



### Deliverable 3.3

#### Summary of Primary Care Practice-Level Implementation: Successes and Barriers

This document provides a high-level summary of the primary care practice implementation and key learnings related to successes and barriers. Per the contract, **Deliverable 3.4** provides a summary of the data collected by the primary care sites evaluating the impact of the implementation efforts; **Deliverable 5.2** is a Toolkit for Primary Care Practices that includes the tools OPIP developed and that were modified based on learnings from the implementation.

**Primary Care Sites:** Overall, four primary care sites agreed to serve as the pilot sites for the project and received implementation support and technical assistance through the CPCCO grant: 1) Tillamook County Community Health Center, 2) Adventist Women’s and Family, 2) OHSU Scappoose and 4) Columbia Memorial Hospital – Pediatrics. As part of their agreement to serve as a pilot site, the staff were required to:

- 1) Identify a **multidisciplinary project team** for the project. This team was required to participate in **monthly facilitation meetings with OPIP** and to support the ongoing quality improvement implementation efforts.
- 2) Participate in **community-level stakeholder engagement** which included participating in the original stakeholder interview and attending the semi-annual community level stakeholder meetings.
- 3) Provide **baseline and evaluation data** based on information in the **electronic health record (EHR)**. The practices provided baseline data (1 year) and then subsequent updates during the implementation period (5 quarterly data runs). Secondly, in an effort to examine disparities between practice-level reported numbers of referrals to Early Intervention (EI) vs. EI’s number of referrals from the practice site, each site provided child-level data files to EI of children they referred to EI. A total of 6 child-level data files were transferred to EI for examination of practice sites that had large discrepancies.
- 4) **Develop and implement small tests of change** informed by the evaluation data and that support implementation of the improvement tools developed by OPIP.
- 5) **Engage a parent partner** in this work. This could involve having a parent on the quality improvement team or having parents review and provide feedback and input on the improvement tools and strategies identified and implemented in the primary care site.

To support the practice-level implementation, OPIP:

- Developed the **improvement tools** to implement, conducted an all-staff training, and conducted facilitation site visits. OPIP also refined the improvement tools based on learnings. **Appendix A** provides example slides from the training.
- **Facilitated conversations with community-level partners** about the barriers experienced by practices.
- **Analyzed the raw data** provided by the practices and EI and created practice-level and provider-level reports summarizing the findings and implications.
- Provided an opportunity for meaningfully engaged providers to obtain **Part IV Maintenance of Certification (MOC) credit**.



The following is a summary of successes and barriers experienced during the practice-level implementation relative to the five key activities required of the pilot sites.

Activity #1: Identify a **multidisciplinary project team** for the project. This team was required to participate in **monthly facilitation meetings with OPIP** and to support the ongoing quality improvement implementation efforts.

### **Successes:**

- Each primary care practice developed a multi-disciplinary team and had at least some members engaged and maintained consistent involvement.
- The engagement and collaboration was particularly strong in Adventist Women and Children's and Tillamook County Community Health Center.
- **That said, the facilitation meetings and implementation support offered by OPIP was reported by most of the sites as critical and is ongoing.** Facilitation work with primary care included understanding baseline workflows within the practices and doing "gap analysis" for why children may not be getting the best match follow up services. This gap analysis leveraged data collected, but it was also important to understand the clinic's implementation strategies to help identify where and why the improvement strategies may not be working.

### **Barriers:**

- There were significant transitions in clinical leadership in nearly all of the sites, which led to some barriers in meaningful engagement or in competing demands for time. While transition is a constant reality when working with primary care, it helps illuminate the importance of creating a standardized process for improvement so that this important work is not contingent on one person's job.
- In two of the sites, there was also significant staff turnover of primary care providers or behavioral health staff that led to barriers in implementation and/or a need to retrain staff.
- One site was inconsistent in their attendance at meetings and site visits (CMH Astoria) and was sporadic in their engagement regarding next steps.

Activity #2: Participate in the **community-level stakeholder engagement** which included participating in the original stakeholder interview and attending the semi-annual community level stakeholder meetings.

### **Successes:**

- Each of the four sites meaningfully engaged in the community-level meetings. This was seen by community partners as a strength of the project and a collaboration builder. There were many meetings where the simple face-to-face interaction of the primary care office staff and the local community-based provider created "aha" moments about what each other offered and ways they could work together.

- This was particularly meaningful and important in Tillamook County, where deep and robust **engagement by Adventist** primary care and Rehabilitation Services was critical and seen as a “big win” by the community. Prior to this pilot, many community stakeholders reported Adventist’s lack of participation in other quality improvement initiatives. As our pilot work started, critical staff had transitioned from TCCHC to Adventist Women’s and Family which provided OPIP the opportunity to continue to engage this thought leader on the importance of improved pathways for follow up to developmental screening. Not only did this site agree to participate, but we also saw the most openness to improvement opportunities as well as changes in the quantitative data.
- In Clatsop County, when the community-level stakeholders reviewed the practice-level data, saw the tools developed and saw a lack of improvement/engagement from CMH Pediatrics, they strongly encouraged OPIP to reach out and share the tools with the other primary care site that saw a vulnerable group of children - **Coastal Family Health Center**. OPIP agreed to reach out, and partially due to the strong community engagement and local “word on the street” about the project, they were eager to set up a training. In June 2019, OPIP conducted an all site training in Astoria.

### **Barriers:**

- Following the overall training to the primary care practice sites, “meet and greets” were held where the community-based providers noted in the medical decision tree were invited to come to the primary care practice and to share about their services and to answer questions. Unfortunately, this meetings was not well attended by the primary care physicians at OHSU Scappoose and required a lot of facilitation at Adventist Women’s and Family due to a tense political landscape.

Activity #3: Provide **baseline and evaluation data** based on information in the **electronic health record**.

### **Successes:**

- All four sites provided data for the required time periods.
- All four sites developed baseline skills and abilities to understand what data was needed to assess follow-up to developmental screening.
- Two of the four sites were able to eventually use data in the EHR that was searchable and therefore required fewer manual chart reviews.
- The data dispelled myths about current behaviors and illuminated opportunities for improvement.
- Provider-level reports were created and disseminated and is an essential component of the Part IV Maintenance of Certification (MOC) opportunity.
- Before this project, none of the sites had a standardized process to generate an EI referral nor were the referrals consistently tracked, but now systems are in place for both.

### **Barriers:**

- Two of the four sites did not develop EHR templates or USE their EHR in a way that would allow them to generate data using reports and based on data entered into searchable fields. Therefore, manual chart review was required in these two sites.
- Another limitation of the EHR templates used by our pilot sites was the **lack of documentation opportunity to rescreen/monitor** at a closer interval. An important nuance to OPIP's decision tree is when neither the parent nor provider has concerns about the child's development it is then recommended to monitor that child's development. Unfortunately a majority of the practices did not have a way to document this decision outside of free texting into the note (which is not trackable or reportable). This led to limited data for this decision; the practices and OPIP think this resulted in a sizable undercounting of this decision.
- CMH Astoria is still unable to generate a report for this population, based on their EHR, and therefore unable to manage the population of children identified at-risk on developmental screening tools and related follow-up steps.
- OHSU Scappoose changed their EHR in the middle of the project. The EHR transition also made it hard to compare data over time as structured fields that providers once relied on for documentation aligned with the medical decision tree were no longer available.
- **Unintended negative consequence of screening at every visit** – In collecting longitudinal data, a concern that OPIP has identified for all our pilot sites practices is that there may be an overreliance on 'watchful-wait' to see if that child 'grows' out of the delay, since they all screen at every visit. The goal of developmental screening is to identify delays early and to provide developmental promotion and/or supports to address those delays as soon as possible and when providers start to see the ASQ as a monitoring tool, the next step of providing follow up when a delay has been identified may be lost.

Activity #4: **Develop and implement small tests of change** informed by the evaluation data and that support implementation of the improvement tools developed by OPIP.

### **Successes:**

- **Primary care providers' high satisfaction with the tools.** All sites have reported that the medical decision tree is of value to the practices since the national recommendations do not align with Oregon's strict EI eligibility criteria and lack of Developmental Behavioral Pediatricians statewide. The enhanced guidance provides primary care practices a more critical approach to follow up that considers all resources that are available in the community.
- As is described in **Deliverable 3.4**, improvement was observed in three of the four sites. These three sites demonstrated commitment to implementation and had some level of meaningful engagement in the facilitation visits. Of note, increased referrals to EI and enhanced outcomes of those referrals was observed.

- Applicable providers in the pilot sites will obtain Part IV MOC credit for their meaningful engagement in this improvement efforts.

### **Barriers:**

- **Lack of EHR templates that map to the medical decision tree and guide the providers to do the right thing for the right child at the right time.** Three of the four practices had structured templates for follow up to developmental screening, allowing them to report what was available and used in these forms, but none were tailored to the medical decision tree or provided quick links to the right referral forms and parent education material. Adventist Women’s and Family and Tillamook County Community Health Center have *very similar EHR structures and yet the implementation of these templates was vastly different* leading to different levels of follow-up and different data outcomes.

OCHIN’s template for developmental screening can be helpful for decision support, but in practice many of these supports are not seen by providers. For example, within the screening tab drop downs are available that align with a number of the prioritized pathways in OPIP’s medical decision tree, yet unfortunately Medical Assistants are the ones who are documenting in this template and do not yet know the follow up that will be recommended by the provider and so this documentation opportunity that aligned with reportable data elements is skipped. Within Adventist Women’s and Family, the two providers collectively agreed that they would go back into the screenings tab and document follow-up within the ASQ templates – which is not a workflow a lot of providers would agree to for time and efficiency purposes.

- **Lack of Capacity or Feasible Access to Services Recommended in the Medical Decision Tree:** In examining the data and based on facilitated conversations with providers, it is clear that providers in Tillamook and Clatsop are still *hesitant to refer to a Developmental and Behavioral Pediatrician*. Most providers noted their hesitancy to refer was due to wait times that are about a yearlong and the time commitment for an evaluation is extensive. An additional barrier to the Developmental Behavioral Pediatrician referral is the limited capacity of resources for Occupational Therapy, Speech Therapy and Physical Therapy in these counties for young children to help execute the plan identified by a Developmental Behavioral Pediatrician. While primary care providers have noted the value of referral to a Developmental Behavioral Pediatrician to identify if there are any etiological reasons for the child’s development, the follow up plans developed are often not able to be executed to fidelity based on capacity of services available, causing providers to under refer to this resource.
- OHSU Scappoose changed their EHR in the middle of the project, making it difficult to focus on the project. The EHR transition also made it hard to compare data over time because the structured fields that providers once relied on for documentation aligned with the medical decision tree were no longer available.



**Activity #5: Engage a parent partner** in this work. This could involve having a parent on the quality improvement team or having parents review and provide feedback and input on the improvement tools and strategies identified and implemented in the primary care site.

**Successes:**

- This project requirement helped illuminate the value that parent feedback on quality improvement initiatives could offer as NWEHL parent partners actively participated in community level stakeholder meetings and primary care pilots saw the great insight they provided. This requirement also served as a tangible project for families to participate in, instead of an open-ended request for family involvement within the practice.
  - CMH Astoria identified a parent to provide feedback on tools and workflows for follow up to developmental screening.

**Barriers:**

- While TCCHC and OHSU Scappoose had Patient/Family Advisory Committees (PFACs), neither site had representation from parents of young children or people who had exposure to developmental delays, so they could not leverage existing infrastructure.
- OHSU Scappoose also wanted to leverage a parenting class that is offered in their clinic, but no classes were offered in the course of our project work.



**Pathways from Developmental Screening to Services:  
Project led by the Northwest Early Learning Hub –  
in collaboration with the *Oregon Pediatric Improvement Partnership*  
in Columbia, Clatsop and Tillamook Counties**

**Appendix A : Primary Care Training Slides  
Coastal Family Health Center Training  
June 2019**





# Agenda



## 1. Setting the Stage - Background & Context

- Need and goal for the community-based project to the Northwest Early Learning Hub, with OPIP as a key partner

## 2. Brief Overview of the Community-level Project Focused on Pathways from Developmental Screening to Services in NW Oregon

## 3. Tools to Help You with Follow-Up to Developmental Screening Tailored to Referrals Available in Clatsop County

### A. Follow-Up to Developmental Screening Decision Tree

- Based on Age, ASQ domain scores, Parent/Provider Concern & Child/Family Risk Factors → Best match resources in your community

### B. Supporting Families Referred: Enhanced strategies to close the referral loop

- Shared Decision Making and Parent Education Sheet – Version 1
- Phone Follow-up Script for Families Referred
- Communication back from Early Intervention when family can't be contacted and/or to provide information on evaluation findings

