Pathways for Referral & Follow-Up to Developmental Screening in Marion and Polk Counties

Stakeholder Meeting to Inform the Community-Based Quality Improvement (QI) Project
Marion and Polk Early Learning Hub Conference Room - 2611 Pringle Rd SE, Salem OR
May 18th, 2017 @ 9AM-11:30AM
1) **Refresher on Project Activities and Goals**
   - Stakeholder engagement & asset mapping
   - Use of data across systems
   - Pilot of improvement strategies with three partners

2) **Overview of Improvement Strategies Developed**
   a) Primary Care
   b) Early Intervention (WESD)
   c) Early Learning (Family Link and Parenting Classes)

3) **Group-Level Facilitated Discussion:** Interest and opportunity to sustain work, spread tools and strategies across the community

4) **Wrap Up and Final Steps**
This Meeting Will Be a Success If:

**By the end of the meeting, attendees:**

1) Understand the **project activities**
2) Understand the **improvement strategies piloted** in Primary Care, Early Intervention, and with two Early Learning providers
3) Learn about initial **results of the pilots, including successes and barriers**
4) Group identifies **interest and opportunity to sustain work**, spread tools and strategies across the community

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Funding to Willamette Education Service District (WESD)

- Willamette Education Service District (WESD) received funds to improve follow-up to developmental screening for young children (age 0-3). Includes a specific focus on secondary processes for children referred to EI and then found ineligible. *(Ends June ‘17)*
  - Three-County Effort: Marion, Polk, and Yamhill Counties

- WESD is using a portion of those funds to contract with OPIP to lead a community-based improvement effort in Marion, Polk, and Yamhill:
  - Time Period for OPIP’s Subcontract: May 2016 - June 2017
    - Engage Stakeholders
    - Collect data to inform efforts
    - Engage parent advisors
    - Partner with primary care providers, WESD, and community-based providers to pilot methods to enhance follow-up
    - Summarize findings from improvements across Marion, Polk, Yamhill
      - Findings shared with Oregon Department of Education, Early Learning Council, and Legislature
# Stakeholders Engaged in Marion and Polk Counties

## a. Primary Care Providers
- Childhood Health Associates of Salem
- Woodburn Pediatric Clinic
- Salem Pediatric Clinic
- Willamette Family Medical Center
- Lancaster Family Health Center (reached out)

## b. Health System Reps.
- WVP & WVCH
  - Stuart Bradley
  - Dean Andretta
  - Anna Stern
- Mid-Valley BCN
  - Margaret Terry
- Salem Health Rehabilitation Center
  - Steve Paysinger

## c. Early Learning Hub
- Marion & Polk Early Learning Hub - Lisa Harnisch and Staff
- Marion and Polk Early Learning Hub Board of Directors
  - 27 Members
- Marion and Polk Early Learning Hub Regional Implementation Team
  - Over 30 Members
- External (ELD) Hub Facilitator
  - Tab Dansby

## d. WESD/EI
- WESD
  - Linda Felber
- Marion EI
  - Tonya Coker
- Yamhill/Polk EI
  - Cynthia Barthuly
- WESD- EI Intake
  - Sandra Gibson

## e. Community Based Providers Who Conduct Dev. Screening and/or Provider Follow-Up
- CaCoon, BabiesFirst, Healthy Families
  - Judy Cleave (Marion)
  - Jean DeJarnatt (Marion)
  - Jacqui Beal (Polk)
  - Wendy Zieker (Polk)
- Polk County Early Learning and Family Engagement, OPEC- Polk
  - Heather Smith
- Creating Opportunities
  - Cheryl Cisneros
- Community Action Head Start of Marion and Polk
  - Eva Pignotti and Staff
- Oregon Child Development Coalition
  - Berni Kirkpatrick
- Marion County Children’s Behavioral Health
  - Gwen Kraft
- Valley Mental Health
  - Kim Buller
- Childcare Resources and Referral Network
  - Shannon Vandehey and Jenna Sanders
- NW Human Services
  - Marybeth Beal
- OR Family Support Network
  - Sandy Bumpus
- ASQ Oregon
  - Kimberly Murphy, Liz Twombly
- 211 Statewide
  - Emily Berndt
- OPEC-Marion County
  - Margie Lowe
- Family Building Blocks
  - Heather Peasley
  - Sara Matthews
Community Asset Mapping and Pathway Identification in Marion and Polk Counties

**KEY STEPS**

**Part 1:** Children Identified At-Risk via Developmental Screening

**Part 2:** Referral of Child Identified At-Risk

**Part 3:** Referred Agency Ability to Contact Referred At-Risk Child/Family

**Part 4:** Children Evaluated and Deemed Eligible/ Ineligible for Referred Service

**Diagram:**
- Pathway for Developmental Screening & Referral and Triage Pathways for Children Identified At-Risk in Marion and Polk County
- ASQ Screening Database (MPELH, WVCH)
- Community-Based Providers: E.g. Early Head Start, Head Start, Home Visiting Programs, Public Health
- Child Care Programs ASQ Online (Outside Scope of Project)

Legend:
- **TYPE OF ARROW:**
  - Method and/or tool has been developed.
  - Exists, but is NOT standardized or improvements in process could be made
- **COLOR OF ARROW:**
  - Communication
  - Referral to Early Intervention (EI) services
  - Early Learning and Family Support Referral Form
  - Referral to Community-Based Agencies
  - Referral to Medical or Therapy services
  - Communication that child not able to be contacted, not eligible, or not served.

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## Data Collected to Inform Baseline & Evaluation Assessments

<table>
<thead>
<tr>
<th>DATA ELEMENTS:</th>
<th>DATA SOURCES:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>CCO Data Based on Claims (WVCH, YCCO)</td>
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<tr>
<td></td>
<td>Primary Care Data Based on EMR (CHAoS, WPC, PMC)</td>
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<tr>
<td></td>
<td>WESD Data on Referrals &amp; Evaluation, Follow-Up for EI Eligible</td>
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<tr>
<td></td>
<td>Centralized Home Visiting Data (Family Link, Family CORE)</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>X</td>
</tr>
<tr>
<td>Of those screened in Primary Care:</td>
<td></td>
</tr>
<tr>
<td># at-risk, Types of Risk</td>
<td>X</td>
</tr>
<tr>
<td>Referrals</td>
<td>X</td>
</tr>
<tr>
<td>Provision of other follow-up (i.e. rescreen, developmental promotion)</td>
<td>X</td>
</tr>
<tr>
<td>Outcome of referral (i.e. Were they able to contact and evaluate?)</td>
<td></td>
</tr>
<tr>
<td>Outcome of evaluation/assessment (i.e. Did child get a service?)</td>
<td>X</td>
</tr>
<tr>
<td>Follow-up steps of ineligible</td>
<td>X</td>
</tr>
</tbody>
</table>

*Do not copy or reproduce without proper citation.*
Examination and Use of Data About Developmental Screening and Follow-Up for Children age 0-3 to Understand Current Processes and Needs

• **CCO-level data about developmental screening**
  - Total number of children screened as defined by 96110 claims
  - Screening rates by practices to which children age 0-3 are assigned
  - Examining data for disparities by race ethnicity

• **Pilot Practice-level data**
  - Of developmental screens conducted, how many identify a child at-risk for delays
  - Of developmental screens where child identified at-risk for delays, follow-up steps

