediatric Improvement Partnership (OPIP) is providing training, development of tools and resources to improve their follow-up, and providing at-the-elbow implementation support to the staff in the primary care practices who are leading the improvement efforts.

In the last six months of the project, OPIP was actively working with all four primary care sites, but the focus was shifting to a sustainability model for the quality improvement conducted during this project once monthly facilitation and quarterly data collection is no longer required. Additionally, three of the four sites were asked by the CCO to support vaccine distribution in this time period, so their availability and engagement needed to shift.

Content in This Summary: This summary report is anchored to the successes, barriers and implications for future efforts that we have identified through work conducted December 2020 – May 2021 within COPA, Mosaic, Madras Medical Group (MMG) and St. Charles Prineville

1. Success in Working with the Pilot Primary Care Sites

1.A Trainings and Supports Provided to Primary Care Pilot Sites

1.A.i. Provided Madras Medical Group Providers a Booster on Social Emotional Health

- Provided in more detail in Deliverables 2.7 and 4.2, OPIP trained **Madras Medical Group providers in February 2021 on best match supports for children identified with social emotional delays** on developmental screening. This training provided a refresher and deeper context on the pathways to support social emotional health including:
  - What contributes to social emotional health in young children and how does it affect their development
  - Which children to send to Internal Behavioral Health Services
  - Developmental Promotion to Consider and How to Engage Families in Referrals to Behavioral Health Services
  - Referrals to Internal Behavioral Health & Overview of their High Level Overview of Specialty Behavioral Health for Children Birth-5
- **Positive Feedback from the Madras Providers and their Internal Behavioral Health provider on Booster Training:** The compendium of services and modalities in the region had high value to these providers in helping to improve their understanding of different service modalities, including availability and capacity in their region, and better support the engagement of their patients in these pathways. Madras' Internal Behavioral Staff, who was new to the position, found a lot of benefit from the tools and resources provided. Additionally, as she was working to build her panel internally, she strategically aligned this pathway into her scope of work to support the breadth of patients served by MMG.

1.B Success in Quality Improvement Aligned with Medical Decision Tree

1.B.i. Joined and Facilitated an Across Clinic Quality Improvement Meeting for COPA focused on the Referral Pathway to Early Intervention

- Quarterly COPA facilitates an Across Clinic multi-disciplinary Quality Improvement Meeting. In their February meeting, OPIP helped to facilitate a conversation about refinements to the proposed workflow to support referrals to Early Intervention. Based on feedback and conversations that OPIP had facilitated with the HDESD team, it was identified that COPA was often referring the same child multiple times to EI services. Upon further examination in this meeting, it was found to be due to a lack of clarity about roles and responsibilities by the Medical Assistants and the Referral Coordination team during the COVID response when the Referral Coordinators were working from home and did not have general access to a fax machine. In an effort to stream line communication and coordination it was determined that a different staff position, a Referral Manager, would take responsibility for faxing the EI referral forms as they had availability every day in clinic and access to the fax machine. This enhancement to the process will likely cut down on duplicative efforts within COPA and reduce confusion within HDESD.

1.B.ii. Facilitated a Meeting between Mosaic and High Desert ESD

- After the December 2020 Stakeholder Meeting, where data findings were shared that illuminated the lack of access and eligibility to EI for children served by Mosaic, the Mosaic East Bend team wanted to understand better ways to partner with HDESD to support these children and families. As identified in the data, the outreach strategies used by HDESD (limited by the funding and resources they

have) have impacted their ability to evaluate and serve children referred by Mosaic. The goal of the conversation, as agreed upon by both entities, was to identify better and more timely communication between HDESD EI staff and the Mosaic Nurse Care Coordination team, who manages these referrals, to allow Mosaic the opportunity to try and re-engage families in the referral process before their referral expires. The following action areas were identified to achieve the goal:

- Mosaic and HDESD set up a secure email portal to engage in more real time conversations
- Quarterly huddles on the children referred to EI services and understanding eligibility – which would be conducted over email

Both of these outcomes were exciting opportunities and connections facilitated by this project, that OPIP believes will lead to better outcomes for children served by Mosaic. That said, this level of communication is not a feasible model to spread across all practices served by HDESD.