# Momentum Around **Developmental Screening** in Oregon

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

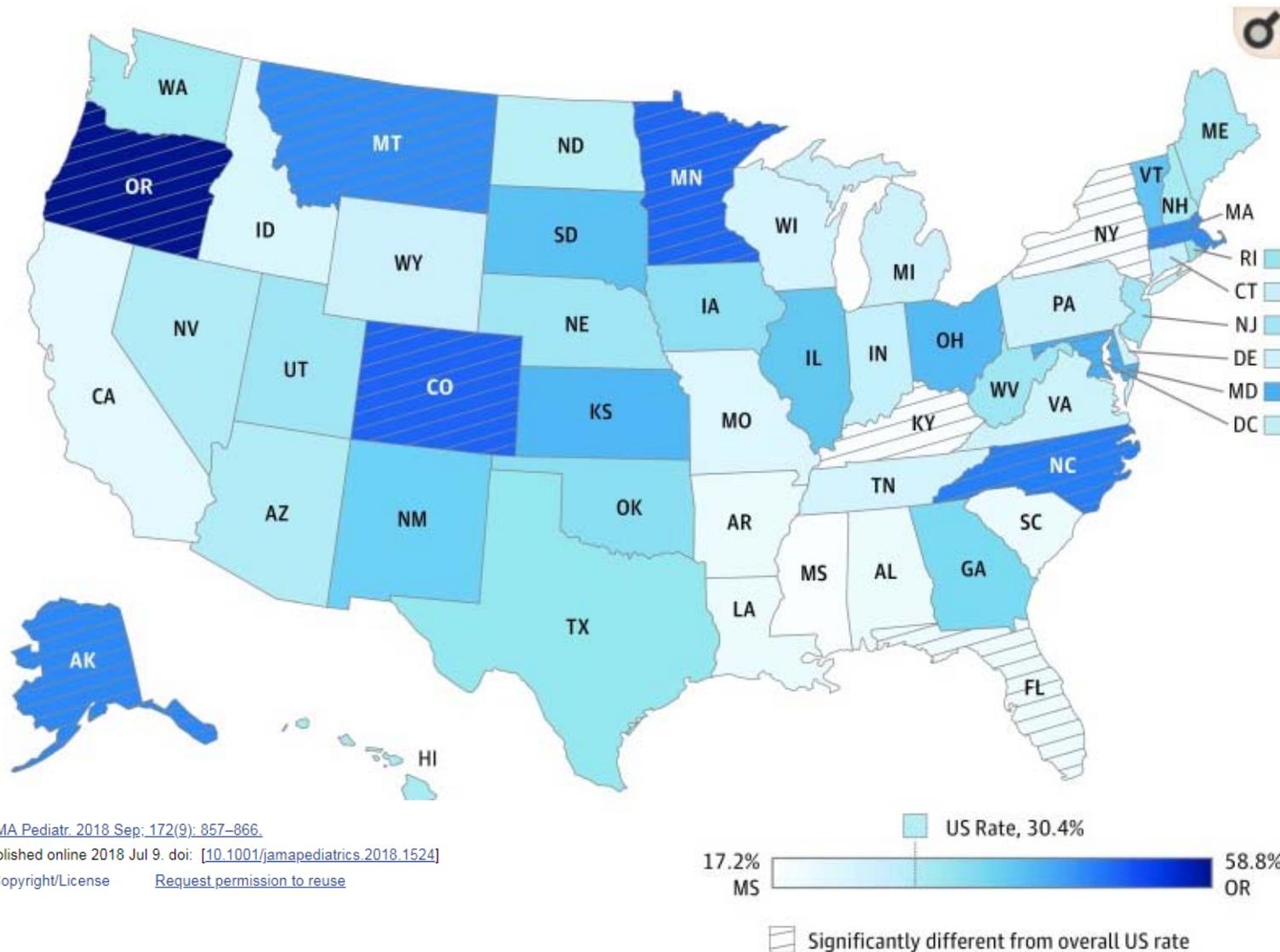
- Coordinated Care Organization Incentive Metric – Developmental Screening
- Oregon Patient Centered Primary Care Homes (PCPCH) Standards - Includes Developmental Screening as “Must Pass” Standard

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

- Early Learning Hub Metrics
  - 1<sup>st</sup> wave Included CCO Developmental Screening Incentive Metric
- Developmental screening a key part of many home visiting programs
- High quality child care – part of highest level designation - SPARK



# National Survey of Children's Health: Finding Based on Parent Report



PMC full text: [JAMA Pediatr. 2018 Sep; 172\(9\): 857-866.](#)

Published online 2018 Jul 9. doi: [10.1001/jamapediatrics.2018.1524]

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- That said, there still 2 in 5 children in Oregon NOT receiving a recommended standard of care. Recommendations existed since 2011.

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

- Goal of screening
  - Identify children **at-risk** for developmental, social, and/or behavioral delays
  - For those children identified, **1) provide developmental promotion, 2) refer to services** that can further address delays
- Many of these services live outside of traditional health care
- Previous trainings and guidance recommended referrals for all children identified at risk to a developmental behavioral pediatrician and EI.
  - These services often have long waits (DB PEDS) or kids are often ineligible (EI)
- Barriers to access of follow-up services:
  - ❖ Lack of knowledge of services
  - ❖ Lack of capacity of services
  - ❖ Lack of availability of services that would be best match
  - ❖ Parent engagement

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

*These are children who 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). 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:*

- Data shows that while screening has increased, children receiving services earlier addressing delays in not increasing at the same rate
- Health Aspects of Kindergarten Readiness
  - Follow-up to developmental screening a part of the four-part metric strategy
- **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

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

- While Oregon is seeing an increase in screening, most children identified at-risk are not receiving follow-up aligned with recommendations
- Primary care providers are not referring all children identified at-risk
  - OPIP has collected data across dozens of practices
  - **60-80%** of children identified at-risk for delays on the ASQ **do not receive a best match follow-up**

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

Referral rates to Early Intervention (EI) have increased in Oregon, but not proportional to screening rates

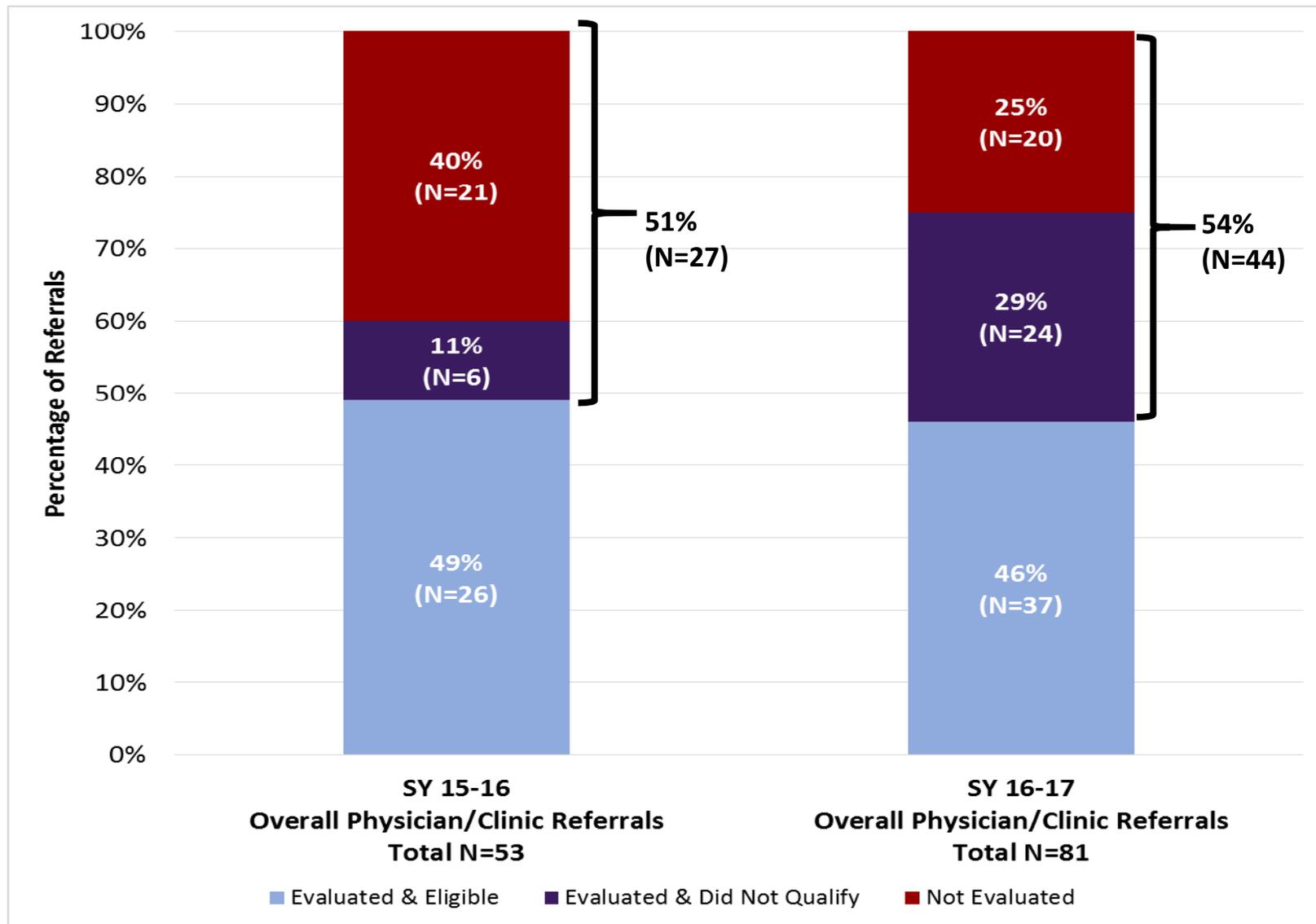
- Number of children served by EI has not increased in a way aligned with early identification through screening.

In Clatsop:

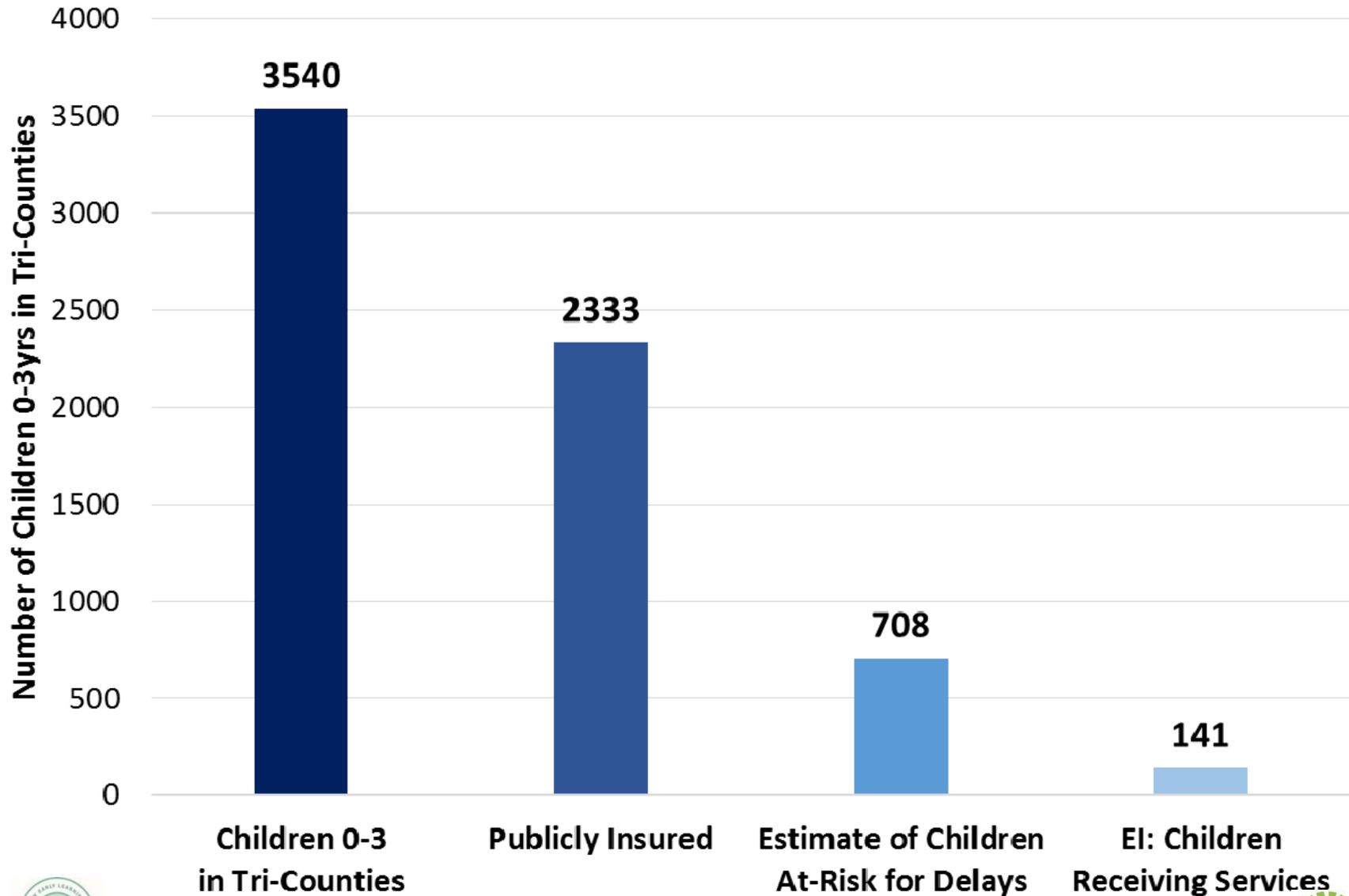
- **1 in 4** children referred by PCP to EI **not able to be evaluated (despite EI outreach attempts)**, no communication back to referring entity
  - Of those evaluated, 60% were found to be eligible for services, **meaning 40% were ineligible for services**

Other child health data indicate that the goal of early identification to address early delays to ensure kids are ready for school are not yet being achieved