• **Early Intervention data**
  - Referrals
  - Evaluation Results
  - Examining data for disparities by race ethnicity
Qualitative Findings Related to Follow-Up to Developmental Screening for Young Children

• Follow-up to screening in Primary Care
  – Confusion and lack of awareness within primary care about difference between recommendations for when to refer to EI vs EI Eligibility
    o Perception that many children referred will not be eligible impacts if and when they refer
  – Need for referral criteria that take into account child and family factors, particularly for those children for whom the delay may be because of lack of exposure to the developmental tasks asked about in the ASQ
  – Lack of awareness of resources within Early Learning and/or WHEN to refer to them
  – Parent push back on referrals, cultural variations

• Need for parent supports
  – Developmental promotion that could in occur in the home
  – Education about referrals when provided
  – Parent support in navigation
2015 WESD EI Referral Outcomes in Marion, Polk, & Yamhill Counties

Marion, Polk & Yamhill Counties

Total N=353 (39%)

562 (61%)

170 (19%)

154 (17%)

22 (2%)

Total: N=915

N=7 (1%)

Percentage of Referrals

- Evaluated
- Parent Delay
- Not Able to Be Contacted
- No Parental Concerns
- Other Reason for No Evaluation

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

Percentage of Evaluations

- 166 (34%): Evaluated & Placed
- 111 (23%): Could Not Locate
- 105 (21%): Evaluated & DNQ
- 11 (2%): No Concerns
- 99 (20%): Other

N=326 (66%)

Total N=492

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Three Priorities Areas Identified for WHERE to Focus Improvement Pilots

1) **For primary care practices** conducting developmental screening, **enhance follow-up** for children identified
   - At a population-level, this is where the most “car seats” for children age 0-3 are parked
   - Develop tools for medical providers to inform their follow-up, parent supports that operationalize the community asset mapping into easy to use decision supports

2) **For Early Intervention:**
   - Enhance coordination and communication with the entity that referred the child;
   - Follow-up steps for EI ineligible

3) **Within** identified early learning, **pilots of referrals & connections**
   - Home visiting (Pilot of PCP to Family Link Referral)
   - Parenting classes (PCP Info about OPEC-supported Parenting Classes)
Community-Based Improvement Opportunity: Pilot Sites Implementing Efforts to Improve Follow-up to Developmental Screening

Primary Care Practices Conducting Developmental Screening

1) Enhanced Follow-Up Medical Decision Tree anchored to:
   A) ASQ scores, B) Child and family factors, C) Resources within the community
2) Parent support related to developmental promotion
3) Parent education when referred to other services
4) Care Coordination

Early Intervention

1) Enhanced communication and coordination for children referred, not able to be evaluated
2) Communication about evaluation results
   • For Ineligible Children: Referral to Early Learning supports
   • For Eligible Children: Communication about EI services being provided
3) Examination of WESD Data:
   • Examining EI Eligibility by presenting ASQ scores

Early Learning

NEW referrals from PCP/EI being to:
• Centralized home visiting referral
• Parenting classes within the OPECs

Do not copy or reproduce without proper citation.
Community-Based Improvement Opportunity: Pilot Sites Implementing Efforts to Improve Follow-up to Developmental Screening

**Primary Care Practices Conducting Developmental Screening**

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     - B) Child and family factors,
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**Early Learning**

NEW referrals from PCP/EI being to:
- Centralized home visiting referral
- Parenting classes within the OPECs

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Pilots of Improved Follow-Up and Connection to Early Learning by Primary Care Practices

1. **Piloted methods with three primary care practices** who see the most publicly insured children and are already doing developmental screening
   - Pilot Practices caring for children in Marion and Polk: 1) Childhood Health Associates of Salem (CHAoS); 2) Woodburn Pediatrics

2. **Components of OPIP Support and Collaboration with Primary Care Practices**
   1. Development of new tools operationalizing community asset map & supporting families
      - a) Follow-up to developmental screening decision support
      - b) Parent education sheet/ Shared Decision Making tool
      - c) Phone Follow-up Script
      - d) WVCH Summary of Services Addressing Delays
      - e) Use of Enhanced Communication from EI
   2. Implementation Support
      - a) Workflow Analysis
      - b) Training of Providers, Subsequent Trainings by Community-Based Providers
      - c) Monthly site visits by OPIP practice facilitator to support implementation, problem solve
      - d) EMR modifications to support implementation
      - e) Refinement and improvement of processes, addressing “hiccups” with community-based providers
   3. **Practice-Level Data** to Inform Community-Level Conversations & Evaluate Pilots
   4. Analysis of Practice-Level Data Re: **ASQ and WESD Eligibility**
Follow-Up to Developmental Screening: Priority Resources Identified in Community Asset Map

Based on data and community engagement, **six priority referrals** are included in the medical decision tree:

1) **Medical and Therapy Services** (developmental evaluation and therapy services)
2) **Early Intervention** (EI)
3) **CaCoon/Babies First**
4) **Centralized Home Visiting Referral** (Includes Early Head Start and Head Start)
5) **Parenting Classes**
6) **Mental Health**
Determining the “Best Match” Follow Up for the Child and Family

**ASQ Screen:**
- Identified At-Risk

**Numerous Factors Determine the Best Match for Follow-Up**

1. **Traditional Factors for Referral**
   - ASQ Scores by Domain
   - Provider Concern
   - Parental Concern

2. **Other Factors Considered as Part of Pilot**
   - Provider Concern
   - Medical Risk Factors
   - Adverse Childhood Events (ACEs)
   - Social Risk Factors
   - Family Income
   - County of Residence

**Medical Services**

**Early Intervention**

**Mental Health**

**CaCoon/Babies First**
- Centralized Home Visiting
- Parenting Classes

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

**Figure 1.0: Childhood Health’s Decision Tree: Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks**

**KEY:**
- **ASQ Domain Scores**
- **Developmental Promotion Provided At Visit**
- **Referral**
- **Child Factors**
- **Family Factors**
- **Family Income**
- **County**
- **Referral**

**Follow-Up Based on Total Score Across Domains:**

**GROUP A:**
- **2 or More in the Black**
  - Developmental Promotion:
    1. ASQ Learning Activities for Specific Domains Identified At-Risk
    2. Information on Vroom
  - **Refer to Early Intervention For An Evaluation**
  - To Determine Eligibility Use Universal Referral Form, FERPA Signed, Indicate “Summary Evaluation Form” To Receive Summary of Services
  - Consider Referral to Developmental/Behavioral Pediatrician (See DB Peds Referral Cheat Sheet)
  - Consider Supplementing Medical and Therapy Services Under Insurance Coverage Medical & Therapy Services (See One-Page Summary of WVCH Providers and Coverage)

**GROUP B:**
- **“At-Risk”: 1 or more in Black; OR 2 or more in Grey And could benefit from EI**
  - Developmental Promotion:
    1. ASQ Learning Activities for Specific Domains Identified At-Risk
    2. Information on Vroom
  - **Refer to Early Intervention For An Evaluation**
  - To Determine Eligibility Use Universal Referral Form, FERPA Signed, Indicate “Summary Evaluation Form” To Receive Summary of Services

