Ensuring Young Children Identified At-Risk for Developmental, Behavioral & Social Delays Receive Follow-Up Services

Consulting and Technical Assistance to Support Yamhill Coordinated Care Organization & the Yamhill Early Learning Hub

*Please Note: The project was supported by Funding Opportunity Number CMS-1G1-12-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. That said, the content described on this page and disseminated through the project is solely the responsibility of OPIP does not necessarily represent the official views of HHS or any of its agencies.

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Objectives for Today’s Meeting

• To review the core grant activities funded
• To understand priority areas and needs for each stakeholder and, within the design parameters of the funding, and what you would define as success of the project
• To review priority activities for the next few months and get input and guidance on the direction
• To understand existing efforts/processes that need to be built off and who leads those efforts so that OPIP can conduct follow-up interviews
• To confirm next steps and communication agreements
Context:
A Refresher from Our July Discussion's
Project Funding

- Oregon Health Authority supporting Oregon Pediatric Improvement Partnership (OPIP) to provide consulting and technical assistance to a community pilot focused on ensuring children identified at-risk for developmental, behavioral, and social delay receive follow-up services.
  - One year-project – January-December 2016
  - Report to Child Health and Well-Being Group, Within OHA and Title V (Public Health), & Transformation Center
  - Every other month meetings with OHA stakeholders, including Early Learning Division
- Meant to address areas of synergy in the goals of the CCOs and Early Learning Hub

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The Need for the Project

- Focus on community- and population-based approaches to conducting developmental screening.
  - Screening is occurring AND increasing in community-based providers and PCPs and
  - These efforts often uncoordinated and sometimes duplicative.
- Majority of children identified at-risk for delays using developmental screening tools don’t receive follow-up services
  - Data from the Assuring Better Child Development-III project (Led by OPIP)
    - Less than half of children identified at risk for (40%) referred for services.
    - Of the children referred for Early Intervention services, a majority had no documentation of receipt of the services and coordination of the services
  - Within Early Intervention many local EI contractors report that they are unable to connect with at least half of the children referred to them
  - Interviews with primary care providers: Don’t refer children to EI services if they know they won’t be eligible, unaware of other services
    - Given EI eligibility, a group of referred children will not be eligible for services, so what then?
The Need for the Project

Early Learning Hub Goals Related to:

1) Family Resource Management
2) Coordination of services
3) Ensuring children are kindergarten ready

CCO Goals Related to:

1) Developmental Screening
2) Well-Child Care
3) Coordination of services

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Four Primary Activities Supported by the Project

1. **Engage and facilitate key stakeholders** on the **shared goal** of ensuring children identified **at-risk receive follow-up** services that are the best match for the child and that are **coordinated** across systems.

2. Develop a **triage and referral system map** that can be used to identify the best set of services for children identified at-risk, using the Ages and Stages Questionnaire, and that ensure that services are accessed.

3. To develop methods and processes for how **care can be coordinated**, at a child-level, across **primary care and community-based providers**.

4. **Summarize key learnings to inform** spread and innovation in other communities.
• **“At Risk” Population:** Pilot is anchored to children identified at risk using the Ages and Stages Questionnaire

  – That said, some providers may be collecting social determinant information at the time of screening children OR be able to report on valuable social determinants (maternal depression screening, ACES, SEEK Parent Questionnaire)

  – **Questions:**
    • Is everyone using ASQ?
    • Who is gathering standardized info on social determinants? Include if we can?
Key Parameters for Pilot Project Given Funding

- “Triage and referral system map meant to identify the best set of services for children identified at-risk
  - Services within community and within health system
  - Services that address family risk factors that may be cause of delays (again within community and within health system)
  - Includes HOW to refer and talk to families about services in a way that increases likelihood of access
  - Includes steps and processes when children found not eligible for referred services
  - Includes steps and processes for when children/families don’t access referred services

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Key Components of Each of the Four Activities

1. Engage and facilitate key stakeholders on the shared goal of ensuring children identified at-risk receive follow-up services that are the best match for the child and that are coordinated across systems.

2. Develop a triage and referral system map that can be used to identify the best set of services for children identified at-risk, using the Ages and Stages Questionnaire, and that ensure that services are accessed.

3. To develop methods and processes for how care can be coordinated, at a child-level, across primary care and community-based providers.

4. Summarize key learnings to inform spread and innovation in other communities.
Activity #1: Engage and facilitate key stakeholders

• Discussion anchored to shared goal of ensuring children identified at-risk receive follow-up services that are:
  1) The **best match for the child** and
  2) **Coordinated** across systems

• Specific Tasks within Activity #1:
  – Conduct key stakeholder interviews among early learning system, early intervention, community-based providers, primary care providers, health system representatives, 211 and parents of young children
  – Convene stakeholders to provide input and to receive periodic summaries (**proposal is this is group, with additions over time**)
  – Recruit parent advisors
  – Conduct periodic meetings with parent advisors

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**Activity #2:** Develop a triage and referral system map that can be used to identify the best set of services for children

- Specific Tasks within Activity #2:
  - Develop general design parameters for triage and referral map anchored to risks identified in ASQ-3
  - Develop general triage and referral system map anchored to potential risks and related resources in a community
  - Tailor and customize the general map based on resources in Yamhill County
  - Solicit review and input from stakeholders and parents on that map

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Activity #3: To develop methods and processes for how care can be coordinated across primary care & community-based providers