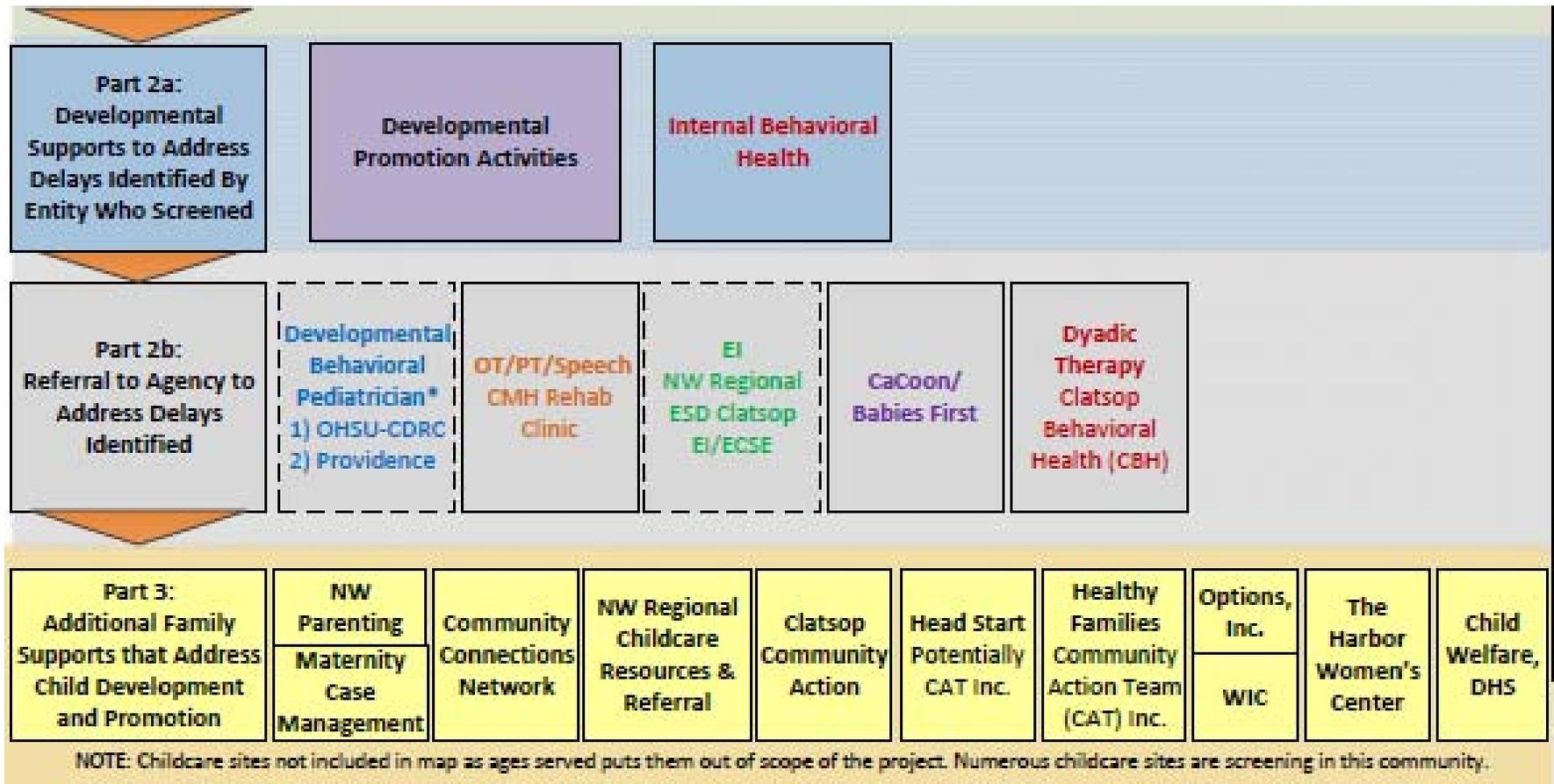
# Outcomes of EI Evaluation in Clatsop By: Overall Physician Referrals



# The Story of Young Children in Tillamook, Clatsop and Columbia Counties



# Identified Assets in Clatsop County that Can Provide Follow-up and Supports to Families of Young Children



# Pathways from Developmental Screening to Services for Young Children Identified At-Risk



Project #1: Northwest Early Learning Hub Funded by Columbia Pacific Coordinated Care Organization (CPCCO), Oregon Pediatric Improvement Partnership (OPIP) is a key partner

- Two-year project – August 2017-July 2019
- Aim: To improve the **receipt of services** for young children who are identified at-risk for developmental and behavioral delays.
- Four Primary Care Clinics Part of the Pilot to Improve Follow-Overall, Track Evaluation Outcomes
  - Today we are sharing with you the improvement tools and templates developed for these pilots sites that have demonstrated positive impact

Project #2: Greater Oregon Behavioral Health In. (GOHBI)

- One-year project – October 2018-September 2019
- Aim: To improve the **receipt of services** for young children who are identified with **social-emotional delays**
- In this region, CBH and EI have started a pilot to improve pathways

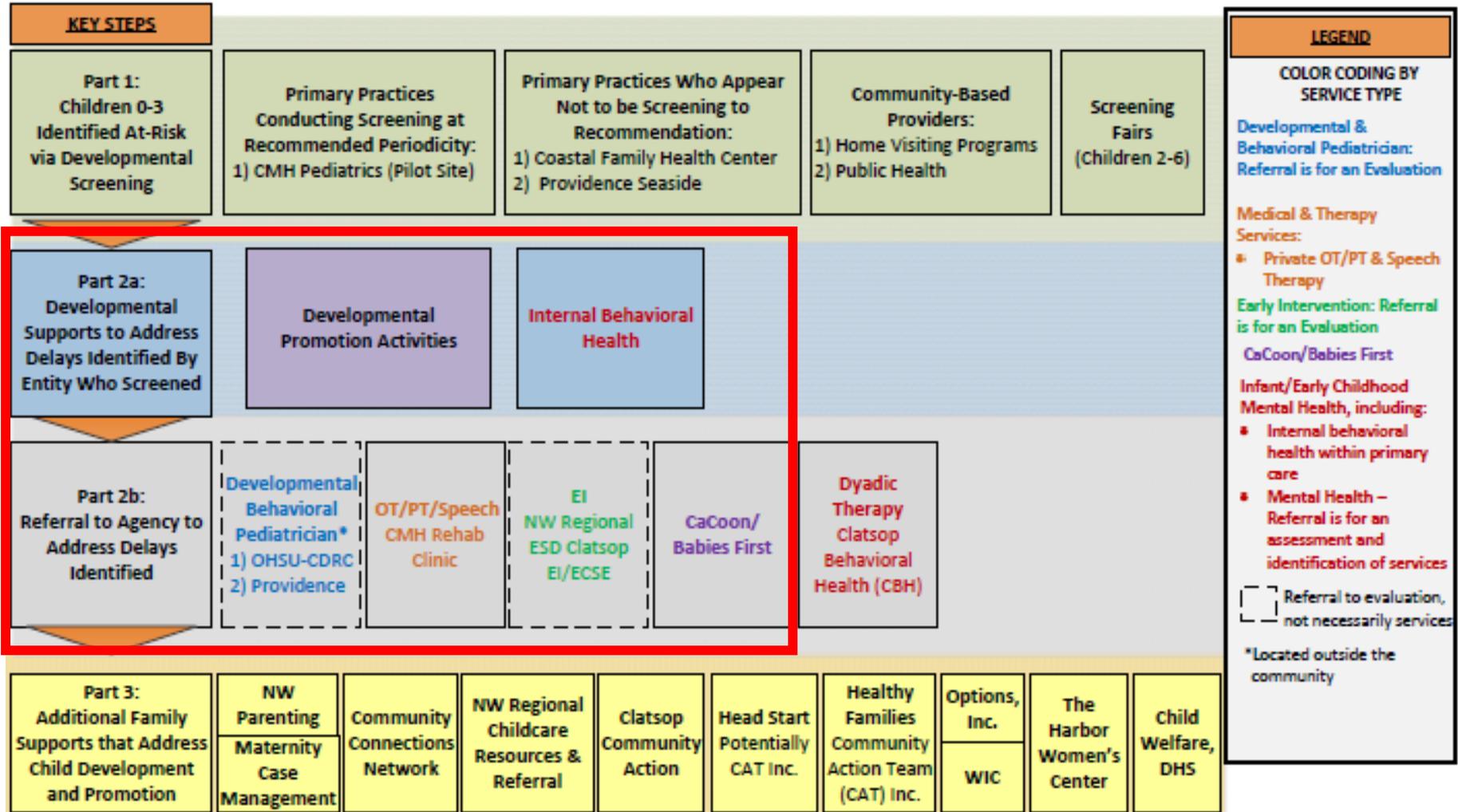
# Training Today

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- Share the tools that we have **developed to help you in identifying the best match set of services** for children currently in Clatsop County
  - Today: Overarching overview of the follow-up to screening medical decision tree and deep dive on first set of services
- Share the tools that we have **developed for shared decision making & care coordination support**
  - Shared decision making sheet anchored to first phase set of resources
  - Follow-up phone call script for families who may need supports
- **Prepare you for communication back from Early Intervention** if you use the referral form to fidelity

# Focus of Today's Training is on Best Match Follow-Up in the Red Box Below

## PATHWAY FOR DEVELOPMENTAL SCREENING OF CHILDREN 0-3 & REFERRAL FOR CHILDREN IDENTIFIED AT-RISK IN CLATSOP COUNTY



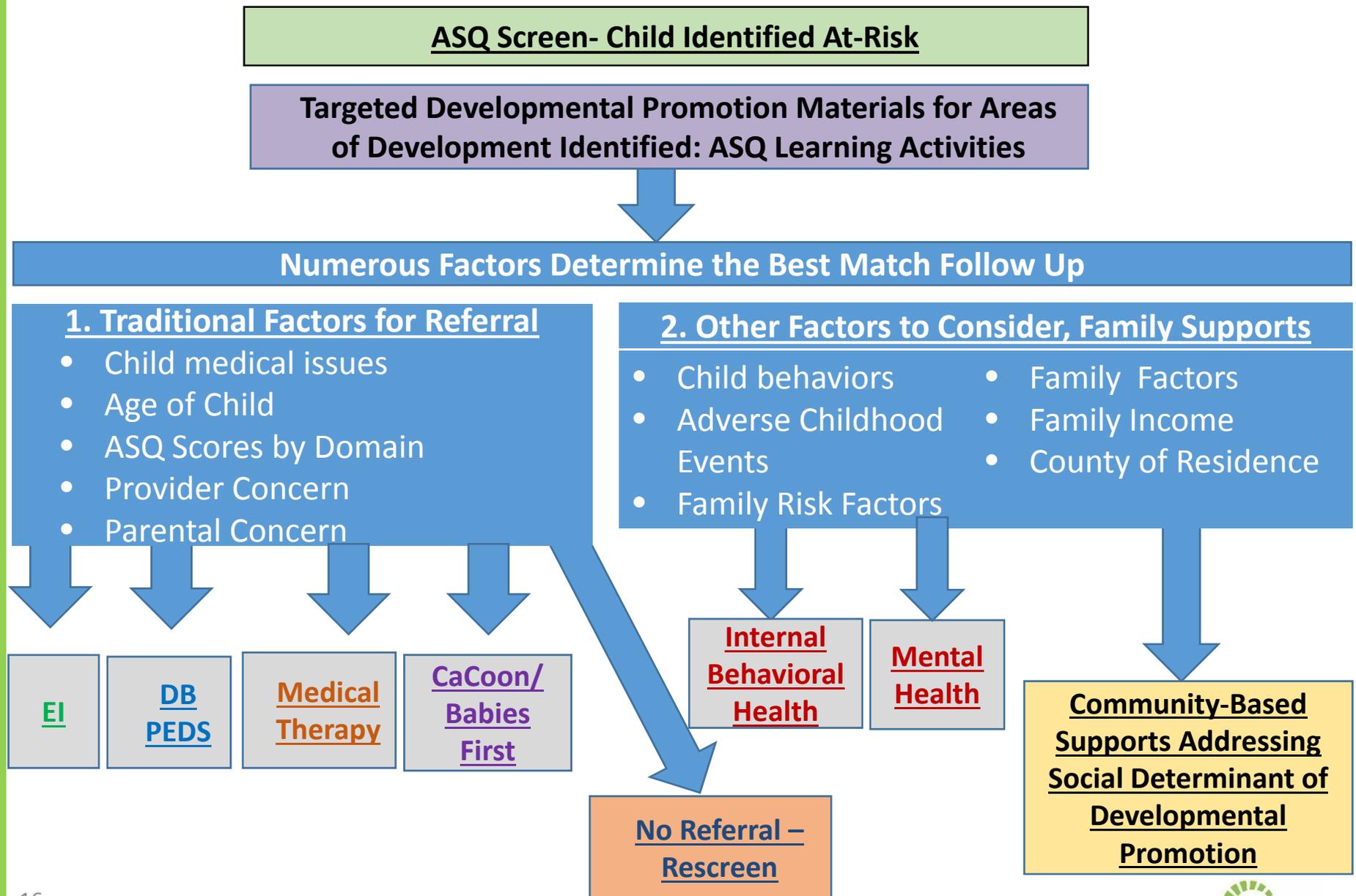
NOTE: Childcare sites not included in map as ages served puts them out of scope of the project. Numerous childcare sites are screening in this community.

## Follow-Up to Screening Decision Tree: Determining the “Best Match” Follow-up Services

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- It is not as simple as “at-risk” or not based on the ASQ  
(*1 in the **Black**, 2 in the Grey*)
  - Your front-line experience suggests, and the data confirms, that not all children identified “at-risk” should be referred to EI and medical evaluation in Oregon
  - Parents may push back on specific referrals
- 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) Resources in your community

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



# Follow-Up to Developmental Screening: Priority Resources that Address Specific Delays

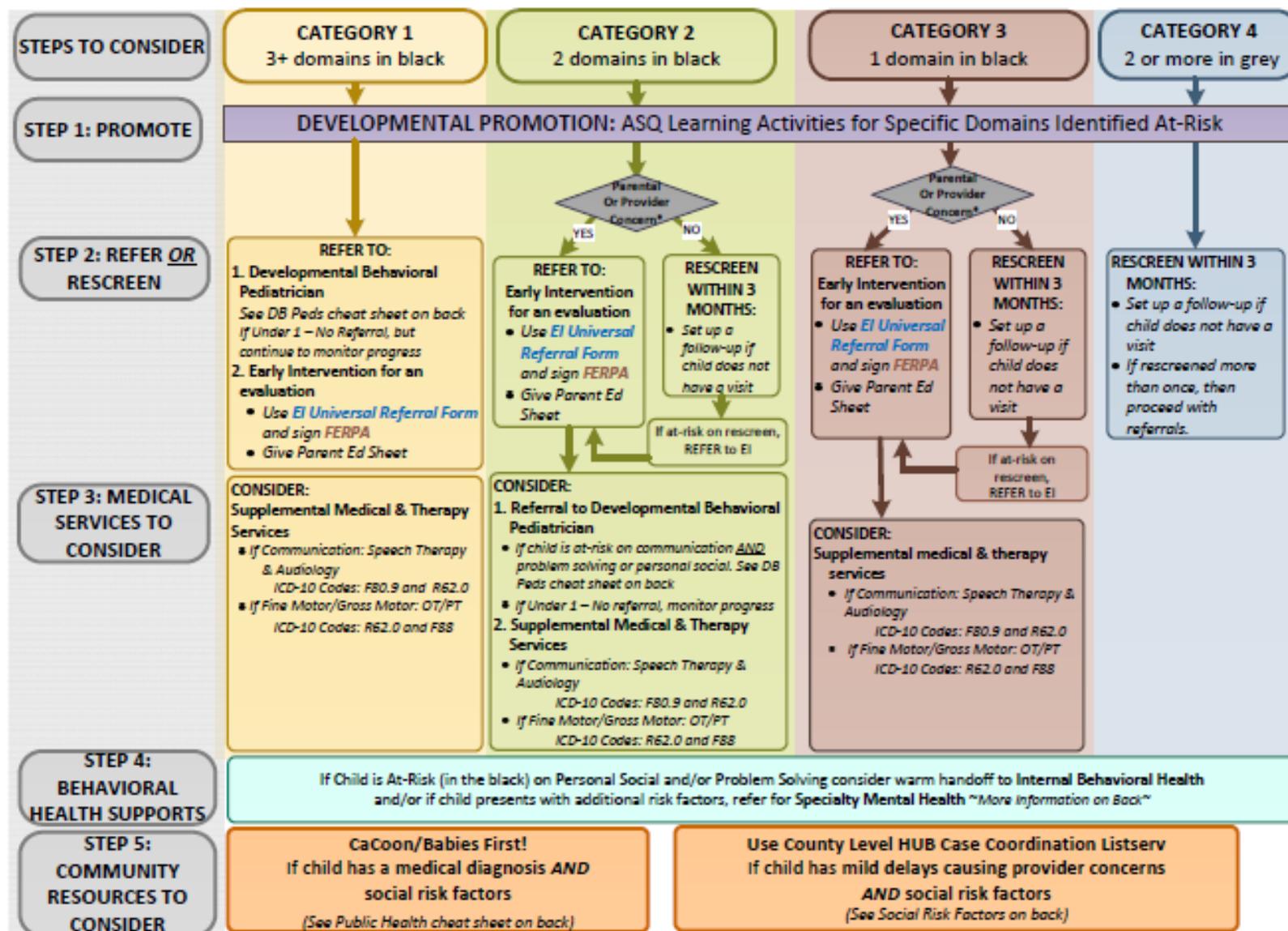
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Based on asset map, priority follow-up referrals included in our training today:

1. Developmental Behavioral Pediatrics (DBP)
2. Early Intervention (EI)
3. Medical and Therapy Services
4. Internal Behavioral Health Supports
5. CaCoon/Babies First

# Follow-Up to Screening Decision Tree

FOLLOW-UP TO DEVELOPMENTAL SCREENINGS CONDUCTED IN CLATSOP COUNTY IN FIRST 3 YEARS: MEDICAL DECISION TREE

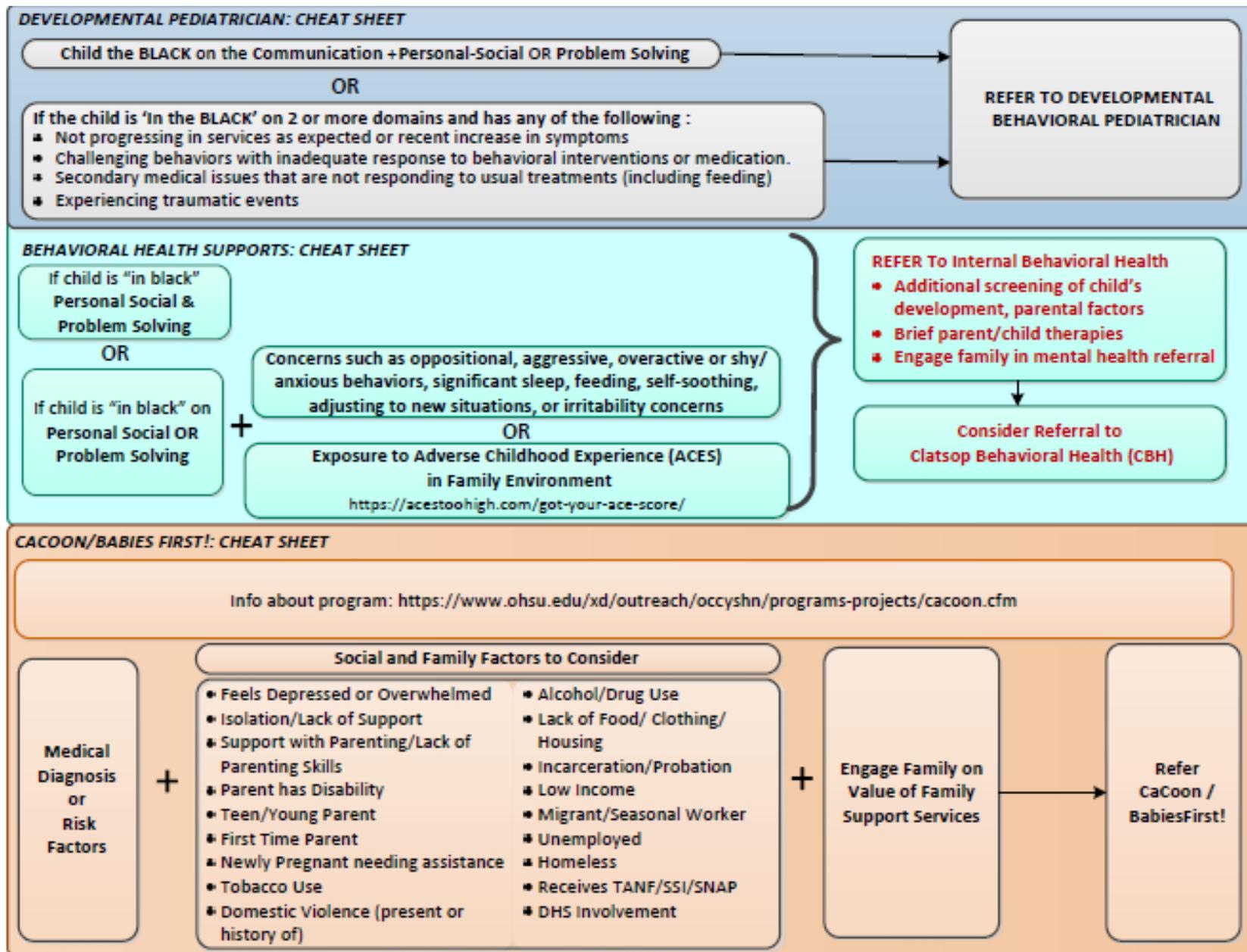


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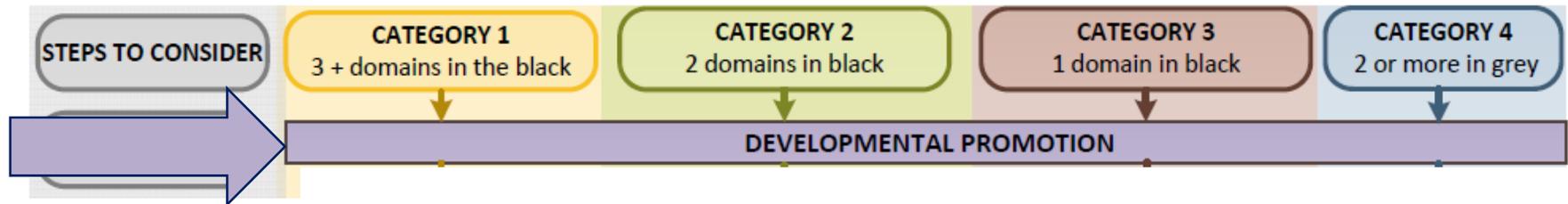
\* One example of when a provider should be concerned is if a child is well-below the cut-off in the domain(s).



# Follow-Up to Screening Decision Tree (BACK)



# Medical Decision Tree: Developmental Promotion



- 1) ASQ Learning Activities for the Specific Domains
- 2) CDC Act Early
- 3) Option of ASQ Online  
*(Also for the Rescreen, Include ASQ and ASQ Online)*

# Medical Decision Tree: Developmental Promotion

## Specific follow-up: ASQ Learning Activities for the Specific Domains

These suggestions<sup>1</sup>:

- Encourage progress in the 5 developmental areas of the ASQ
- Give parents age-appropriate and safe activities to complete at home with their children
- Promote close parent-child interaction

1. <https://agesandstages.com/products-pricing/learning-activities/>

## 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!

# GENERAL DEVELOPMENTAL PROMOTION Could Benefit All Children



**Try CDC's FREE Milestone Tracker app today...**  
*Because milestones matter!*

- Illustrated milestone checklists for 2 months through 5 years
- Summary of your child's milestones to share
- Activities to help your child's development
- Tips for what to do if you become concerned
- Reminders for appointments and developmental screening

<https://osp.uoregon.edu/home/whatIsTheASQ>

**OREGON SCREENING PROJECT**  
Check your child's development  
Ages 1 month to 6 years

English Spanish

Home Questions? ASQ ASQ:SE About Us Contacts

### What is screening?

**Let's Get Started!**

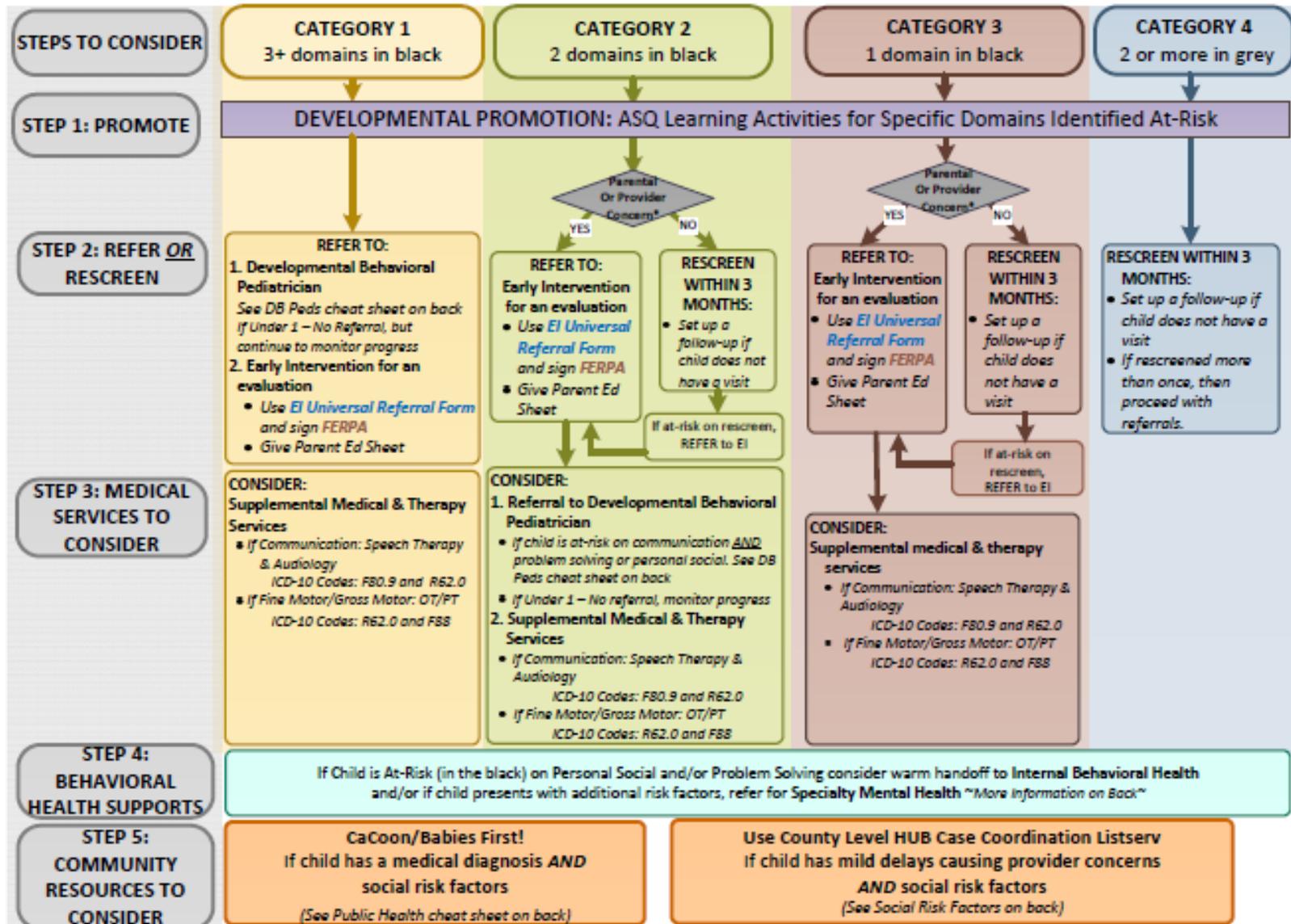
**HOW IS YOUR CHILD DOING?**  
Use this free online site to check early development

**PARENT RESOURCES**  
Explore research-based parenting tips

**PROVIDERS' TOOLKIT**  
Engage families in your screening program  
**New! - ASQ Review Guide**

# Follow-Up to Screening Decision Tree

FOLLOW-UP TO DEVELOPMENTAL SCREENINGS CONDUCTED IN CLATSOP COUNTY IN FIRST 3 YEARS: MEDICAL DECISION TREE

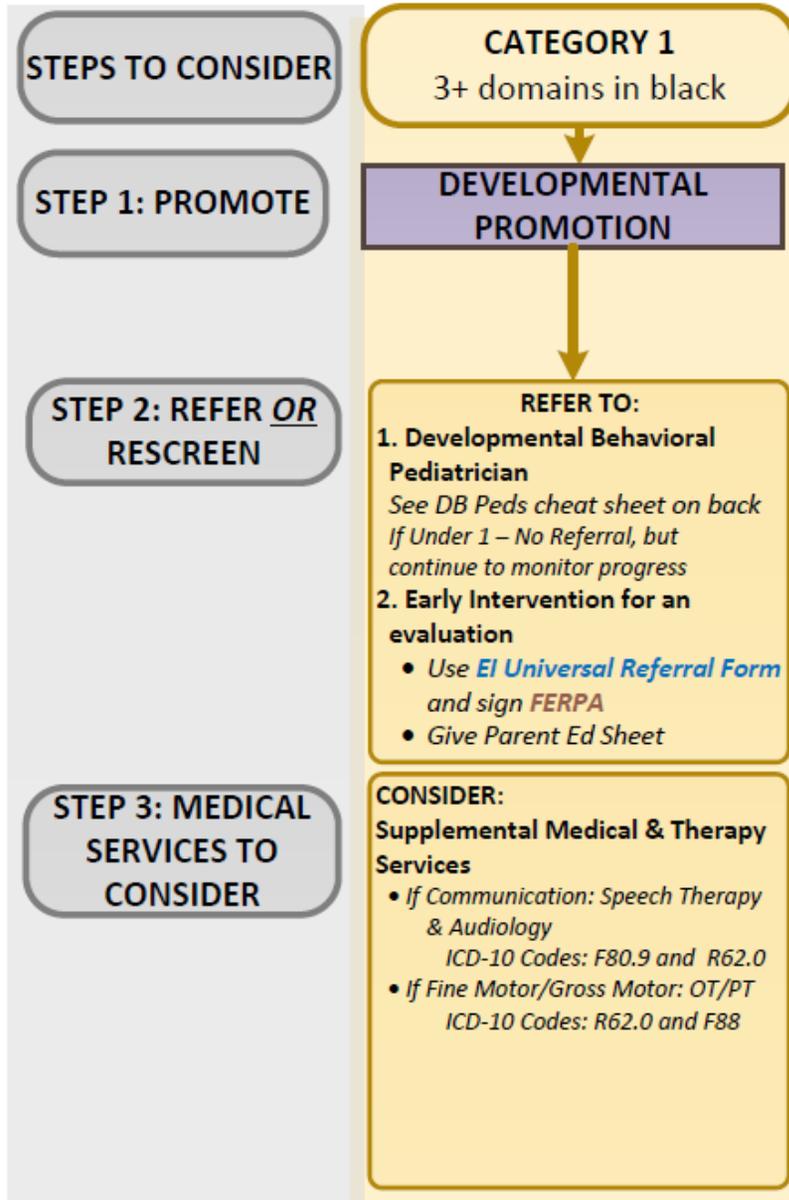


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\* One example of when a provider should be concerned is if a child is well-below the cut-off in the domain(s).