**GROUP C:**
- **‘Watchful Waiting’ Borderline: 2 or more Grey or 1 in Black But Not Ready to Refer to EI**
  - Developmental Promotion:
    1. ASQ Learning Activities for Specific Domains Identified At-Risk
    2. Information on Vroom
  - Re-Screen in 3-6 Months, Set up a Follow-Up if Child Does Not Have A Visit

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

**GROUP D:**
- **In Black on Social Emotional Domain**
  - **Provide:**
    1. Providing ASQ Learning Activities for SE Domain
    2. Information on Vroom
  - **Behavior/Impulsivity with significant functional impact e.g. expelled from child care**
  - **Consider Use of Early Childhood Mental Health Dx Codes**

**Three Community Resources To Consider for Groups A-D**

**Resource #1**
- **Social Risk Factors** (Ex: parent with inadequate knowledge/supports, alcohol/substance abuse, or mental illness; teen parent)
- **Yes**
- **Refer to**
  - CaCoon/ Babies First
  - Use CaCoon Program Referral Form

**Resource #2**
- **Family Risk Factors**
  - Present or Exposure to Adverse Childhood Events & would benefit from Home Visiting and/or Head Start
  - **Publicly Insured**
  - Yes
  - **Refer to**
    - Mid-Valley Parenting
      - [www.midvalleyparenting.org](http://www.midvalleyparenting.org)
      - Email: parentresources@co.polk.or.us
    - Marion & Polk Early Learning Hub
      - [www.earlylearninghub.org](http://www.earlylearninghub.org)
      - Email: parentinhub@earlylearninghub.org

**Resource #3**
- **Support developmental promotion by addressing issues such as literacy/reading, parenting skills, food insecurity**
  - **Could benefit from parenting classes?**
  - **Publicly Insured**
  - Yes
  - **Private/Insured**
  - Yes
  - **Refer to**
    - Marion County Child. Behv. Health for PCTT
    - Options Counseling North, Valley Mental Health, Salem Psychiatry
    - Options Counseling North-Child, Marion County Children’s Behavioral Health, Mid Valley DCN, Valley Mental Health, Inter-Cultural Ctr for Psychology, Polk Mental Health-Child, Legacy Silverton Health

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Developmental Promotion

ASQ Learning Activities for the Specific Domains

Fine Motor
Activities to Help Your Toddler Grow and Learn

Of note: Since our last Stakeholder Meeting, both practices have purchased the ASQ Learning Activities and have incorporated them as a follow-up step for children identified at-risk.
Phone Follow Up within 36 Hours

Hello- May I speak with (name of patient’s primary caregiver). My name is (your name) and I’m Dr. XX’s (whatever your position is). Your son / daughter, (Name of child) had an appointment with Dr. XX on (time, date, location) for a well visit.

At your appointment, Dr. XX recommended that your child go to (Insert EI program Name i.e Early Intervention at Willamette Education Service District). We realize it can be overwhelming to get a lot of information about next steps at your appointment, so I wanted to call and answer any questions that you have may have had come up since then.

So what questions do you have about why Dr. XX wanted (insert child’s name) to go to Early Intervention at Willamette Education Service District, or about what will happen next?

Answer questions (frequent questions or concerns highlighted in blue)

- When completing the referral, you were asked to sign the consent form. This gives Early Intervention permission to share information about the evaluation back to us. This helps us to provide the best care for (insert child name)

- **Why go to EI? What does EI do:** At the appointment Willamette Education Service District will be doing a more detailed evaluation of (insert child’s name) development. Then, based on their assessment they will help us understand what we can do to support (insert child’s name) and whether your child may benefit from services.

Can you think of any barriers that might come up for you and your family in getting (insert child)’s name to these services?

  - Barrier is transportation – discuss TripLink and how to set up a ride as needed

Are there any other questions that you have or anything else I can do to help you in getting to these appointments?

If no further questions: Great. You should be getting a call from the Early Intervention Coordinator, their names are Sandra or Gemma, to schedule an appointment.

We are here to support you, so if you have any questions, feel free to contact (insert name) at (phone number).
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 (El)**
  - El helps babies and toddlers with their development. In your area, Willamette Education Service District (WESD) runs the El program.
  - El focuses on helping young children learn skills, El services enhance language, social and physical development through play-based interventions and parent coaching. There is no charge (it is free) to families for El services.
  - What to expect if your child was referred to El:
    - WESD will call you to set up an appointment for their team to assess your child.
    - If you miss their call, you should call back to schedule a time for the evaluation. They have a limited time to set up the appointment. Their phone number is (503) 385-4714.
    - The results from their assessment will be used to determine whether or not El can provide services for your child.
  - **Contact Information**: WESD Intake Coordinator 503-385-4714 | www.wesd.org

- **Family Link**
  - Family Link connects families with early childhood family support programs in Marion and Polk Counties. There is no charge (it is free) to families for Family Link services.
  - What to expect if your child was referred to Family Link:
    - The Family Link Referral Coordinator will call you to learn more about your child and family. They will work with you to find available services that best meet your needs, and link you to them based on eligibility.
  - **Contact**: Ivette Guervara Referral Coordinator 503-590-7431 ext. 929 familylink@familybuildingblocks.org

- **CaCoon**
  - CaCoon is a public health nursing program serving families. CaCoon public health nurses work with your family to support your child's health and development. A CaCoon nurse will meet with you in your home, or wherever works best for you and your child. There is no charge (it is free) to families for CaCoon services.
  - **Contact**: Judy Cleave, Program Supervisor 503-361-2693 www.ohsu.edu/xd/ourreach/occuphysn/programs-projects/cacoon.cfm

- **Medical/Therapy Services**
  - Your child’s health care provider referred you to the following:
    - Speech Language Pathologist: Specializes in speech, voice, and swallowing disorders
    - Audiologist: Specializes in hearing and balance concerns
    - Occupational Therapist: Specializes in performance activities necessary for daily life
    - Physical Therapist: Specializes in range of movement and physical coordination
    - Developmental-Behavioral Pediatrician: Specializes in child development areas including learning delays, feeding problems, behavior concerns, delayed development in speech, motor, or cognitive skills
    - Child Behavioral Health Services: Specializes in mental health assessments, individual/family group counseling, skills training and crisis intervention
    - Autism Specialist: Specializes in providing a diagnosis and treatment plan for children with symptoms of Autism

Why did you sign a consent form?

As your child’s primary care provider, we want to be informed about the care your child receives so that we can provide the best care possible. The consent you signed allows the programs to share information back to us. Different programs have different consent requirements. You will likely be asked to sign more of these to give permission for different providers to communicate about your child's care.

Any Questions?