2. Barriers Identified in Working with Primary Care Sites

i. Impacts of COVID-19 Response on Pilot Clinics Prioritizing Vaccine Distribution

- In the last six months of our project, COVID vaccines became more readily available and healthcare providers were asked by the Oregon Health Authority and PacificSource to help support and administer vaccines. COPA, Mosaic and St. Charles all took active roles in administering COVID vaccines, which deterred leadership's availability to support the quality improvement work of Pathways. There were varying impacts to the work, including St. Charles not being able to support the Social Emotional Booster Training and pathway and Mosaic not being able to pull their last data report. While these impacts are important to note, it is also important to celebrate the work these practices were able to complete during the COVID 19 response and the impact this project was able to achieve despite a global pandemic.

ii: Impacts of COVID -19 Response on Access to Well Care, especially at visits when vaccines are not due

- In the last 6 months, practices have noted that while more families were starting to return to access well-care, there was still a lot of reservations on accessing care at visits when other services such as vaccines were not scheduled. This is of important consideration for the 9 month, 18 month, 24 month and 30 month well visits, where vaccines may not be scheduled but developmental screening with an Ages and Stages Questionnaire (ASQ) is due to be administered. The ASQ gets more specific and accurate with age and so while families may not think they are missing important components of well-care we know we may have missed the opportunity to get a more accurate understanding of that child's development.

iii: Impacts of Capacity of Services within OPIP'S Medical Decision Tree

- Based on the capacity mapping completed in this project, it is clear that there continues to be **significant capacity issues within two best match referral pathways in the Medical Decision Tree: 1) to PEDAL** and **2) to Supplemental Medical Therapy Services**
  - Primary Care sites have expressed the concern that these well-established capacity issues will continue to have long term effects on the patients that they serve.
- **Within St. Charles Prineville there is lack of capacity by their Internal Behavioral Health staff to complete additional assessments and evaluations of young children and their families prior to sending to Specialty Behavioral Health**. This gap in internal capacity will

increase the number of direct referrals to Specialty Behavioral Health, but could potentially lead to fewer children and families from these sites being eligible for Behavioral Health services.

3. Final Data Summaries Assessing Impact

PART 1: OVERVIEW OF EVALUATION DATA COLLECTION

Table 1 provides an overview of the data collected within each of the four pilot sites during this reporting period. It is important to note that Madras Medical Group and St. Charles Prineville were recruited as a pilot site after work had already begun with COPA and Mosaic.

Table 1 - Overview of Data Collection Periods within the Primary Care Sites

ELHCO Project Data Collection	Timeline							
	Baseline (note St. Charles and Madras are 2019)			Collection 2	Collection 3	Collection 4	Collection 5	Collection 6
	2017	2018	2019	2019	2020	2020	2020	2021
						COVID-19 response		
PRIMARY CARE Data: Medical Chart Review								
COPA Data Collection Periodicity	7/1/17-6/30/18			10/14/19-11/10/19 (paper collection)	Jan – March 2020	March-August 2020	Oct 2020 – Dec 2020	Jan 2021-March 2021
Mosaic Medical Data Collection Periodicity	July 2017 – June 2018			Sept 2019 - Oct 2019	Jan – March 2020	March-August 2020	Oct 2020 – Dec 2020	
Madras Medical Data Collection Periodicity	January 2019 - December 2019					June 2020 - August 2020	Oct 2020 – Dec 2020	Jan 2021 – March 2021
St. Charles Prineville Data Collection Periodicity	January 2019 - December 2019						Oct 2020 – March 2021	

PART 2: DATA ON SCREENING AND THE PROPORTION OF SCREENS THAT IDENTIFIED A CHILD AT RISK (DENOMINATOR FOR THE FOLLOW-UP METRIC)

Table 2 provides a descriptive overview of the characteristics of the screens during the data collection period. Baseline numbers are based on a year of data before sites were trained. Post-Training data is based on data collection post initial training, which happened on a staggered timeline, so represents different allocations of time as noted in the table below.