# Follow Up Aligned with Medical Decision Tree: Screens 3+ Domains in the Black



~ 1-2% of Screens with 3+ in the Black

Follow up provided should include:

1. Give the **ASQ Learning Activities** for the domains identified in the black
2. Refer to **Developmental Behavioral Pediatrician** for children over the age of 1
3. Refer to **Early Intervention**

**Consider:**

**Supplemental Medical and Therapy Services (speech, OT, PT)**

# Referral to **Developmental Behavioral Pediatrician**

What is a Referral to *Developmental Behavioral Pediatricians* for:

Developmental-behavioral pediatricians evaluate, counsel, and provide treatment for children and their families with a wide range of developmental and behavioral concerns, including learning delays, behavioral issues, delayed development in speech, language, motor skills, or thinking ability, and feeding/sleeping problems.

## Who to refer:

- The ASQ domains which put the child “at-risk” **matter** in terms of whether you should refer to Developmental Behavioral Pediatrician
- After consultation with experts in the field, the children most likely **to be delayed** in getting a medical evaluation and/or will not receive robust enough services from EI to address their needs:
  1. **Intellectual disability**
  2. **Autism**
- Flags for these under-identified children are
  - Delays in communication domain (always one of the factors)

## And

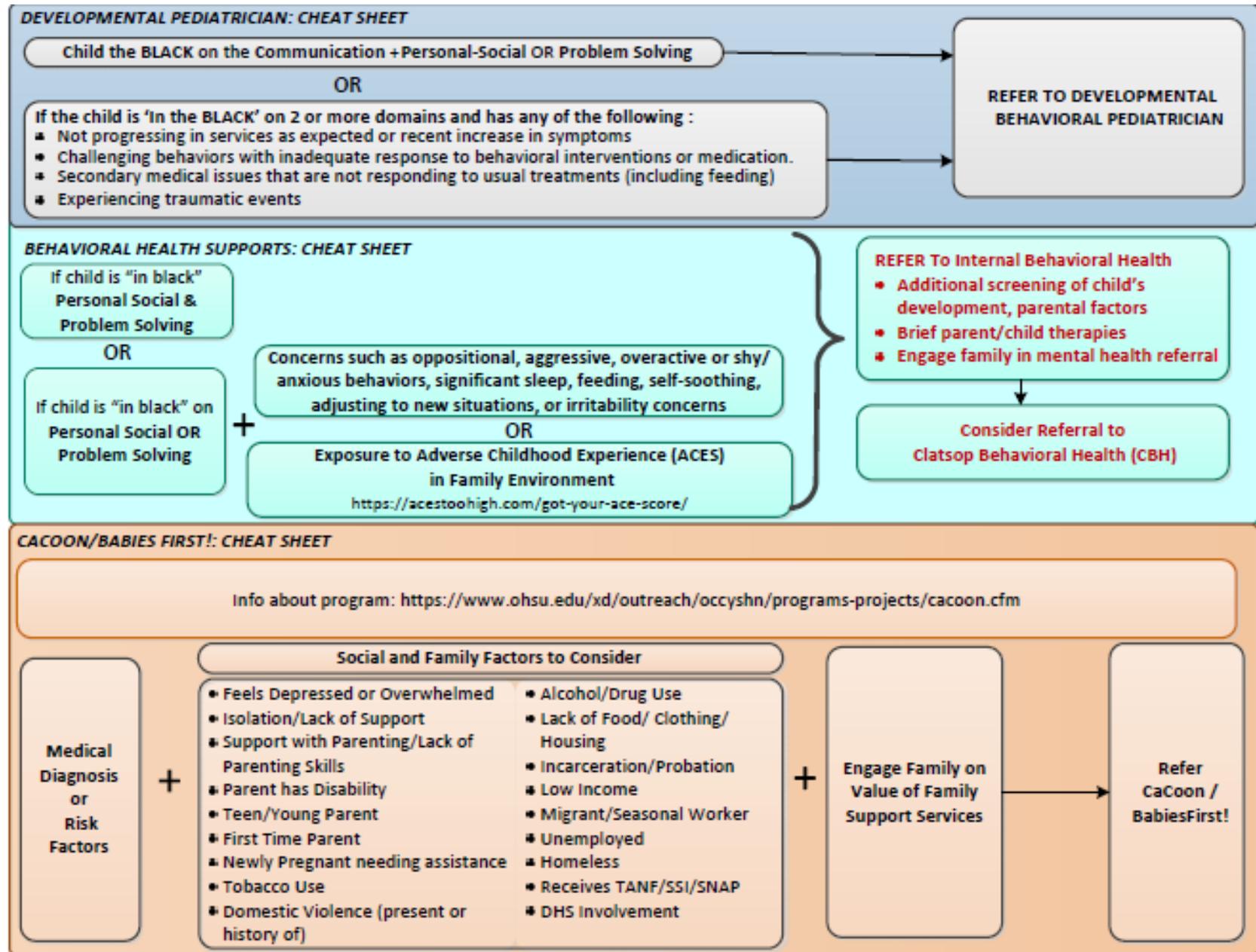
- Delays in problem solving or personal social domains

## Part 2: Which KIDS To Referral to Developmental Behavioral Pediatrician

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- Child “**In the BLACK**” in the **Communication** domain **AND** either the **Personal-Social domain** or **Problem Solving Domain**
- **Or if the child is in the Black on 2 or more other domains and has any of the following presenting concerns (On Back of Decision Tree)**
  - ✓ Kids who are not progressing in services as expected or recent increase in symptoms
  - ✓ Kids who have challenging behaviors with inadequate response to behavioral interventions or medication.
  - ✓ Kids with secondary medical issues that are not responding to usual treatments (including feeding and nutrition)
  - ✓ Kids who may be experiencing traumatic events

# Follow-Up to Screening Decision Tree (BACK)



## Referral to Early Intervention: Overall Note

### Important Context:

The purpose of the decision tree is to provide guidance on follow-up to ASQ developmental screening, the services on the decision tree provide follow-up

- That said, there is a broader group of children who should be referred to services for reasons outside of the ASQ scores
  - ***Therefore, the decision tree isn't a complete guide of which kids to refer to those services.*** It is a guide to which, kids based on the ASQ, should get referred to the services
- Example: Children who were low birth weight infants weighing less than 1,200 grams should be referred to EI, regardless of ASQ scores

# Physician Statement for Early Intervention



**Some children eligible for Early Intervention based on a Oregon Administrative Rules (OAR).**

**Provided diagnoses are associated with a higher risk of developmental delay and referrals should be generated early. These kids should be referred to EI regardless of ASQ Scores**

Examples of diagnosed physical or mental conditions associated with significant delays in development include but are not limited to:

- Chromosomal syndromes and conditions associated with delay in development
- Congenital syndromes and conditions associated with delays in development
- Sensory impairments
- Metabolic disorders associated with delays in development
- Infections, conditions, or event, occurring prenatally through 36 months, resulting in significant medical problems known to be associated with significant delays in development, such as: recurring seizures or other forms of ongoing neurological injury, an APGAR score of 5 or less at five minutes, evidence of significant exposure to known teratogens
- Low birth weight infants weighing less than 1,200 grams
- Postnatal acquired problems resulting in significant delays in development, including, but not limited to, attachment and regulatory disorders based on the Diagnostic Classification: 0 – 3

# Physician Statement for Early Intervention

**MEDICAL CONDITION STATEMENT FOR EARLY INTERVENTION ELIGIBILITY  
(BIRTH TO AGE 3)**

Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

The State of Oregon, through the Oregon Department of Education (ODE), provides Early Intervention (EI) services to infants and young children ages birth to three with significant developmental delays. ODE recognizes that disabilities may not be evident in every young child, but without intervention, there is a strong likelihood a child with unrecognized disabilities may become developmentally delayed.

ODE is requesting your assistance in determining eligibility for Oregon EI services for the child named above. Under Oregon law, a physician, physician assistant, or nurse practitioner licensed in by the appropriate State Board can examine a child and make a determination as to whether he or she has a physical or mental condition that is likely to result in a developmental delay.

Please keep in mind that, while many children may benefit from Oregon's EI services, only those in whom significant developmental delays are evident or very likely to develop are eligible.

Thank you for your time and assistance with this matter.

**Medical Condition:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please indicate if this child has a:**

Vision Impairment  
 Hearing Impairment  
 Orthopedic Impairment

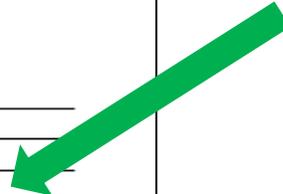
**Comments:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	<b>This child has a physical or mental condition that is likely to result in a developmental delay.</b>
--	---------------------------------------	---

\_\_\_\_\_  
Physician/Physician Assistant/Nurse Practitioner

\_\_\_\_\_  
Date

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_



This form is part of the Early Intervention Referral (page 3)

If your patient has a diagnosis that fits the Administrative Rule, note the condition and mark the Yes box here and sign.

# Review of Modifications Made to Early Intervention Universal Referral Form (URF)



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

<b>CHILD/PARENT CONTACT INFORMATION</b>	
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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Best Time to Contact: _____
Primary Language: _____	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)</b>	
<i>Consent for release of medical and educational information</i>	
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: ____/____/____
<i>Your consent is effective for a period of one year from the date of your signature on this release.</i>	
<b>OFFICE USE ONLY BELOW:</b>	
<i>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</i>	
<b>REASON FOR REFERRAL TO EI/ECSE SERVICES</b>	
<i>Provider: Complete all that applies. Please attach completed screening tool.</i>	
Concerning screen: <input type="checkbox"/> ASQ <input type="checkbox"/> ASQ:SE <input type="checkbox"/> PEDS <input type="checkbox"/> M-CHAT <input type="checkbox"/> Other: _____	
Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):	
<input type="checkbox"/> Communication _____	<input type="checkbox"/> Fine Motor _____ <input type="checkbox"/> Personal Social _____
<input type="checkbox"/> Gross Motor _____	<input type="checkbox"/> Problem Solving _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> Clinician concerns (including vision and hearing) but not screened: _____	
_____	
<input type="checkbox"/> Family is aware of reason for referral.	
Provider Signature: _____	Date: ____/____/____
<i>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.</i>	
<b>PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS</b>	
Referring Provider Name: _____	Referral Contact Person: _____
Office Phone: _____	Office Fax: _____
Address: _____	City: _____ State: _____ Zip: _____
Primary Care Provider: _____	
<i>If the child is eligible, medical provider will receive a copy of the Service Summary.</i>	
<b>EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER</b>	
<i>EI/ECSE Services: please complete this portion, attach requested information, and return to the referral source above.</i>	
<input type="checkbox"/> Family contacted on ____/____/____. The child was evaluated on ____/____/____ and was found to be:	
<input type="checkbox"/> Eligible for services <input type="checkbox"/> Not eligible for services at this time, referred to: _____	
<input type="checkbox"/> Parent Declined Evaluation <input type="checkbox"/> Parent Does Not Have Concerns	
<input type="checkbox"/> Unable to contact parent <input type="checkbox"/> Attempts _____ <input type="checkbox"/> EI/ECSE will close referral on ____/____/____.	

\* The EI/ECSE Referral Form may be duplicated and downloaded at this Oregon Department of Education [web page](#).

Updates were made to the Universal Referral Form based on collective feedback from a previous pilot facilitated in partnership between OPIP and Willamette Education Service District (WESD).

The goals of the updates were 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 timely 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 will enhance communication and coordination.

# CHILD/PARENT CONTACT INFORMATION

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: <input type="checkbox"/> Yes <input type="checkbox"/> No      Best Time to Contact: _____	
Primary Language: _____	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No

Under the **CONTACT INFORMATION** section, the new Universal Referral Form (URF) includes:

1. Option for families to note if they can/would accept text messages
2. Ability for family to note the best time to contact

# REASON FOR REFFERAL

## 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.

Under the **REASON FOR REFERRAL** section, the new Universal Referral Form (URF) includes:

- Section for the referring entity to document concerning screening scores and indicate the tool used. The “Concerns for possible delays” boxes now map directly to the ASQ domains.
  - Also send completed ASQ with referral to help ensure the best match evaluation team at EI

# PROVIDER INFORMATION

PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS	
Referring Provider Name: _____	Referral Contact Person: _____
Office Phone: _____	Office Fax: _____
Address: _____	
City: _____ State: _____ Zip: _____	
Primary Care Provider: _____	
<i>If the child is eligible, medical provider will receive a copy of the Service Summary.</i>	

Under the **PROVIDER INFORMATION** section:

- Referring Providers no longer have multiple options to request the types of feedback they would like to receive. Instead, a copy of the ***Service Summary*** will be sent to providers for ALL ELIGIBLE children

# Service Summary Overview

Clatsop Columbia  
**NWR**  
 ESD

**Tillamook Washington**  
**ESD**

**NORTHWEST REGIONAL EDUCATION SERVICE DISTRICT**  
**Early Intervention/Early Childhood Special Education**

<u>Clatsop Service Center</u>	<u>Columbia Service Center</u>	<u>Tillamook Service Center</u>	<u>Washington Service Center</u>
3194 Marine Drive Astoria, OR 97103 Phone: 503-325-2862 Fax: 503-325-1297	800 Port Avenue St. Helens, OR 97051 Phone: 503-366-4100 Fax: 503-397-0796	2515 Third Street Tillamook, OR 97141 Phone: 503-842-8423 Fax: 503-842-6272	5825 NE Ray Circle Hillsboro, OR 97124 Phone: 503-614-1428 Fax: 503-614-1290

Toll Free 888-990-7500

Date: 08/03/18

### Service Summary

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

CHILD was found eligible for Early Intervention services on: 08/03/18.