At Childhood Health Associates, we are here to support you and your child. If you have any questions about the process please call our Referral Coordinators: (503) 364-3176

Education Sheet for Parents

Added a “Parenting Support” section since last meeting that sites are piloting

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# Services Covered by WVCH

**Version 1.0**

**WVCH Coverage of Medical and Therapy Services for Children with Developmental, Behavioral or Social Delays**

<table>
<thead>
<tr>
<th>Type of Medical or Therapy Service Addressing Developmental Delays</th>
<th>Covered (Y/N)</th>
<th>Benefit Coverage, Any Requirements for Service to be Approved</th>
<th>Providers in WVCH Contract That are Able to Provide Services</th>
<th>Serve Children aged 1 month - 3 years old?</th>
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<tbody>
<tr>
<td>Occupational Therapy Services</td>
<td>Yes</td>
<td>Authorization required for therapy visits beyond the initial evaluation/re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.</td>
<td>Creating Pathways&lt;br&gt;Mighty Oaks Therapy Center (Albany)&lt;br&gt;PT Northwest&lt;br&gt;Salem Hospital Rehab</td>
<td>Yes&lt;br&gt;Yes&lt;br&gt;No&lt;br&gt;Yes</td>
</tr>
<tr>
<td>Physical Therapy Services</td>
<td>Yes</td>
<td>Authorization required for therapy visits beyond the initial evaluation/re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.</td>
<td>Capitol PT&lt;br&gt;Keizer PT&lt;br&gt;Pinnacle PT&lt;br&gt;Promotion PT&lt;br&gt;PT Northwest&lt;br&gt;Salem Hospital Rehab&lt;br&gt;Therapeutic Associates&lt;br&gt;Creating Pathways</td>
<td>No&lt;br&gt;No&lt;br&gt;No&lt;br&gt;No&lt;br&gt;No&lt;br&gt;Yes&lt;br&gt;No&lt;br&gt;Yes</td>
</tr>
<tr>
<td>Speech Therapy Services</td>
<td>Yes</td>
<td>Authorization required for therapy visits beyond the initial evaluation/re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.</td>
<td>Chatterboks&lt;br&gt;Creating Pathways&lt;br&gt;Mighty Oaks Therapy Center (Albany)&lt;br&gt;PT Northwest&lt;br&gt;Salem Hospital Rehab&lt;br&gt;Sensible Speech</td>
<td>Yes&lt;br&gt;Yes&lt;br&gt;Yes&lt;br&gt;No&lt;br&gt;Yes&lt;br&gt;Yes</td>
</tr>
<tr>
<td>Pediatric Psychological Testing Services</td>
<td>Yes</td>
<td>Authorization required</td>
<td>Valley Mental Health&lt;br&gt;Willamette Family Medical Center&lt;br&gt;Intercultural Psychology Services</td>
<td>Yes - 18 months and up&lt;br&gt;Yes - 18 months and up&lt;br&gt;Yes - 18 months and up</td>
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<tr>
<td>Behavioral Health Services</td>
<td>Yes</td>
<td>Enrolled in services</td>
<td>Marion County Child Behavioral Health*&lt;br&gt;Polk County Mental Health*&lt;br&gt;Inter-Cultural Center for Psychology</td>
<td>Yes&lt;br&gt;Yes&lt;br&gt;Yes</td>
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*Bilingual provider

Do not copy or reproduce without proper citation.
**Support to Pilot Primary Care Sites to Support Implementation**

Example of meeting and support to CHAoS:

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<tr>
<th>Key:</th>
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<tbody>
<tr>
<td>Practice Facilitation Site Visits</td>
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<td>Practice-Level Data Collection</td>
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<td>Meetings Re: EMR</td>
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<tr>
<td>Stakeholder Meetings</td>
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<tr>
<td>Provider Trainings on New Tools (Medical Decision Tree, Parent Education Sheet, 36-Hour Script) developed by OPIP</td>
</tr>
<tr>
<td>All-Provider Training: Community-Based Providers (Family Link &amp; Marion/Polk OPEC)</td>
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<tr>
<td>Kick-off meeting for Family Link Pilot</td>
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<td>Continuous Quality Improvement &amp; PDSA cycles within the practice</td>
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<td>(Medical Decision Tree, Parent Education Sheet, 36-Hour Script) developed by OPIP</td>
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<td>(Family Link &amp; Marion/Polk OPEC)</td>
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<td>Kick-off meeting for Family Link Pilot</td>
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<td>Continuous Quality Improvement &amp; PDSA cycles within the practice</td>
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*Do not copy or reproduce without proper citation.*
Data that Will be Evaluated to Gauge Impact of PCP Pilot

• Practice and Primary care sites will be submitting data early June
  – Given trainings and implementation occurred in January, want to ensure as robust information as possible

1) **Qualitative data** from site visits about implementation and impact
2) Data Based on **Primary Care Level Data** in the **Electronic Medical Record**
3) Data Based on **EI Data** – For Referrals From Pilot Practices
4) Data Based on **Family Link Data** – For Referral from CHAoS
Data that Will be Evaluated to Gauge Impact of PCP Pilot

Data Based on Primary Care Level Data in the Electronic Medical Record

• For children identified at-risk on the ASQ:
  – Whether Follow-Up Steps Occurred
    o Developmental Promotion
    o Referral
    o Retest

• For those referred, which referrals and was there an increase in referrals from the sites since baseline:
  o DB Peds
  o Early Intervention
  o Mental
  o CaCoon
  o Home Visiting (new referral), We already know an increase 😊
    *Can’t track OPEC

• For those referred, provision of parent education sheet

• All data examined by overall risk and by specific risk groups (number of ASQ domains identified, specific ASQ domains)
Data that Will be Evaluated to Gauge Impact of PCP Pilot

Data Based on EI Data – For Pilot Practices
  – Whether there was an increase in referrals compared to baseline
  – Whether there was an increase in ability to evaluate referred children compared to baseline
  – Whether there was increase number of children served

Data Based on Family Link Data – For Pilot Practices
  – Number of new referrals compared to baseline (which was zero)
  – Number of children enrolled in a service
Findings from Primary Care Pilot Sites: Successes

1) Tools are feasible and valuable to enhancing follow-up
   - Providers report and preliminary data indicate better and more robust follow-up
     • e.g. N=17 new kids referred to Family Link since pilot started in February
   - High value in the medical decision tree, although refinements and barriers identified in eligibility and capacity of programs (will be noted in barriers)
     • Essential for sustainability that it is built into the EMR
     • Resources not in the EMR or that can’t be tracked, less likely to be used
   - High value in the ASQ Learning Activities
   - High value in the parent education sheets from provider perspective
   - Overall improved communication with WESD

2) Providers report processes are more supportive of families and support shared decision making
   - Parent education sheet and value of written information
   - Phone follow-up reminder
Increases in referrals doesn’t necessarily mean increase in services received
  – More kids referred to EI= more kids not eligible
  – Given capacity, services seem targeted for those with most delays, even though moderately delayed may have highest impact before kindergarten

**Short Time and length of the pilot:** Total project 13 months, Training in January ‘16
  – Even with two high functioning practices, it takes time to train and implement new workflows so that they become part of the standard of care
  – Building decision support into the EMR is essential, but takes time

Cultural stigma and barriers to care exist – especially for home visiting, mental health and parenting classes
  – This is important to address, as access alone does not mean families will go
  – Value of training on how to talk about “home visiting”

Referrals to mental health likely did not increase for a number of reasons

Referrals to Parenting Classes still felt “clumsy”, interested in normalizing it

Concern about referral criteria outlined in Bright Futures related to EI and how it does not map to OR EI Eligibility requirements
  – Perception and experience that many of these children are not actually eligible for EI, even though they felt they were taught that ASQ results and EI eligibility were related

---

**Diagram:**

- **Question:** Are the screening tool results positive/concerning?
  - **Yes:** Make referrals for:
    - Developmental and medical evaluations
    - Early developmental intervention/early childhood services
  - **No:**
    - **Group A:** 2 or more in grey and could benefit from EI
    - **Group B:** ‘Watchful waiting’ borderline: 2 or more grey or 1 in black but not ready to refer to EI
    - **Group C:** ‘Watchful waiting’ borderline: 2 or more grey or 1 in black but not ready to refer to EI