Table 2: Pre-Training and Post-Training Data Collection: Descriptive Information about Developmental Screens

	Metric	Descriptive Information about Medical Chart Review Data Collected by Pilot Primary Care Sites							
		COPA		Mosaic		Madras Medical Group		St. Charles Prineville	
		Baseline*	Post Training (1 yr and 4 mo)	Baseline	Post Training (1 yr 2 mo)	Baseline	Post Training (9 mo)	Baseline	Post Training (6 mo)
1) Develop-mental Screening Completed	**Screens conducted**	641*	4485	1022	463	302	141	146	73
	Proportion of screens with 96110 claim	641*	4485	975	389	302	125	128	48
2B) Proportion of Screens Identifying Risk	**Overall At-Risk**	117* (**18.3%**)	893 (**19.9%**)	244 (**23.9%**)	93 (**20.1%**)	51 (**16.9%**)	28 (**19.9%**)	23 (**15.8%**)	12 (**16.4%**)
	3-5 domains in black	5*	86	31	5	5	2	4	0
	2 domains in black	22*	104	49	12	5	4	6	0
	1 domain in black	50*	406	94	52	21	13	8	8
	2 or more in gray	40*	297	70	24	20	9	5	4
*At baseline COPA had limited EHR capacity, so their Pre-Training/Baseline data is based on a sample of chart reviews (the first 5 days of every month)									

PART 3: FOLLOW-UP TO DEVELOPMENTAL SCREENING RATES

Scoring Follow-up to Developmental Screening

- OPIP developed a set of metrics that would identify whether the child received "best match follow-up" that is aligned with the medical decision tree practices were trained on.
- Anchored to the medical decision tree, the **scoring is dependent on the levels of risk identified**.
- Additionally, s best match follow-up for some risk groups (2 in the black or 1 in the black) is **based on whether or not the parent or provider had any concerns**.
- Given that information about parental/provider concern is NOT documented in the chart, **OPIP created two versions of the follow-up metric**, one that assumes that the parent and/or provider has concerns and the second version that assumes no parental/concern. Lastly, within each of these versions, **OPIP also calculated the score in two ways:**
    - Option A requires that the best match follow up was provided at the time of the visit and
    - Option B allows for credit to be given if the chart documentation indicated a best match follow up was provided at the visit, was previously provided, OR if the provider attempted a referral but the parent declined.

Table 3 provides an overview of the scoring used and how it relates to the figures shown in this section.

Table 3. Scoring Methodology for Follow-Up to Developmental Screening

Follow-up aligned with medical decision tree	What "counts" as appropriate follow up	Scoring Options
Figure 1– Assuming parental/ provider concern	**3+ in the black** Referral to EI **AND** DB Peds (only EI if < 1 yr)	**Option A -** Best match follow up provided at time of visit (solid bar) **Option B** – Best match follow up provided at time of visit, provided previously, **or** declined by parent (outlined bar)
	1 or 2 in the black Referral to EI	
	2+ in the grey Documentation of rescreen within 3 months	
Figure 2 – Assuming NO parental/ provider concern	**3+ in the black** Referral to EI **AND** DB Peds (only EI if < 1 yr)	
	1 or 2 in the black Referral to EI **OR** rescreen within 3 months	
	2+ in the grey Documentation of rescreen within 3 months	

Figure 1: Percent Change Post-Training in Follow Up Aligned with OPIP's Medical Decision Tree: Uses the Scoring Version that Assumes there **WAS parental or provider concern** at the Time of Visit