She was found eligible under the category:  
Developmental Delay

As required under Oregon law, she will be evaluated again before 10/03/19 to determine if she is eligible for Early Childhood Special Education Services.

A new Individual Family Service Plan (IFSP) was developed for CHILD on 08/03/18.

**IFSP Goal Areas**

Cognitive  
  Social / Emotional  
  Motor  
  Adaptive  
  Communication

**Services Provided**

Service	How Often	Provider
Service Coordination	12 hours/year	
Physical Therapy	1 hour/year	
Occupational Therapy	1 hour/month	

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

Electronically signed by Michelle Rodriguez on 08/03/18.  
 \_\_\_\_\_  
 XXXX, EI/ECSE Specialist, NWRES (503)

NWRESD will 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 on **IMPLEMENTATION** should be on how to 'catch' and 'use' this information

# EI/ECSE Unable to Contact



## NORTHWEST REGIONAL EDUCATION SERVICE DISTRICT Early Intervention/Early Childhood Special Education

<b>Clatsop Service Center</b> 3194 Marine Drive Astoria, OR 97103 Phone: 503-325-2862 Fax: 503-325-1297	<b>Columbia Service Center</b> 800 Port Avenue St. Helens, OR 97051 Phone: 503-366-4100 Fax: 503-397-0796	<b>Tillamook Service Center</b> 2515 Third Street Tillamook, OR 97141 Phone: 503-842-8423 Fax: 503-842-6272	<b>Washington Service Center</b> 5825 NE Ray Circle Hillsboro, OR 97124 Phone: 503-614-1428 Fax: 503-614-1290
---	---	---	---

03/22/18

George & Gigi  
PO Box 123  
Aloha, OR 97007

Re: Ginny Sample, birthdate 11/03/13

Dear George & Gigi

We received a referral for Ginny in regards to (unavailable) development. We made attempts on [DATES] to contact you to schedule a developmental evaluation appointment. We also mailed a letter on [DATE]. We've been unable to contact you by phone or mail. We are now making Ginny's file inactive.

If you have any questions, please do not hesitate to contact us at 503-614-1446 for assistance. The Early Intervention/Early Childhood Special Education program stands ready to provide a developmental screening and/or evaluation at a parent's request.

We welcome you to monitor your child's progress as they grow older. You can use the Ages & Stages website to check your child's development, and you can return every three months or so to complete a new questionnaire. The website is [asqoregon.com](http://asqoregon.com). Please feel free to contact us at any time if you have any questions, concerns, or would like to schedule an evaluation or in-person screening.

Thank you, and have a wonderful day!

Sincerely,

NWRES D will send this letter as a flag to referring providers that the ESD Coordinator was unable to contact the referred family.

This letter will be faxed to your practice. Follow up action can be determined at this time.

# EI/ECSE EVALUATION RESULTS

## EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

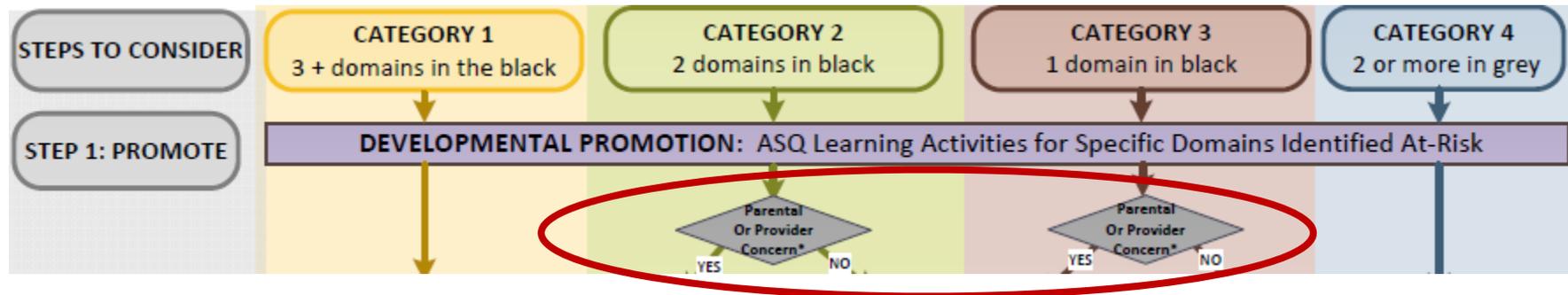
***EI/ECSE Services:*** please complete this portion, attach requested information, and return to the referral source above.

- 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: \_\_\_\_\_
- Parent Declined Evaluation                       Parent Does Not Have Concerns
- Unable to contact parent     Attempts \_\_\_\_\_     EI/ECSE will close referral on \_\_\_\_/\_\_\_\_/\_\_\_\_.

Under the **EVALUATION RESULTS** section, the new Universal Referral Form (URF):

- Is very similar to the old Universal Referral Form, but it is now the intention of ODE (Oregon Department of Education) for all ESDs to ***improve the use of this section if FERPA release is signed.***

# Operationalizing Parental or Provider Concern



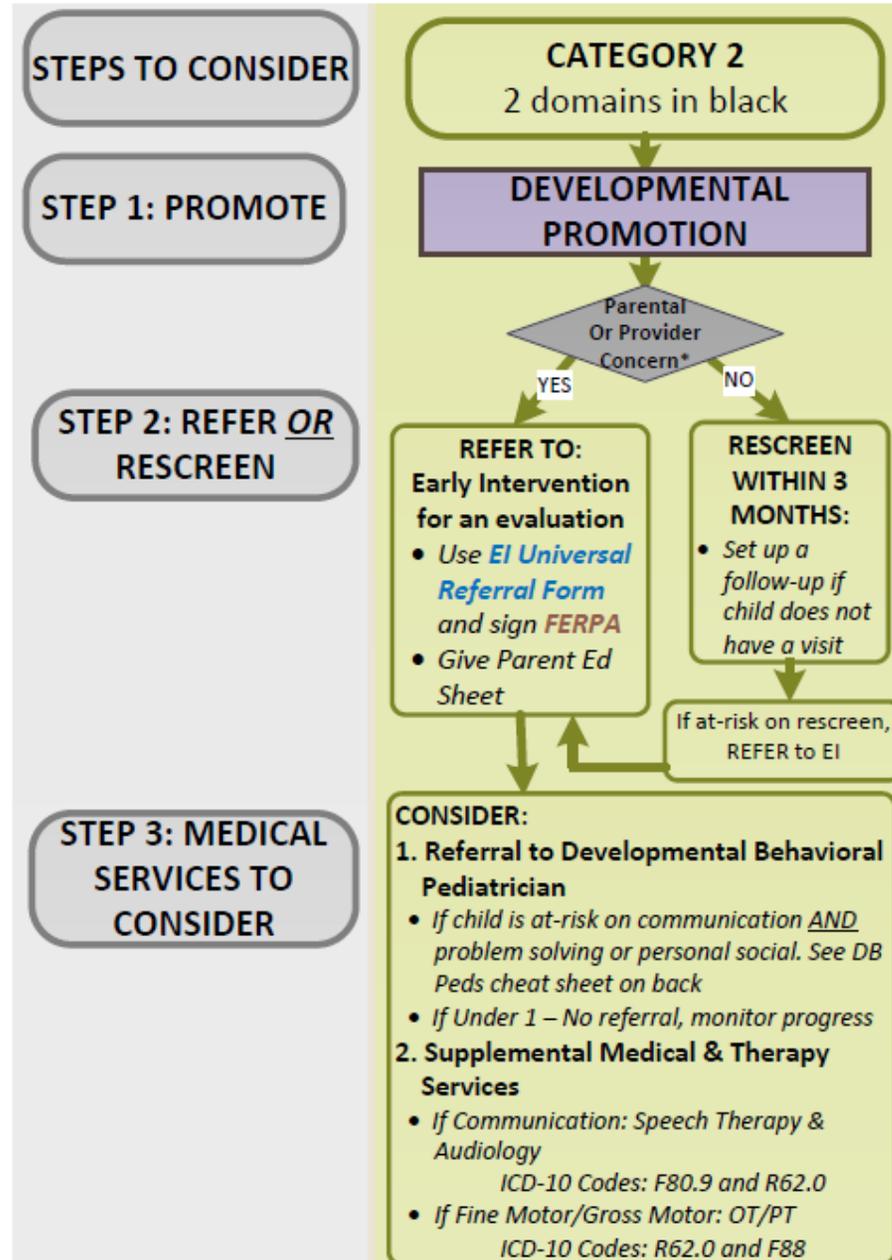
For screens with **1 or 2 domains in the black** a key component of the medical decision tree is **PARENTAL OR PROVIDER CONCERN**

## Reasons this was added:

- Parents are an **important partner** in understanding developmental concerns
  - “Parental concerns about speech, motor, and behavioral development yielded a high sensitivity to the final diagnosis of the same developmental domain (77-89%)<sup>1</sup>”
- Providers need to be able to use their **clinical judgement** to help validate the completion of the tool for which:
  - ✓ Parents may not have had the time or materials to try items with child
  - ✓ Score not adjusted for prematurity
  - ✓ Score not adjusted for omitted items

38 1. Chen, C. The relationship between parental concern and professional assessment in developmental delays in infants and children <https://www.ncbi.nlm.nih.gov/pubmed/15357111>

## Follow Up Aligned with Medical Decision Tree: Screens 2 domains in the Black



For a screen with **2 domains in the black**, ***follow up*** is:

1. Give the **ASQ Learning Activities** for the domains identified in the black

If there is Parental or Provider Consider

- Refer to **Early Intervention**

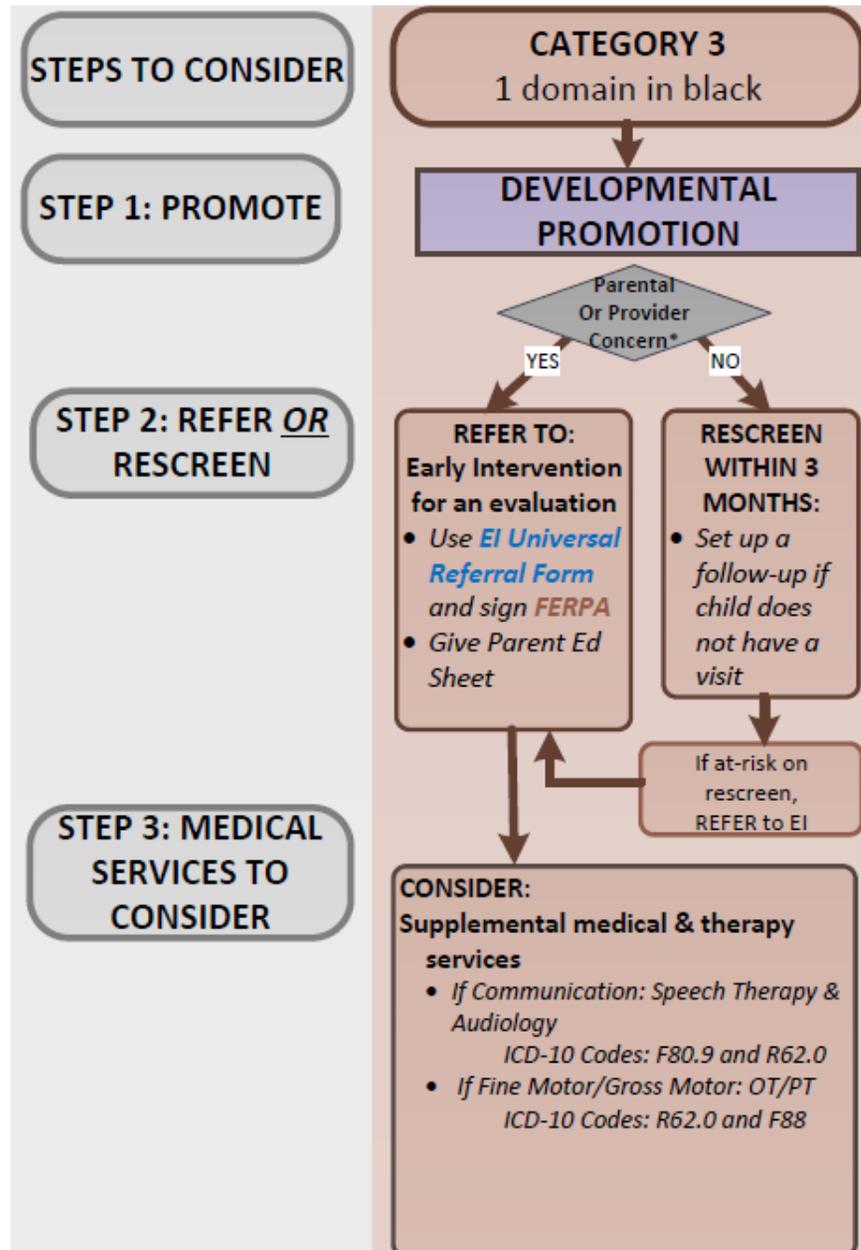
If there is **NOT** Parental or Provider Consider

- Rescreen within 3 months

**Consider:**

1. Referral to **Developmental Behavioral Pediatrician** for kids over the age of 1
2. Use of **Supplemental Medical and Therapy Services**