---

*Do not copy or reproduce without proper citation.*
Examining Presenting ASQ Domain-Level Scores Provided by Referral and EI Eligibility

- Identified children who were referred to EI and domain-level ASQ scores were provided
  - Only 25% of referrals over last two school years had a domain-level scores for ASQ
- This required WESD to complete manual chart review and data entry
- WESD provided OPIP with blinded data base that included
  - ASQ scores
  - EI eligibility and for which domains
  - Other descriptive factors to inform analysis. For example: Age of child, Medicaid insurance, Referral source, Medical eligibility, Medical eligibility
- Primary care pilot sites also provided data on children referred to EI and their information about the child’s domain-level score
- OPIP conducted analyses to identify any trends to inform better referrals from primary care to EI

*Do not copy or reproduce without proper citation.*
Number of Referrals with Attached ASQ Scores

- **SY 14-15**:
  - Total Children Evaluated by WESD: 572
  - Total Children Evaluated with Presenting ASQ: 114 (20%)

- **SY 15-16**:
  - Total Children Evaluated by WESD: 582
  - Total Children Evaluated with Presenting ASQ: 180 (31%)

- **TOTAL**:
  - Total Children Evaluated by WESD: 1154
  - Total Children Evaluated with Presenting ASQ: 294 (25%)
Children Identified as At-Risk on ASQ by Referring Provider & EI Eligibility

At-Risk on ASQ, Across Five Domains:

- 2 STDs from Normal on One Domain (Black) or
- 1.5 STD from Normal on Two Domains (Grey)

Total N=238

119 (50%)

At-Risk on ASQ

- EI Eligible
- Did Not Qualify for EI
Children Identified as At-Risk on ASQ by Referring Provider and EI Eligibility: By Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Total N=58</th>
<th>Total N=100</th>
<th>Total N=80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1yr</td>
<td>35 (60%)</td>
<td>55 (55%)</td>
<td>29 (36%)</td>
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<tr>
<td>1-2 yrs</td>
<td>23 (40%)</td>
<td>45 (45%)</td>
<td>51 (64%)</td>
</tr>
<tr>
<td>2-3 yrs</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Percentages are approximate and may not sum to 100% due to rounding.*
Groups of “At-Risk” within Primary Care Follow-Up to Developmental Screening Decision Support

**GROUP A**
2 or More in the Black

Developmental Promotion:
1) ASQ Learning Activities for Specific Domains Identified At-Risk
2) Information on Vroom

Refer to Early Intervention For An Evaluation
To Determine Eligibility Use Universal Referral Form, FERPA Signed, Indicate “Summary Evaluation Form” To Receive Summary of Services

Consider Referral to Developmental/Behavioral Pediatrician
(See DB Peds Referral Cheat Sheet)

Consider Supplementing Medical and Therapy Services Under Insurance Coverage Medical & Therapy Services (See One-Page Summary of WVCH Providers and Coverage)

**GROUP B**
“At-Risk”:
1 in Black; OR
2 or more in Grey
And could benefit from EI

Developmental Promotion:
1) ASQ Learning Activities for Specific Domains Identified At-Risk
2) Information on Vroom

Refer to Early Intervention For An Evaluation
To Determine Eligibility Use Universal Referral Form, FERPA Signed, Indicate “Summary Evaluation Form” To Receive Summary of Services

Consider Supplementing Medical and Therapy Services Under Insurance Coverage Medical & Therapy Services (See One-Page Summary of WVCH Providers and Coverage)

**GROUP C**
Monitoring’:
2 or more Grey or 1 in Black But Not Ready to Refer to EI

Developmental Promotion:
1) ASQ Learning Activities for Specific Domains Identified At-Risk
2) Information on Vroom

Re-Screen in 3-6 Months. Set up a Follow-Up if Child Does Not Have A Visit

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

**GROUP D**
In Black on Social Emotional Domain

Provide:
1) Providing ASQ Learning Activities for SE Domain
2) Information on Vroom

Refer to internal Behavioral Health Staff for further assessment and support

Behavior/Impulsivity with significant functional impact (e.g. expelled from child care)

And/Or

Consider Use of Early Childhood Mental Health

Do not copy or reproduce without proper citation.
EI Eligibility by ASQ Scores:
By Medical Decision Tree Groups

Percentage of referrals

Overall At-Risk
- Total N=294
  - EI Eligible: 119 (50%)
  - Does Not Qualify for EI: 119 (50%)

Group A
(2+ in the black)
- Total N=106
  - EI Eligible: 66 (62%)
  - Does Not Qualify for EI: 40 (38%)

Group B
(2+ in the grey or only 1 in the black)
Specific groups within Group B:
  - 2+ in the grey
    - Total N=30
      - EI Eligible: 7 (23%)
      - Does Not Qualify for EI: 23 (77%)
  - Only 1 in the black
    - Total N=102
      - EI Eligible: 46 (45%)
      - Does Not Qualify for EI: 56 (55%)

Group D
(Black in the Personal Social Domain)
- Total N=65
  - EI Eligible: 42 (65%)
  - Does Not Qualify for EI: 23 (35%)

Black = 2 standard deviations from normal on ASQ
Grey = 1.5 standard deviations from normal on ASQ
Implications to Inform Future Efforts

• Developmental screening is going to increase in primary care sites
  – CCO benchmark increased
  – Component of PCPCH requirements

• Current recommendations are for all children identified “at-risk” to be referred to EI
• That said, given Oregon’s eligibility requirement for EI, we know that many of the children identified “at-risk” on ASQ, will not be eligible within EI
  – If all children referred, more children will be evaluated and not eligible
  – Eligibility rates impact referral
    ✓ Providers stop referring
    ✓ Parents may not go back to referral if not found eligible at one point in time

• OPIP’s Recommendation Looking Forward:
  – Develop better referral criterion anchored to ASQ and EI in Oregon
    ✓ Convene EI contactors, Early Learning, Primary Care, Developmental Pediatricians
  – Obtain more robust data to allow for better examination
  – Once this is done, refine the decision support tool for practices and evaluate impact

Do not copy or reproduce without proper citation.
Community-Based Improvement Opportunity:
Pilot Sites Implementing Efforts to Improve Follow-up to Developmental Screening

Primary Care Practices Conducting Developmental Screening

1) Enhanced Follow-Up Medical Decision Tree anchored to:
   A) ASQ scores, B) Child and family factors, C) Resources within the community
2) Parent support related to developmental promotion
3) Parent education when referred to other services
4) Care Coordination

Early Intervention

1) Enhanced communication and coordination for children referred, not able to be evaluated
2) Communication about evaluation results
   • For Ineligible Children: Referral to Early Learning supports
   • For Eligible Children: Communication about EI services being provided
3) Examination of WESD Data:
   • Examining EI Eligibility by presenting ASQ scores

Early Learning

NEW referrals from PCP/EI being to:
• Centralized home visiting referral
• Parenting classes within the OPECs

Do not copy or reproduce without proper citation.
Focus of Improvement Efforts
Within Willamette Education Service District (WESD)

1. Provided data to inform discussions about priority areas of focus and improvement
   – Shared at the previous two meetings and informed the priority pathways, provided data presented earlier)

*Implement new processes focused on:*

2. Improve communication and coordination:
   A) For children *not evaluated*
   B) For children *evaluated and found eligible*

3. Follow-Up Steps for found *El ineligible*
   A) Provision of Act Early materials
   B) Referral of Ineligible Children Centralized Home Visiting
Over Course of Project: Increase in Referrals to Early Intervention

Marion and Polk County:
- Marion and Polk County: + 10% (N=80 Children)
- Marion county: + 9% (N=67 Children)
- Polk County: + 11% (N=13 Children)

*SY 16-17 data will be collected at the end of the school year to determine impact over full project timeframe.