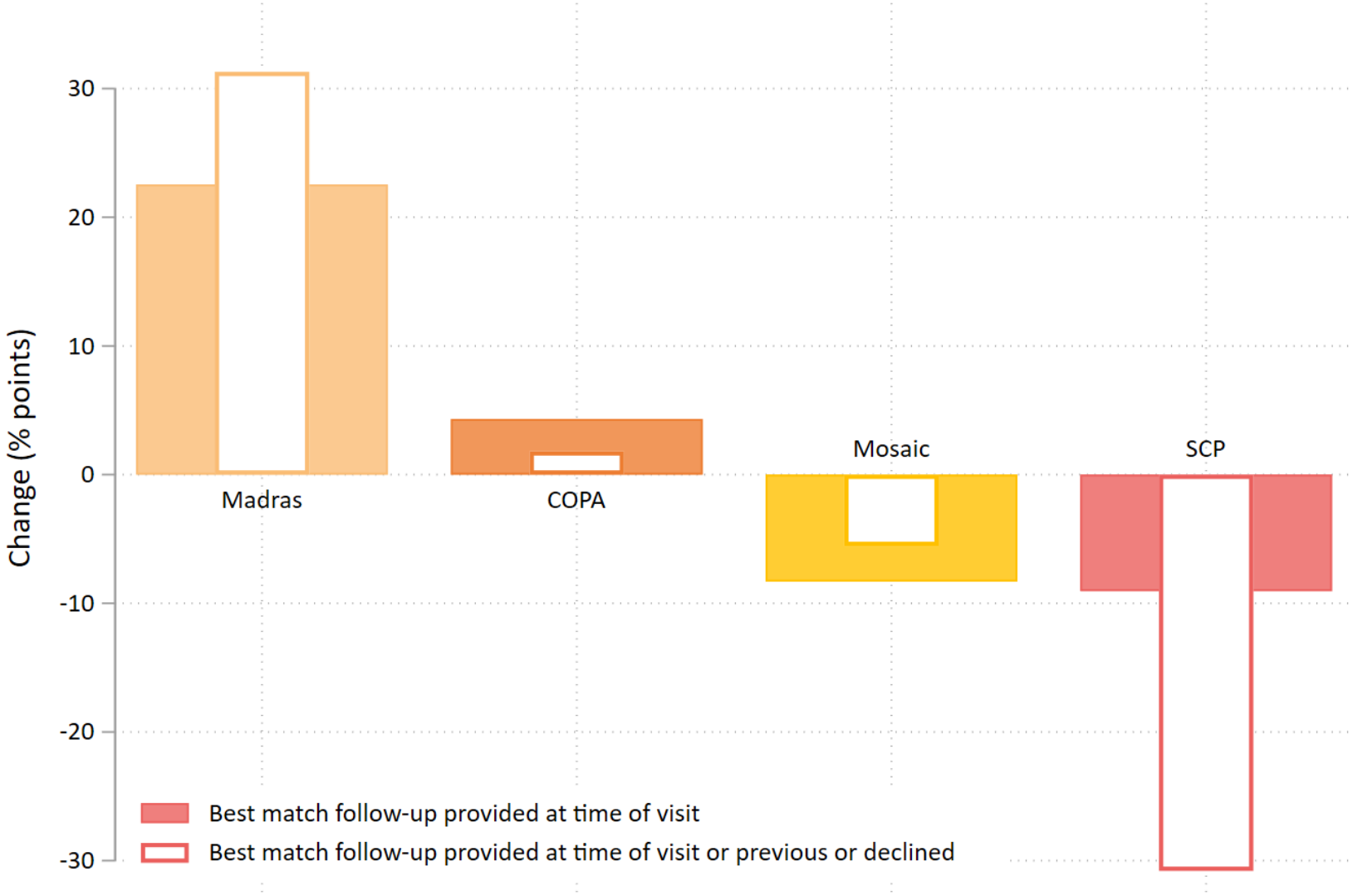