## Follow Up Aligned with Medical Decision Tree: Screens 1 domain in the Black



For a screen with **1 domains in the black**, ***follow up*** is:

1. Give the **ASQ Learning Activities** for the domains identified in the black

If there is Parental or Provider Consider

- Refer to **Early Intervention**

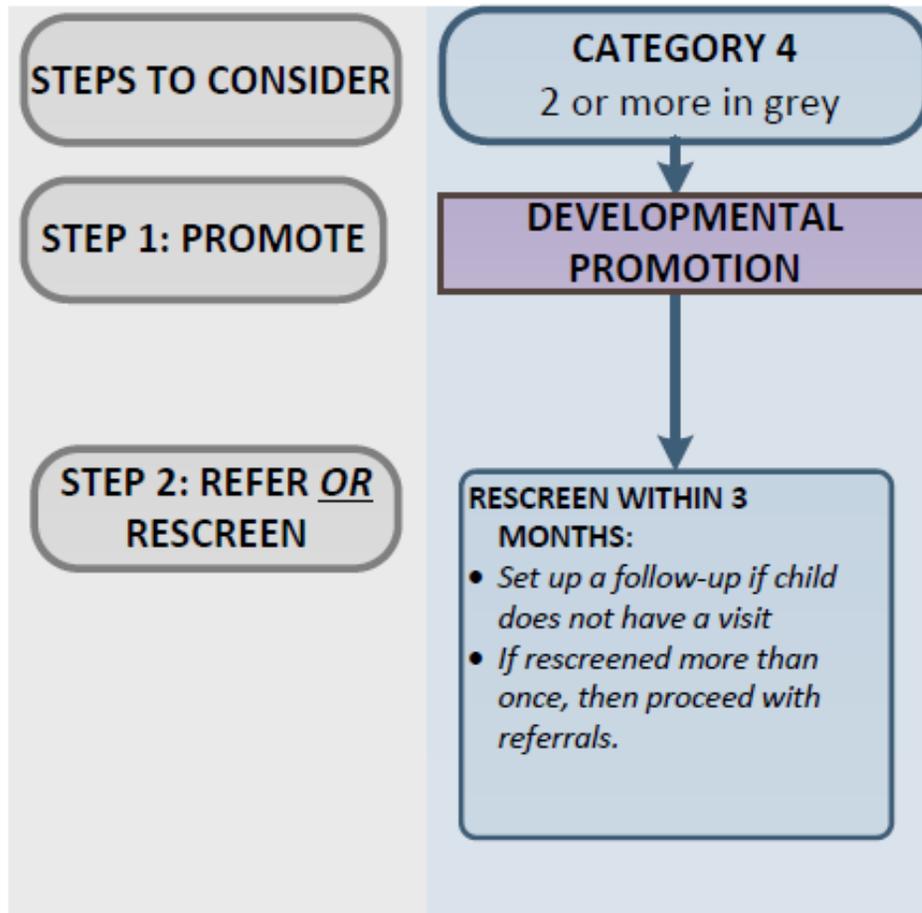
If there is **NOT** Parental or Provider Consider

- **Rescreen** within 3 months

**Consider:**

Use of **Supplemental Medical and Therapy Services**

## Follow Up Aligned with Medical Decision Tree: Screens 2 or more domains in the Grey

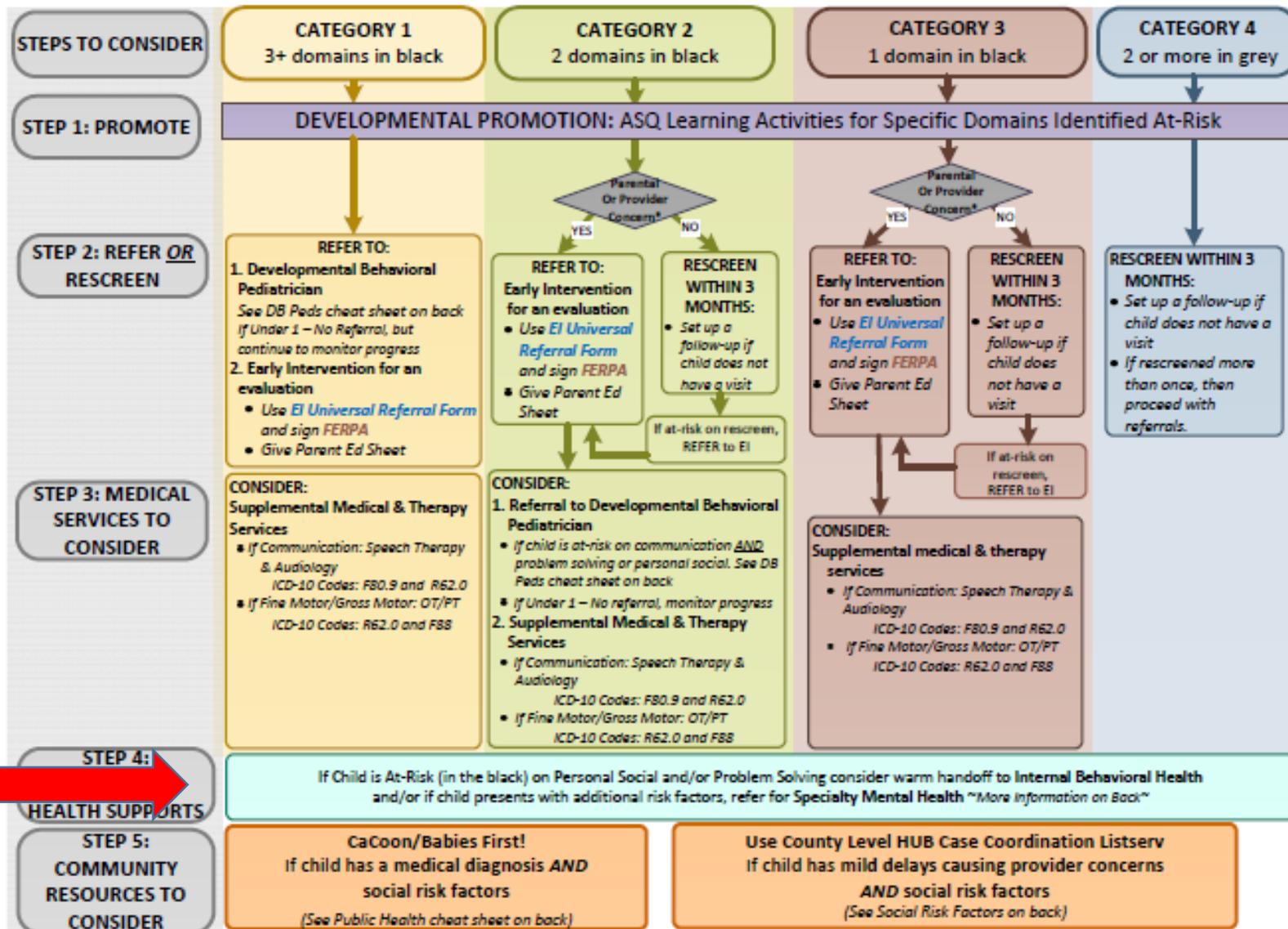


For screen with **2 or more domains in the grey**, ***follow up*** is:

1. Give the **ASQ Learning Activities** for the domains identified in the black
2. **Rescreen** within 3 months

# Follow-Up to Screening Decision Tree – Behavioral Health

FOLLOW-UP TO DEVELOPMENTAL SCREENINGS CONDUCTED IN CLATSOP COUNTY IN FIRST 3 YEARS: MEDICAL DECISION TREE



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\* One example of when a provider should be concerned is if a child is well-below the cut-off in the domain(s).

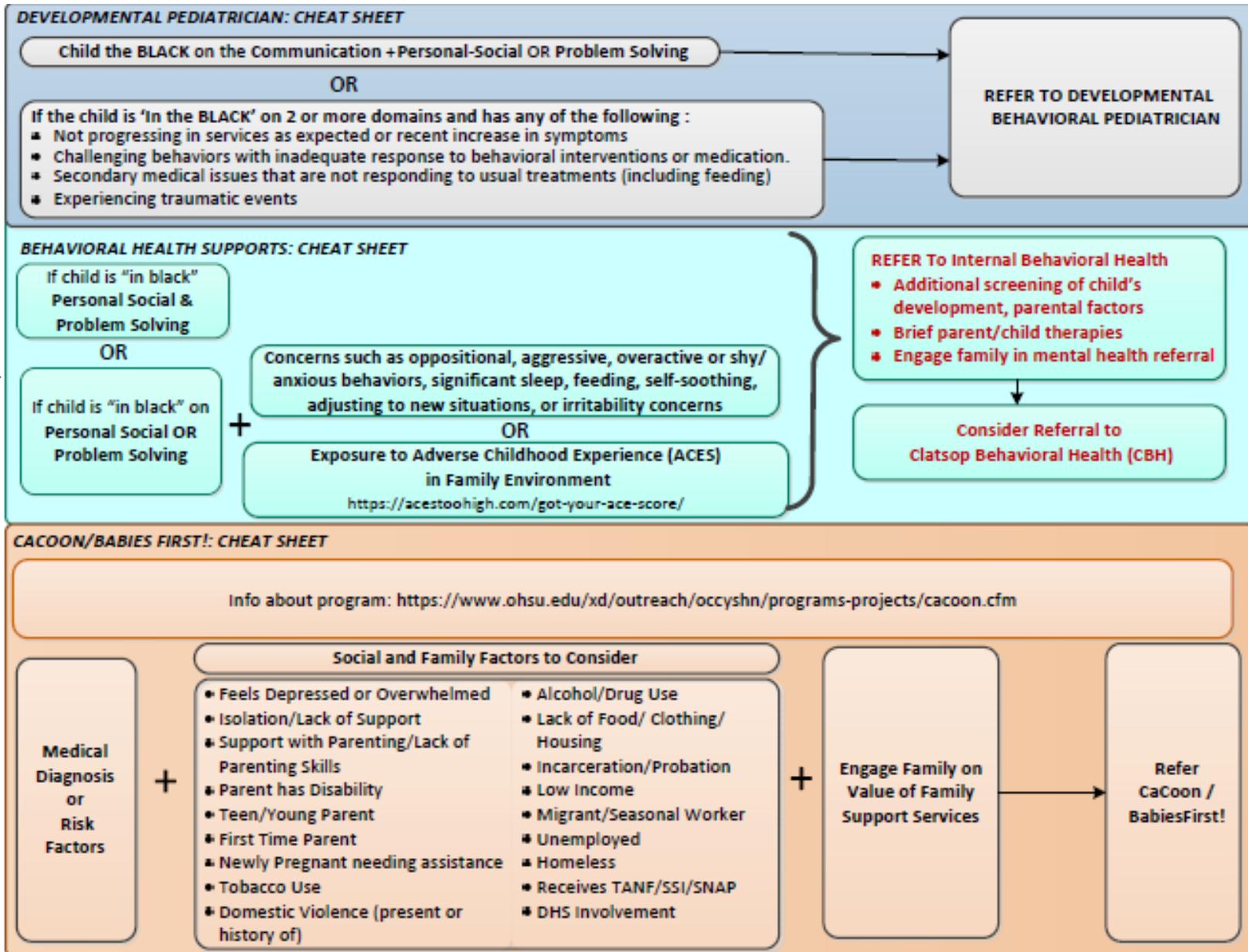


**STEP 4:  
BEHAVIORAL  
HEALTH SUPPORTS**

- 1) At-Risk (in the black) on Personal Social AND Problem Solving
- 2) In the black in Personal Social OR Problem Solving AND concerns such as oppositional behaviors, aggression, overactive or shy, significant sleep, feeding issues, concerns adjusting to new situations or irritability

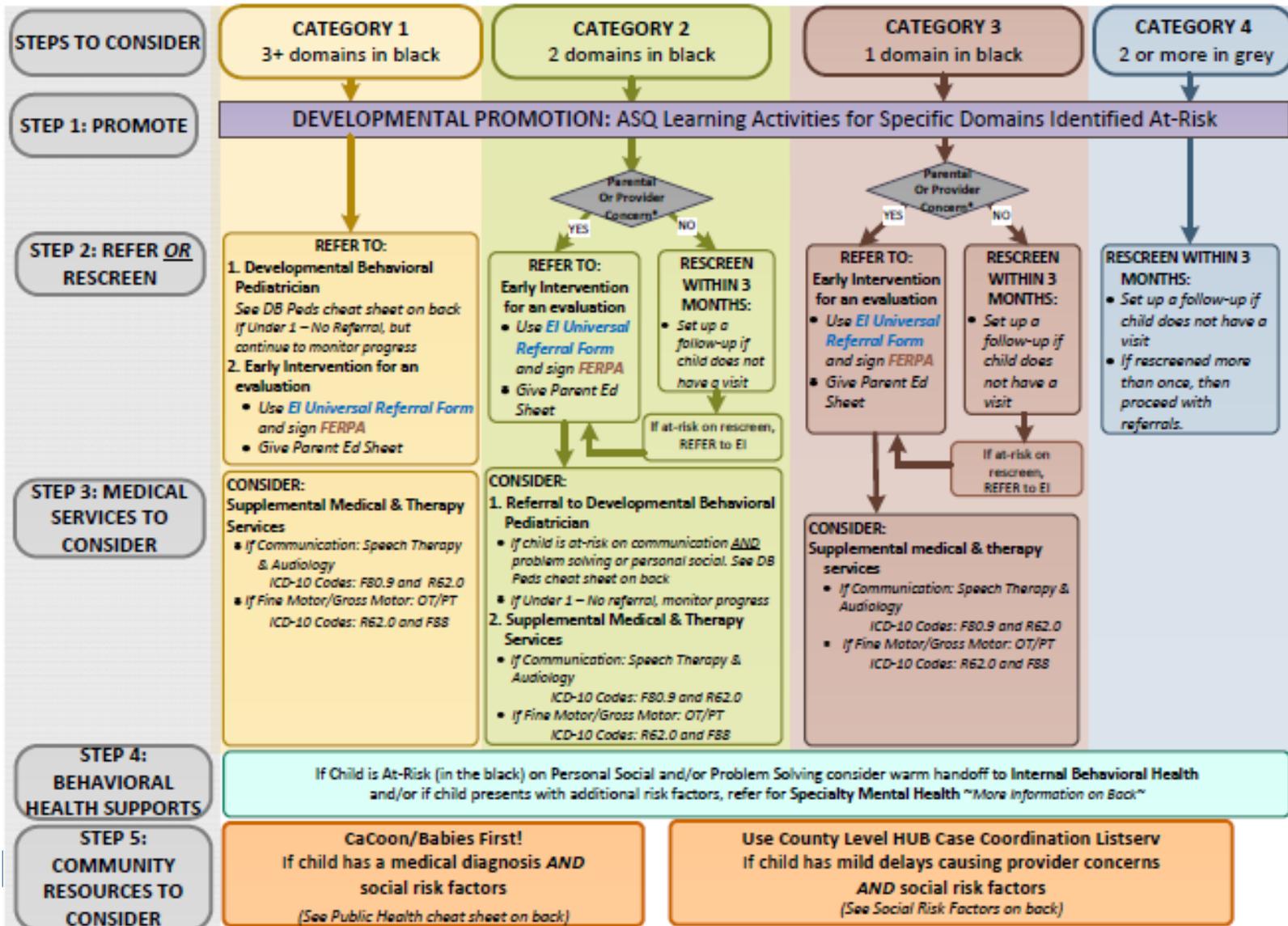
**Refer to Internal Behavioral  
Health**  
*See cheat sheet on the back*