Do not copy or reproduce without proper citation.
Focus of Improvement Effort

Within Willamette Education Service District (WESD)

1. Provided data to inform discussions about priority areas of focus and improvement
   – Shared at the previous two meetings and informed the priority pathways, provided data presented earlier

**Implement new processes focused on:**

2. Improve communication and coordination:
   A) For children not evaluated
   B) For children evaluated and found eligible

3. Follow Up Steps for found EI ineligible
   A) Provision of Act Early materials
   B) Referral of Ineligible Children Centralized Home Visiting
Pilots of New Processes to Improve Communication and Coordination by WESD - Early Intervention

**GREEN**- new process implemented

**Improved Processes Related to Communication and Coordination**

- Referral Using URF
  - Phone Call Attempt #1
    - Made contact
      - Schedule Evaluation
        - Evaluation (to happen within 45 days)
          - Yes
            - Eligible?
              - Yes
                - Phone Call Attempt #2
                  - Made contact
                    - Schedule Evaluation
                      - Evaluation
                        - Eligible?
                          - No
                            - Close Referral (After 60 Days)
                          - Yes
                            - Provider Feedback - Bottom of El Form
                              - Close Referral
- Phone Call Attempt #2
  - Made contact
    - Send Letter
      - Provider Feedback - Bottom of El Form

**Improved Processes for InEligible Children**

- Additional Follow Up Identified
  - Act Early Packet
    - Refer to Centralized Home Visiting
    - Refer to Mental Health

Provider Feedback - Top of Summary of Services

Determine Services

Provider Feedback - Summary of Services (to be spent within changes in services and annually)
Early Intervention Universal Referral Form

Feedback to Referring Provider

- Not able to contact
- For those that were contacted and evaluated, general eligibility
Leveraging the Early Intervention Universal Referral Form to Communicate Whether Children Referred But NOT Evaluated

**EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER**

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

- Family contacted on **____/____/____** The child was evaluated on **____/____/____** and was found to be:
  - Eligible for services
  - Not eligible for services at this time, referred to: __________________________
  - EI/ECSE County Contact/Phone: __________________________
  - Notes: __________________________
  - Attachments as requested above:
  - Unable to contact parent
  - Unable to complete evaluation

*The EI/ECSE Referral Form may be duplicated and downloaded at: [http://www.ohsu.edu/xd/outreach/occupyinl/programs-projects/dev-screening-and-referrals.html](http://www.ohsu.edu/xd/outreach/occupyinl/programs-projects/dev-screening-and-referrals.html)*

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**Completed Example:**

**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 **07/11/16** The child was evaluated on **08/12/16** and was found to be:
  - Eligible for services
  - Not eligible for services at this time, referred to: __________________________
  - EI/ECSE County Contact/Phone: __________________________
  - Notes: **Contact attempts:** 8/12/16, 9/20/16, 9/1/16
  - **Closed referral on 9/1/16 due to no contact**

*The EI/ECSE Referral Form may be duplicated and downloaded at: [http://www.ohsu.edu/xd/outreach/occupyinl/programs-projects/dev-screening-and-referrals.html](http://www.ohsu.edu/xd/outreach/occupyinl/programs-projects/dev-screening-and-referrals.html)*

**RECEIVED**

OCT 1.1 2016

BY: AM

8/12 VM 8/20 VM 9/1 Letter

W 13

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

**GREEN - new process implemented**

- Referral Using URF
- Phone Call Attempt #1
  - Made contact
  - Schedule Evaluation
  - No contact
- Phone Call Attempt #2
  - Made contact
- Provider Feedback - Bottom of EI Form
- Close Referral
- Send Letter
- Close Referral (After 60 Days)

- Evaluation (to happen within 45 days)
  - Eligible?
    - Yes
      - Provider Feedback - Top of Summary of Services
      - Determine Services
    - No
      - Act Early Packet
- Additional Follow Up Identified
  - Refer to Centralized Home Visiting
  - Refer to Mental Health

**Improvements made since our last Stakeholder Meeting**

---

Do not copy or reproduce without proper citation.
One-Page Summary of Services

Willamette
EDUCATION SERVICE DISTRICT
Marion Center • 2611 Pringle Rd, Salem, OR 97302 • Phone 503.385.4673 • Fax 503.340.4473
Yamhill Center • 2045 SW Hwy 18, McMininville, OR 97128 • Phone 503.435.5900 • Fax 503.435.5920

Early Intervention Referral Feedback

Child's Name ___________________________ Birthdate: ___

Your patient was found eligible for Early Intervention services on: 11/02/18

She was found eligible under the category: Developmental delay in communication area.

As required under Oregon law, she will be re-evaluated by 03/13/18 to determine if she is eligible for Early Childhood Special Education Services.

Additional referrals: 2/15/17: Eligible for Hearing Impairment

A new Individual Family Service Plan (IFSP) was developed for on 11/16/18. These services will be reviewed again no later than 06/15/17.

IFSP Services

Goal Areas: ☐ Cognitive ☐ Social / Emotional ☐ Motor ☐ Adaptive ☐ Communication

Services Provided by:

☐ Early Intervention Specialist
☐ Occupational Therapist
☐ Physical Therapist
☒ Speech Language Pathologist
☐ Other

Services Frequency Current Provider

1x/2 weeks; 45 minutes Marie Sellke
1x/month; 45 minutes Ann Stevenson- hearing services

This form is submitted annually and any time there is a change in services. Please contact Marie Sellke with any questions.

This document represents services determined by the IFSP to provide educational benefit. Any services identified or recommended by medical providers are separate and not represented on this form.

Signed ____________________________

Marie Sellke, Speech Language Pathologist
2611 Pringle Rd, SE Salem, OR 97302
Process for Implementation of the One-Page Summary of Services

• Once a child is deemed eligible, the evaluation team and the family establish goals and services

• The Service Coordinator will then complete and send the 1-Page Summary of Services back to practices who have a completed Universal Referral Form

• We hope this form will take the place, in most cases, of the full IFSP and the Evaluation Report to make our communication more streamlined
  • Since this form is in the pilot phase—this communication option is not listed on the Universal Referral Form
Focus of Improvement Effort
Within Willamette Education Service District (WESD)

1. Provided data to inform discussions about priority areas of focus and improvement
   • Shared at the previous two meetings and informed the priority pathways, provided data presented earlier

Implement new processes focused on:

2. Improve communication and coordination:
   A) For children not evaluated
   B) For children evaluated and found eligible

3. Follow Up Steps for found EI Ineligible
   A) Provision of Act Early materials
   B) Referral of Ineligible Children Centralized Home Visiting
Focus of Improvement Efforts Within WESD- Early Intervention

**GREEN - new process implemented**

- Referral Using URF
  - Phone Call Attempt #1
    - Made contact
      - Schedule Evaluation
    - No contact
      - Send Letter
      - Close Referral (After 60 Days)
  - Provider Feedback - Bottom of El Form
  - Close Referral

- Evaluation (to happen within 45 days)
  - Yes
    - Eligible?
      - Yes
        - Provider Feedback - Top of Summary of Services
        - Determine Services
        - Provider Feedback - Summary of Services (to be resent upon any changes in services and annually)
      - No
        - Act Early Packet
          - Additional Follow Up Identified
            - Refer to Centralized Home Visiting
            - Refer to Mental Health
  - No

- Provider Feedback - Bottom of El Form
If you have concerns about your child's development please contact:

Marion, Polk & Yamhill Counties
Toll Free Number (888) 560-4665
sandra.gibson@wesd.org

CDC Act Early Materials

Milestone Moments

Learn the Signs. Act Early.