• Goal is to pilot specific methods to ensure coordination.
• Given funding, one priority pathway within the triage and referral map will be given focus for care coordination that include a pilot community-based provider and primary care provider
• Specific Tasks within Activity #3:
  – Work with key community stakeholders to identify priority pathways where shared communication is a priority
  – Identify specific stakeholders for pilot, elements of information to be shared and models of communication
  – Provide support to the pilot stakeholders (community partner and PCP) on their use of the models and key learnings
  – Develop presentation and resource materials outlining care coordination processes
**Activity #4: Summarize key learnings to inform spread & innovation in other communities**

- Specific Tasks within Activity #4:
  - Conduct strategic interviews and gather qualitative information related to successes and barriers
  - Develop interim and final reports for OHA and key stakeholders (May, September, December)
  - Meetings with OHA and Early Learning Division every other month, Staring in March
  - Present at Joint Subcommittee of Early Learning Council and Oregon Health Policy Board
  - Final Report
  - Post resources on OPIP webpage
## Project Activities High-Level Timeline in 2016

<table>
<thead>
<tr>
<th>Activity 1- Engage Stakeholders</th>
<th>Jan-March</th>
<th>April-June</th>
<th>July-Sept</th>
<th>Oct-Dec</th>
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</thead>
<tbody>
<tr>
<td>Stakeholder identification and interviews</td>
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<td></td>
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<tr>
<td>Convene stakeholders, Strategic Summary</td>
<td>Today 😊</td>
<td>April</td>
<td>August</td>
<td>Dec.</td>
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<tr>
<td>Recruit parents advisors, Input, Strategic Summary</td>
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<td>April</td>
<td>August</td>
<td>Dec.</td>
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## Activity 2- Triage and Referral Map

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<thead>
<tr>
<th>Activity 2- Triage and Referral Map</th>
<th>Jan-March</th>
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<th>July-Sept</th>
<th>Oct-Dec</th>
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<td>Design parameter and general map</td>
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<td>Asset mapping of services in Yamhill</td>
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<tr>
<td>Tailored version of map to Yamhill</td>
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<tr>
<td>Implementation and Periodic Review of Map</td>
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## Activity 3- Care Coordination Methods

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<th>April-June</th>
<th>July-Sept</th>
<th>Oct-Dec</th>
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<tbody>
<tr>
<td>Identification of priority pathways</td>
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<td></td>
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<tr>
<td>Identify content and models of care coordination</td>
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<tr>
<td>Support pilot sites in implementation</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Create a summary of learnings</td>
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Component Originally Proposed – But Not Funded Evaluation Data

**An example of what we thought would be valuable:**

- Number/proportion screening
  - Screening results
    - How many fail or are borderline? On what domains? On how many domains?
    - What is the correlation of ASQ scores and social determinants
      » Of those identified at risk, how many are referred? How many referrals?
        - Does this differ by type of domain or by race-ethnicity?
        - Of those referred, how many get to the referrals?
          - Does this differ by type of domain or by race-ethnicity?
          - Of those referred, who get to the service, how many were eligible?
            - Does this differ by type of domain or by race-ethnicity?
Example of Evaluation Data in a Past Project

- **Proportion of Children in the MCO Sample who Received a Standardized Developmental Screening**: 34% of N = 982

- **Proportion of Children Receiving a Standardized Developmental Screening Identified as "At Risk"**: 14% of N = 333

- **Proportion of Children Identified as "At Risk" who were Referred to Early Intervention or Other Services**: 40% of N = 45, 40% of N = 18

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Hearing From You:

How This Project Can Meet Your Community’s Needs & Build Off the Great Work To Date
Hearing From You

Introduction of each person:

1) Role within county,

2) In one year, within the design parameters of the project, what would you define as a success for this project for this community

3) What existing efforts need to be leveraged

4) What role can you play in supporting the project’s success
Project Design Parameters – Input Needed

Conduct key stakeholder interviews among early learning system, early intervention, community-based providers, primary care providers, health system representatives, 211 and parents of young children

- Who needs to be interviewed?
- What efforts do we need to get information about?
- Who in the community is doing the most ASQs? Who is doing the most ASQs and is not referring for services?
- What PCPs or health system should be interviewed?
- 211 in Yamhill

Recruit parent advisors

- Build of ELC Parent Advisory Council?
- Hispanic/Latino Parents?
- Parents who are experiencing the systems?
Priority Activities: Input and Guidance

–Conduct key stakeholder interviews among early learning system, early intervention, community-based providers, primary care providers, health system representatives, 211 and parents of young children
  • Who needs to be interviewed?
  • What efforts do we need to get information about?
  • Who in the community is doing the most ASQs? Who is doing the most ASQs and is not referring for services
  • What PCPs or health system should be interviewed?
  • 211 in Yamhill

–Recruit parent advisors
  • Build of ELC Parent Advisory Council?
  • Hispanic/Latino Parents?
  • Parents who are experiencing the systems?
Triage and referral map anchored to risks identified in ASQ-3

• Who “owns” the Family CORE and how it is used across providers?
  – What is working well? What could be improved?
  – Would it be helpful/valuable to hear about community and primary care providers use of the Family CORE Referral form?

• Yamhill Early Learning Hub ASQ Process Map – how is that going?
  – What is working well? What could be improved?

• Are there any triage maps already anchored to specific ASQ scores (total score, domain score)

• Have there been any referral and work flow assessment done within the medical side?
Next Steps and Communication Agreements

– Interviews with each of the members of this group and those identified, parent recruitment

– April meeting to share strategic findings of information gathered and shared goals

– Communication preference of this group for updates:
  • Summaries of key next steps after each meeting?
  • Information provided at our group-level meetings.
    – Value of information beforehand?
    – Powerpoint?
    – Written briefs?
  • Reports to OHA – who needs to review before we provide them? Reasonable time period for review
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