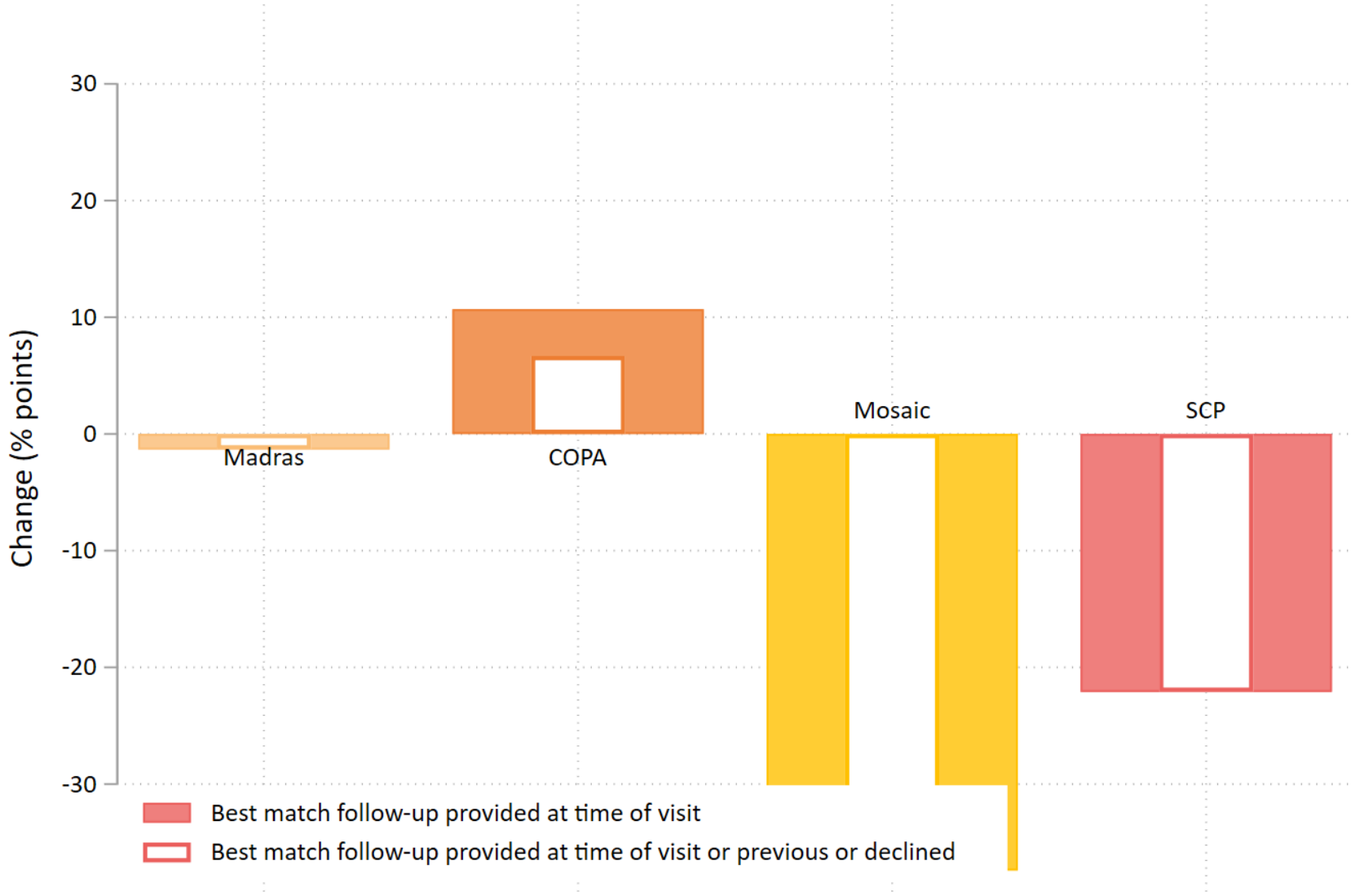