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

You can follow your child’s development by watching how he or she plays, learns, speaks, and acts.

Look inside for milestones to watch for in your child and how you can help your child learn and grow.

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


Special acknowledgments to Susan D. Borge, PhD; Jenny Burt, PhD; Margaret Cresc, MD; Katie Green, MPH, CHES; Georgene Pschrist, MD, MPH; Lara Kinzinger, PhD, MPH; Camille Smith, MS, EdS; Julie Whitney, BS; and Rebecca Wall, MA.

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WESD Referrals for Ineligible Children to Centralized Home Visiting Intake & Mental Health: (To Date) Over Project Period N=61 Children Referred to Services

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<th>County the Child Resides</th>
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<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
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<td># Family Link Referrals</td>
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<td>OVERALL # EI Children Referred to Secondary Resource</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td># Family CORE Referrals</td>
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<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td># Mental Health Referrals</td>
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<td>0</td>
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<td>0</td>
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<td>0</td>
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<td>0</td>
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</tbody>
</table>

OVERALL TOTAL ACROSS COUNTIES: 61

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From Our Perspective: Successes in WESD Efforts

• Sharing of our data has been helpful to inform community conversations, identify the priority pathways

• Refined internal data collection processes, enhanced standardization of our processes

• **New processes implemented**
  – Improved communication and coordination with primary care providers
    o Bottom of the Universal Referral Form
    o One Page Summary of Services
  – Improved follow-up for kids not eligible for EI
    o Dissemination of Act Early Packets for developmental promotion
    o Referral to Family Link or Family CORE
    o Referral to Mental Health
  – Due to success and enhanced coordination, we plan to continue this process

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

• **Staffing bandwidth to ensure these communications are sent in a timely manner**

• **Ensuring all practices are using the Universal Referral Form – and completing the FERPA release**
  – Without proper use and inclusion of signatures, communication between entities is difficult and time consuming
  – While we have worked on this with pilot sites, there have still been a few hiccups- meaning there may be more barriers with sites that do not receive the level of support that the pilot sites did

• **Difference between children identified by the ASQ vs. EI Eligibility and impact on referral, Impacts referrals to WESD**

• **Ability of programs to serve EI Ineligible children**
  – EI referrals have less context about family risk factors given we don’t have an established relationship with the child/family; May impact the number of priority risk factors that are listed on referral form
  – Large number of EI Ineligible are privately insured and/or may not have risk factors that prioritize them
  – Need for services to address moderately delayed given impact
Community-Based Improvement Opportunity: Pilot Sites Implementing Efforts to Improve Follow-up to Developmental Screening

**Primary Care Practices Conducting Developmental Screening**

1) **Enhanced Follow-Up Medical Decision Tree** anchored to:
   - A) ASQ scores,
   - B) Child and family factors,
   - C) Resources within the community
2) **Parent support related to developmental promotion**
3) **Parent education when referred to other services**
4) **Care Coordination**

**Early Intervention**

1) **Enhanced communication and coordination for children referred, not able to be evaluated**
2) **Communication about evaluation results**
   - For Ineligible Children: Referral to Early Learning supports
   - For Eligible Children: Communication about EI services being provided
3) **Examination of WESD Data:**
   - Examining EI Eligibility by presenting ASQ scores

**Early Learning**

NEW referrals from PCP/EI being to:
- **Centralized** home visiting referral
- Parenting classes within the OPECs
Referrals from CHAoS to Family Link

• Piloted referrals to centralized home visiting intake (Family Link) in one site first
• Wanted to understand workflow and capacity before spreading to other sites
Pilot of Referrals from CHAoS to Family Link
At the end of February, CHAoS and Family Link began their pilot

- Agreed upon criteria for referrals were as follows:
  - Children identified at-risk on the ASQ who also have Family Risk Factors, including those listed below:
    - Feels Depressed or Overwhelmed
    - Isolation/Lack of Support
    - Support with Parenting
    - Has Disability
    - Teen/Young Parent
    - First Time Parent
    - Tobacco Use
    - Domestic Violence (present or history of)
    - Alcohol/Drug Use
    - Lack of Food/Clothing/Housing
    - Incarceration/Probation
    - Low Income
    - Migrant/Seasonal Worker
    - Unemployed
    - Homeless
    - Receives TANF/SSI/SNAP
Pilot of Referrals from CHAoS to Family Link

Each month the Referral Coordinator at Family Link, Ivette Guevara, is sending the Referral Coordinator at CHAoS a summary report about the status of each referral they have sent.

The report includes the following information:

For Referrals Received:
- Provider who referred child/family
- Name of Patient
- Date of Birth
- Date of Initial Contact
- Agency Linked to
- Status of Referral

For Referrals Successfully Enrolled:
- Name of Patient
- Date of Birth
- Agency Linked to
- Type of Program
- Date of Enrollment
Between February and April, CHAoS had referred 17 families to Family Link:

<table>
<thead>
<tr>
<th>Status</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pending</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4 (23%)</td>
</tr>
<tr>
<td>Waitlist</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3 (18%)</td>
</tr>
<tr>
<td>Not able to be reached</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>9 (53%)</td>
</tr>
<tr>
<td>Declined</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>8</td>
<td>5</td>
<td>17</td>
</tr>
</tbody>
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### Outcome of WESD Referrals of EI Ineligible to Family Link (Marion and Polk Counties)

<table>
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<tr>
<th></th>
<th>Feb 16</th>
<th>March 16</th>
<th>July 16</th>
<th>Aug 16</th>
<th>Sept 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
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<th>Mar 17</th>
<th>April 17</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrolled</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td><strong>Pending</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td><strong>Waitlist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td><strong>Not able to be reached</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td><strong>Declined</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td><strong>Closed-Did not receive services</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>1*</td>
<td>3*</td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>8</td>
<td>13</td>
<td>6</td>
<td>4</td>
<td>17</td>
<td>4</td>
<td>1</td>
<td>59</td>
</tr>
</tbody>
</table>

*Already connected to Family Link prior to referral.*
Successes and Barriers to Pilot

**Successes:**

*New processes implemented*

- Improved communication and understanding between both entities and community-based organizations that serve young children and their families
- Improved follow-up for kids who need services
  - Referral to Family Link provides at least potential options that may not have even been pursued before the pilot

**Barriers:**

- **Not able to contact**
  - A very large number of families are not able to be contacted. This is true across the board, including in primary care and EI
- **Many children who do get connected are still pending or put on waitlists**
  - This is just the reality when it comes to capacity across organizations to catch these children