# Follow-Up to Screening Decision Tree (BACK)



# Follow-Up to Screening Decision Tree

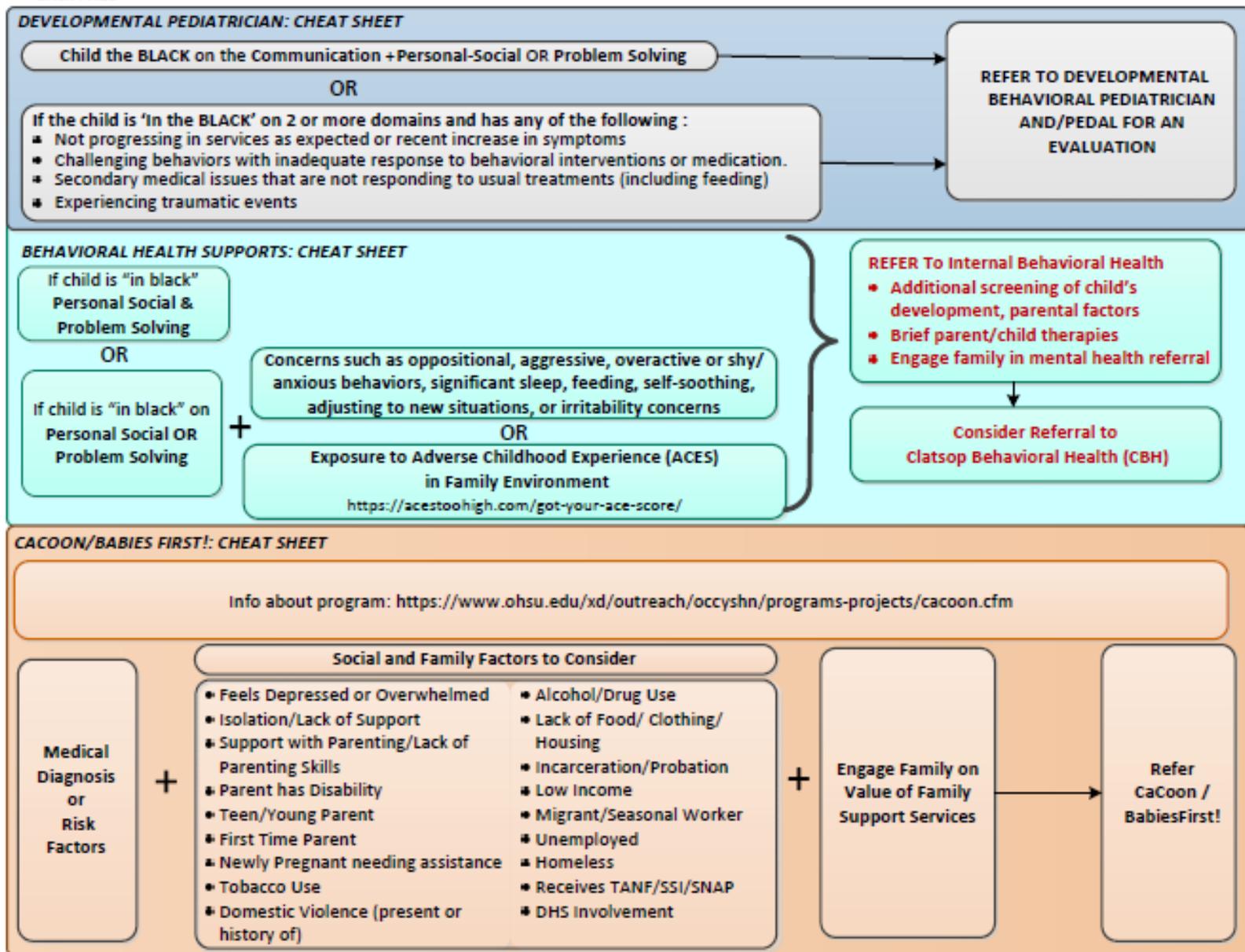
FOLLOW-UP TO DEVELOPMENTAL SCREENINGS CONDUCTED IN CLATSOP COUNTY IN FIRST 3 YEARS: MEDICAL DECISION TREE



FRONT PAGE © 2019 Developed by OPIP for Columbia Pacific Coordinated Care Organization - do not reproduce or modify without consent & review. \* One example of when a provider should be concerned is if a child is well-below the cut-off in the domain(s).



# Follow-Up to Screening Decision Tree (BACK)



## CaCoon/Babies First

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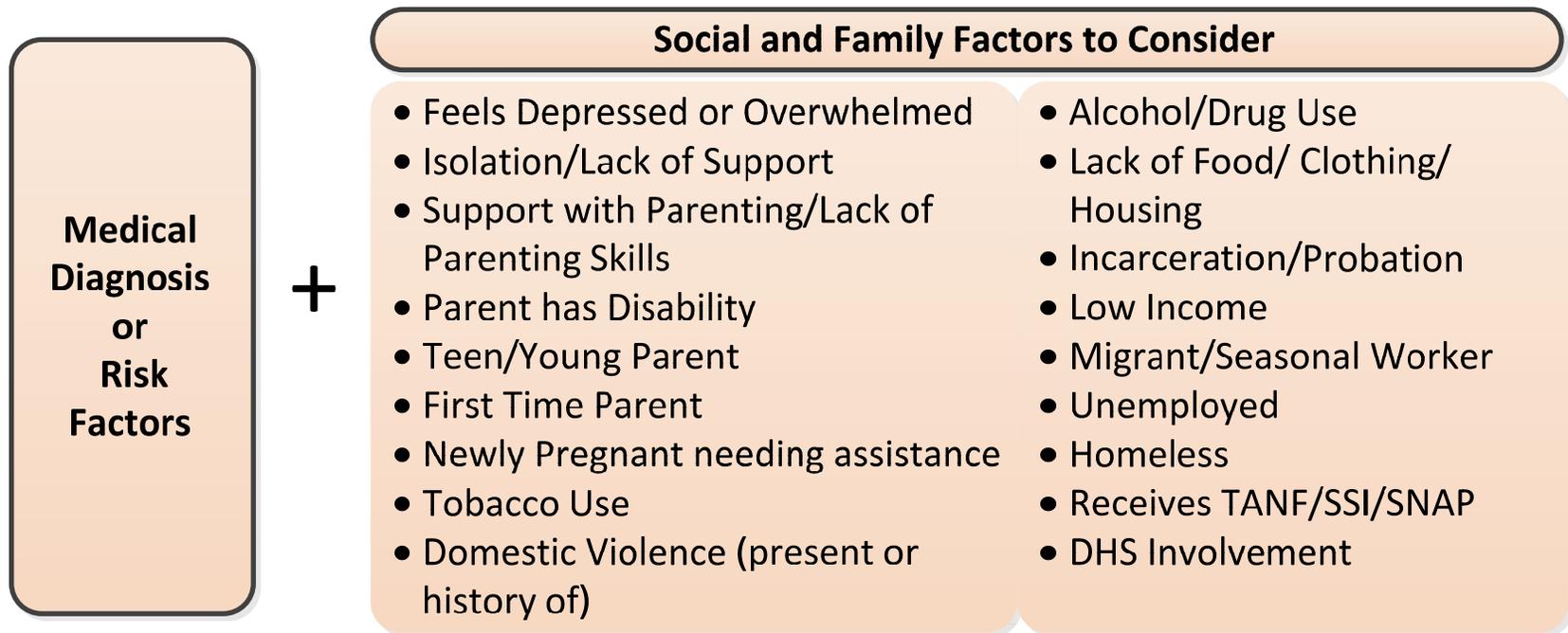
- CaCoon and Babies First! use public health nurses to work with families to support children's health and development
- A nurse will meet with families at a location that is best for them
- There is no charge (it is free) to families for these services

### Services may include:

- Weigh baby or child and screen for normal development
- Provide information and connection to community based resources
- Make sure child's health team works well together.

# CaCoon/Babies First

## Who to Refer to CaCoon/Babies First based on ASQ results



### Important Disclaimer:

Due to staffing capacity, please ensure that families are open and willing to follow through with the referral

# How to Refer to Family Support Services

**CaCoon Program Referral Form**

*Please fax or scan and send this referral form to the CaCoon Program in the child's county of residence.*

CHILD/FAMILY CONTACT INFORMATION	
Child's Name: _____	Date of Birth: ____/____/____
Parent/Guardian: _____	Relationship to the Child: _____
Home Address: _____	Apt # _____ City: _____
County: _____	Primary Phone: _____ Other Phone: _____
Primary Language: _____	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Insurance: <input type="checkbox"/> Private <input type="checkbox"/> OHP/Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Family is aware of the referral	
REASON FOR REFERRAL TO CACOON	
<b>Your concerns are (check all that apply):</b> <input type="checkbox"/> Infant/child has medical condition (describe): _____ <input type="checkbox"/> Infant/child has delayed growth or development <input type="checkbox"/> Screening tool indicates concerns <input type="checkbox"/> Screening tool used: _____ <input type="checkbox"/> Substance abuse/Drug exposed infant <input type="checkbox"/> Teen/Young parent <input type="checkbox"/> Maternal/Infant bonding <input type="checkbox"/> Other concerns: _____	<b>Child/Family is in need of:</b> <input type="checkbox"/> Care coordination <input type="checkbox"/> Medical condition monitoring <input type="checkbox"/> Developmental monitoring <input type="checkbox"/> Parental support or coping assistance related to child <input type="checkbox"/> Assistance with transition to adulthood <input type="checkbox"/> Assistance with housing/food/transportation <input type="checkbox"/> Other: _____
Additional Information: _____	
<b>Child/family has also been referred to:</b> <input type="checkbox"/> Specialty Health Care <input type="checkbox"/> Early Intervention/Early Childhood Special Education <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Early Head Start/Head Start <input type="checkbox"/> Other: _____	
PROVIDER INFORMATION	
Name and title of provider making referral: _____	
Address: _____	
Office Phone: _____	Office Fax: _____
Is the referring provider the child's Primary Care Provider (PCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, indicate name of PCP: _____	
Primary contact for receiving feedback about referral: _____	Best time to communicate: _____
Best communication method for feedback: <input type="checkbox"/> Fax: _____	<input type="checkbox"/> Phone: _____
CaCoon Program: Please complete the section below and return to the referral source above	
FEEDBACK TO REFERRING PROVIDER	
<input type="checkbox"/> Child/Family is getting CaCoon services <input type="checkbox"/> Child/Family is getting Babies First services <input type="checkbox"/> Family was referred to: _____ <input type="checkbox"/> Family declined services <input type="checkbox"/> Contacted family – No response (Date: _____)	<b>Contact Information</b> Public Health Nurse: _____ Phone: _____ Fax: _____ Email: _____

Universal Referral  
Form to CaCoon

Form is available at  
[occyshn.org](http://occyshn.org)

# You Have Identified What They Need..... Now How Do You Get the Child To The Service(s):

---

- 1) Support Shared Decision Making with the Family on the Referrals You Think Are Best Match
- 2) Supporting families to go to referrals

# 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, Northwest Regional Education Service District (NWRESD) 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:

- NWRESD 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: 503-338-3368.

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

#### Contact Information:

NWRESD Intake Coordinator  
503-338-3368 | [www.nwresd.org](http://www.nwresd.org)

### CaCoon

#### Who is 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 these services.

Contact Information:  
Mandy Mattison  
Phone: 503-325-8500

<http://www.co.clatsop.or.us/publichealth/page/maternal-child-health-programs>

### Within Coastal Family Health Center

We have a Behavioral Health Specialist who can help your family with:

- Health and family coaching
- Child development support
- Social and emotional support

### 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

**Shared Decision Making Tool To Explain Referrals – We DRAFTED ONE FOR YOU REVIEW AND EDITS IF YOU CHOOSE TO USE IT.**

**We also translated into Spanish.**

## 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 Coastal Family Health Center, 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!

Phone number: 503-325-8315

# Phone Follow-Up

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- Some studies show that families make a decision on a referral in the first 48 hours
- Phone follow-up (not necessarily contact) within two days of the referral significantly increased follow through
- Phone calls can also identify barriers to obtaining the evaluation

Within Previous Pilot Practices – Potential Process:

- Care coordinator called all families referred
- MA's called families who EI communicated they couldn't contact

# Pilot: 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 Northwest Regional 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 Northwest Regional Education Service District, or about what will happen next?

### Answer questions (frequent questions or concerns highlighted in blue)

- o 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)
- o **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?

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, her name is Laura to schedule an appointment. If you would like to call to schedule at a time that works for you, the best number is 503.338.3368.

We are here to support you, so if you have any questions, feel free to contact (insert name) at (phone number).



# Resources

- [www.oregon-pip.org](http://www.oregon-pip.org)
- <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/DevScreeningFollowUp-BestPractices-PCP.pdf>
- <http://www.oregon-pip.org/projects/PathwaysCPCCO.html>
- PCPCI webinars: Beyond Developmental Screening: Ensuring Follow-Up Services for Children Identified At-Risk  
(March 2017)