Figure 2: Percent Change Post-Training in Follow Up Aligned with OPIP's Medical Decision Tree: Uses the Scoring Version that assumes there was **NO parental or provider concern** at the Time of Visit



Key Takeaways from Figures 1 and 2:

- Madras Medical Group had to manually collect data for each submission, so they were more closely tracking quality improvement throughout the course of the project, which may have led to their significant improvements in aligning with the decision tree, as seen in Figure 1.
- In Figure 2 – documentation of rescreen, which is the recommended follow up for a majority of screens when there is no concern, is not something that is generally documented well within the EHR. In COPA's EHR modification, they were able to build in documentation of a rescreen, which is seen in this graph.
- St. Charles Prineville had an extremely small sample size "Post-Training". While their percentages seem to drop significantly, one reason for that is because they did serve many children for which the ASQ identified a risk after being trained.

PART 5: ASSESSMENT OF WHETHER SPECIFIC FOLLOW-UP REFERRALS SAW IMPROVEMENT

In addition to assessing whether the child received best-match levels of follow-up, individual referrals were also examined. Table 4 shows the referrals made to each of the applicable providers and the change in referrals to these providers post-training as compared to the previous year.

Table 4: Number of Referrals Made to Follow Up Services within Medical Decision Tree at Before and After Training and Changes Observed

Referral to:	Quantitative Baseline and Follow-up Data: States of Data Collection and Analysis												
	Primary Care Practice Data: Medical Chart Review Findings												
	COPA			Mosaic Medical Group			Madras Medical Group			St. Charles Prineville			TOTAL Referrals Made After The Training
	Baseline* (1 year)	Post Training (1 yr 4 mo)	Δ	Baseline (1 year)	Post Training (1 year 2 mo)	Δ	Baseline (1 year)	Post Training (9 months)	Δ	Baseline (1 year)	Post Training (6 months)	Δ	
DB Peds/PEDAL	0	9	↑	6	4	↓	0	0		2	0		15
EI	15	116		23	16	↓	5	10	↑	0	0		142
OT/PT	1	23		1	2		0	0		0	0		25
Speech Therapy	5	64		6	5		0	0		1	0		70
Internal Behv. Health	1	8	↑	2	2		0	0		0	0		10
External mental health	0	1		1	0		0	0		0	0		1

*At baseline COPA had limited EHR capacity, so their Pre-Training/Baseline data is based on a sample of chart reviews (the first 5 days of every month). For general proxies of improvement in referral outs, we multiplied the baseline sample by 4 to represent a month.

4. Implications of Successes and Barriers for Future of Work

Supporting Spread Across St. Charles – While OPIP always planned to stagger the roll out of the additional primary care pilot sites, COVID-19 response further delayed the roll out, onboarding and training of St. Charles Prineville. In an effort to best support this critical health system, OPIP is proposing a strategical meeting of St. Charles Leadership in Summer of 2021 to discuss opportunities to share and leverage across-system quality improvement aligned with the Integrated Care for Kids (InCK) work in Central Oregon.

Improvements to EHRs – During the course of the project, COPA was the only site that was able to facilitate improvements to their EHR to better align with OPIP's Medical Decision Tree and provide decision support at the time of screening to support best practices. It has shown to be beneficial to embed clinical decision support to reduce provider burden in implementation. Both EPIC (St. Charles) and OCHIN EPIC (Mosaic) would have the capacity to support these improvements moving forward, but was not prioritized in this scope of work.

Capacity of Services Identified in OPIP's Medical Decision Tree - While we saw small improvements to assets within Central Oregon that support follow up to developmental screening including PEDAL, Early Intervention and Specialty Behavioral Health, there were still a large number of children who would have benefited from those services and were not referred due to capacity concerns from the providers. To truly support children identified at risk for developmental delay, additional investments are needed to further increase capacity of services available in Central Oregon.