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Pilot to Parenting Classes
Connection to Parenting Classes

Figure 1.0: Pilot Medical Decision Tree for Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks in Marion, Polk and Yamhill County

Follow-Up Based on Total Score Across Domains:

GROUP A
- 2 or more in the Black
- Developmental Promotion:
  1. ASQ Learning Activities for Specific Domains Identified At-Risk
  2. Information on Vroom
- Refer to Early Intervention For An Evaluation
- To Determine Eligibility Use Universal Referral Form, FERPA Signed, Indicate "Summary Evaluation Form" To Receive Summary of Services
- Consider Referral to Developmental/Behavioral Pediatrician (See DB Peds Referral Cheat Sheet)
- Consider Supplementing Medical and Therapy Services Under Insurance Coverage: Medical & Therapy Services (See One-Page Summary of WVCH Providers and Coverage)

GROUP B
- ‘At-Risk’: 1 or more in Black; OR 2 or more in Grey
- And could benefit from EI
- Developmental Promotion:
  1. ASQ Learning Activities for Specific Domains Identified At-Risk
  2. Information on Vroom
- Refer to Early Intervention For An Evaluation
- To Determine Eligibility Use Universal Referral Form, FERPA Signed, Indicate "Summary Evaluation Form" To Receive Summary of Services
- Consider Supplementing Medical and Therapy Services Under Insurance Coverage: Medical & Therapy Services (See One-Page Summary of WVCH Providers and Coverage)

GROUP C
- ‘Monitoring’: 2 or more Grey or 1 in Black But Not Ready to Refer to EI
- Developmental Promotion:
  1. ASQ Learning Activities for Specific Domains Identified At-Risk
  2. Information on Vroom
- Re-Screen in 3-6 Months, Set up a Follow-Up if Child Does Not Have A Visit

Three Community Resources To Consider for Groups A-D

Resource #3
- Support developmental promotion by addressing issues such as literacy/reading, parenting skills, food insecurity
- Could benefit from parenting classes?

Mid-Valley Parenting
- Website: www.midvalleyparenting.org
- Email: parentresources@co.polk.or.us

Marion & Polk Early Learning Hub
- Website: www.earlylearninghub.org
- Email: parentinghub@earlylearninghub.org

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Successes and Barriers to Referrals to Parenting Classes

**Successes:**

- Providers were excited to learn about parenting classes, as this was not a resource they utilized previously.
- General sentiment is that this would be helpful for many families they care for.

**Barriers:**

- Can be an awkward conversation
  - Value of general efforts to normalize efforts
- Negative stigma of ‘parenting classes’
  - Impacting family engagement and follow through
- Since it is not a traditional referral, practices can’t track referrals and “follow-up” on the “referral”
• Need to ensure all young children receive developmental screening
  – Primary care is where the most car seats for young children are parked
  – CCO Benchmark: 60.1%
  – That said, claims data show most practices within WVCH catch not screening to fidelity yet

• Gains in developmental screening **do not** equal improvements in **receipt** of early service provision to address the delay identified to be ready for school
  – Most children screened by primary care are **not referred to follow-up** services
  – Referral to services does not equal **receipt** of services
    • Observing a number of children referred are not able to be contacted by program
    • Observing a number of children referred not able to receive the service
  – This project developed Follow-Up Decision Supports to Enhance Follow-Up
  – Addressing Follow-Up Means Engaging:
    • Health Care
    • Early Learning
    • Early Intervention

• As part of efforts, important to consider funding, capacity, and eligibility for programs that serve children identified
  – Early Intervention
  – Home Visiting
  – Mental Health
Opportunities to Build Off this Improvement Pilot in Marion and Polk Counties

1. Continue and Build off Enhanced Engagement Across Primary Care, EI, and Early Learning
   – Primary care engagement in Hub activities
   – Use and examination of EI data to inform population assessment
   – Use of practice level to inform population assessment

2. Build off tools, methods, and processes developed in this project within these communities
   – Support spread of tools for primary care to other sites
   – Support the primary care sites NOT doing developmental screening, prioritize sites who care for ethnic groups least likely to be screened
   – Modify tools/strategies for others conducting screening (e.g. childcare providers)

3. Refine and Improve Tools Based on Learnings (new work)
   – Improve EI referral criterion based on increased data, community engagement
   – Focus on mental health referrals, evaluation, and services for young children
   – Incorporate tools and workflow into Next Gen EMR supported by WVCH
Needs Identified in this Project Not Addressed (New work)

1) Follow-up for children identified at-risk, and likely to not be kindergarten ready, but who unable to be served by existing programs
   - Privately insured, but can’t afford private therapies
   - Children with family risk factors impacting development and readiness (social-emotional regulation), but for whom current funding or priorities force services to deem them ineligible

2) Assess and address cultural variations needed to ensure follow-up

3) Project to normalize parenting classes and parenting supports

4) Models for parent to parent support, parent navigators for this population
## Tools Developed That Can Be Spread

### Primary Care Sites

**QI Tools/Methods:**
- Follow-up to Developmental Screening Support Tool
- Training slides on referral and follow-up pathways
- Materials to support families
  - Parent education material and
  - Phone follow-up for referred children within 36 hours to answer questions and address barriers

**Summary of WVCH Coverage of Follow-Up Services:**
- Specific services, providers, whether they serve young children
- Services covered within WVCH (Under WVP & BCN)

**Methods to Examine Practice-Level Data to Guide and Evaluate Efforts:**
- Practice-level data related to screening, referral and follow-up

### Early Intervention (WESD)

**QI Tools/Methods Being Implemented:**
- EI communication processes referring provider when not able to contact the child OR the family declines services
- Enhanced processes around directing EI ineligible children to other community-based providers (e.g. centralized home visiting referral form)
- Enhanced feedback forms about service being provided so that secondary referral resources can be identified.

**Methods to Examine Practice-Level Data to Guide and Evaluate Efforts:**
- Referrals, Evaluation and characteristic of ineligible children
- Examining EI Eligibility by presenting ASQ scores

### Community-Based Providers

**Family-Link:**
- Centralized home visiting referral

**Connection to Parenting classes within the OPECs:**
- Mid-Valley Parenting & Marion and Polk Early Learning Hub

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Looking Forward: Group Discussion
What to Sustain? What to Spread?

1. What are priority areas this community should address?
2. Who should take the lead?
3. What are opportunities?
4. How can you keep the momentum going?
Wrap Up and Final Steps

- Wrap Up and Final Steps:
  - Final Report End of June
  - OPIP Website:
    Materials and Tools will soon be Loaded
    http://oregon-pip.org/projects/PathwaysWESD.html

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**THANK YOU FOR YOUR COLLABORATION & INSPIRATION**

- WESD (Funder and Partner)
- Parent Advisors
- Partners in Marion, Polk & Yamhill

- Yamhill CCO
- Yamhill Early Learning Hub
- Head Start of Yamhill County
- Yamhill County Public Health
- Physician’s Medical Center
- Newberg School District
- Discovery Zone Child Development Center
- Willamette Valley Community Health
- Marion & Polk Early Learning Hub (Hub, Inc)
- Childhood Health Associates of Salem
- Woodburn Pediatric Clinic
- Family Link
- FamilyCORE
- Marion County Health Department
- Polk County Health Department

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