Pathways from Developmental Screening to Services:
Spotlight of Effort led by Northwest Early Learning Hub -in collaboration with the Oregon Pediatric Improvement Partnership- in Columbia, Clatsop and Tillamook Counties

Clatsop Stakeholder Meeting 1/2/18
Agenda

1. Setting the Stage- Background & Context
2. Findings from Phase 1:
   Baseline Data Collection to Understand Existing Pathways, People’s Interest in Where to Focus the Pilots of Improvement
   • Stakeholder Engagement and Interviews (Qualitative data)
   • Coordinated Care Organization Data (Quantitative Data)
   • Early Intervention Data (Quantitative Data)
3. Proposal for Phase 2:
   Based on your community-level data, OPIP’s proposal for focus of improvement pilots
   • Three pilot sites
   • Proposed pathways (referral, communication feedback loops, coordination)
   ✓ Group-Level Input and Guidance on the Proposal
   ✓ Confirmation of Focus for Improvement Pilot
4. Next Steps

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From Developmental Screening To Services: Opportunity to Connect the Fantastic Individual Silos

Health Care

Early Learning

Early Intervention

Coordinated Care Organization & Primary Care Sites
Funding to Northwest Early Learning Hub (NWELH)

• Funded by Columbia Pacific Coordinated Care Organization (CPCCO)
• 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.
• The project supports:
  – **Phase 1: Across-sector stakeholder engagement** and baseline data collection about current processes and where children are lost to follow-up;
  – **Phase 2: Implement Pilots to improve** the number of children who receive follow-up and coordination of care.

  *Key partners in implementing these pilots within each of those silos:*
  1. Primary Care Practices (CMH-Astoria)
  2. Early Intervention (NWESD – Clatsop)
  3. Early Learning (Proposal for entity today)

• NWELH included OPIP has a key partner in this project
  – Support the stakeholder engagement, Evaluation data collection and summary
  – Support the improvement pilots within primary care clinics
the perfect PLACE to begin is EXACTLY WHERE YOU ARE right now.

- Dieter F. Uchtdorf -

aYEARofFHE.blogspot.com
Phase 1: Stakeholder Engagement & Data Collection to Understand Where You Are Now, People’s Interest in Where to Focus the Pilots of Improvement

Components of Phase 1:

• Stakeholder engagement
  o Group-level meetings to gather input and guidance
  o Recruitment of parent advisors for the project
  o Individual stakeholder interviews (Qualitative data)

• Coordinated Care Organization Data (Quantitative Data)
• Early Intervention Data (Quantitative Data)
• Pilot Site: Primary Care Practice

(At Next Meeting: Quantitative Data)
# Stakeholder Engagement Across Seven Sectors in Clatsop County

Informs Community Asset Mapping – 35 Interviews

<table>
<thead>
<tr>
<th>CPCCO</th>
<th>Primary Care</th>
<th>Inter-disciplinary Teams:</th>
<th>EI &amp; Education</th>
<th>NW Early Learning Hub</th>
<th>Mental Health</th>
<th>Home Visiting &amp; Head Start/Early Head Start</th>
<th>Child Care and Parenting Supports</th>
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<td>Community Connections-Clatsop</td>
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<td>NWESD: Nancy Ford (Director of Birth to Age 5 Services)</td>
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<td>Clatsop Mental Health</td>
<td>Community Action Team (Head Start &amp; Healthy Families Home Visiting)</td>
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<td>EI/ECSE Program Clatsop County Coordinator:</td>
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*Interviewing January 2018

*Will be engaged as part of the spread efforts

**OPIP**

*Do not reproduce without proper OPIP citation*
Stakeholder Interviews

• Sharing **learnings most relevant** to inform Phase 2 – what and where to focus the improvement pilots
  – Anchors focus to existing processes relative to scope of work and pilot partners

• **Value of each perspective**
  – Community-level commitment to do the best for kids in the area and to support collaboration & communication
  – NWELH/OPIP intentionally conducted individual interviews to share at this group-level meeting to understand each person’s experience & perspective
    • There may be areas where experience and perception may not be the same across partners – that said, perception drives behavior and is integral for this project focused on IMPLEMENTATION

• Also use the interviews/data to identify **current processes and assets in your community**
Key Building Blocks of the Pathways for Developmental Screening, Referral and Follow-Up

Developmental Screening

Referral of Child Identified At-Risk

Children that don’t make it to next part of the process

Referral of Child Identified At-Risk

Referred Agency Ability to Contact Referred At-Risk Child/Family

Communication Back

Communication Back

Number of Children Evaluated and Deemed Eligible for Referred Service

Secondary Processes (Referrals and Follow-Ups) for Ineligible Children

Communication and Coordination Across Services

Communication Back

Communication Back

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

KEY STEPS

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

- Primary Practices Conducting Screening at Recommended Periodicity:
  1) CMH Pediatrics (Pilot Site)

Part 2a: Developmental Supports to Address Delays Identified By Entity Who Screened

- Developmental Promotion Activities
- Internal Behavioral Health

Part 2b: Referral to Agency to Address Delays Identified

- Developmental Behavioral Pediatrician*
  1) OHSU-CBRC
  2) Providence
- OT/PT/Speech CMH Rehab Clinic
- EI NW Regional ESD Clatsop EI/ECSE
- CaCoon/Babies First/Maternity Case Management

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

- NW Parenting
- Community Connections Network
- NW Regional Childcare Resources & Referral
- Clatsop Community Action
- Options, Inc.
- The Harbor Women’s Center
- Child Welfare, DHS

Community-Based Providers:

- 1) Home Visiting Programs
- 2) Public Health

Screening Fairs (Children 2-6)

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.

LEGEND

COLOR CODING BY SERVICE TYPE

Medical & Therapy Services:
- Developmental & Behavioral Pediatrician: Referral is for an Evaluation
- Private OT/PT & Speech Therapy

Early Intervention: Referral is for an Evaluation

CaCoon/Babies First

Home Visiting (Includes Head Start, Healthy Families/Babies First

Infant/Early Childhood Mental Health, including:
- Internal behavioral health within primary care
- Mental Health – Referral is for an assessment and identification of services:
  -- Child Psychotherapy
  -- Parent and Child Interaction Therapy

Referral to evaluation, not necessarily services

*Located outside the community
Stakeholder Interviews Findings: Developmental Screening – Current Systems and Processes

- **Some children are not getting screened because not accessing health care**
  - Numerous stakeholders reported that a number of families may have a bias against government involvement and hesitance to engage with systems, including health care.

- **Group 1: Screening in Primary Care Practices (Health Care Silo):** Varies within & between practices
  - Some practices are screening to fidelity
  - Some practices are screening, but may not be doing the **screening to fidelity** in terms of the **periodicity** and **across all providers** in the practices

- **Group 2: Community-Based Providers (Early Learning Silo):** Screening occurs with number of community-based providers (e.g. *Home Visiting, Head Start**)**
  - That said, the numbers of children able to be served by these programs does not approach the magnitude and number of kids served by PCPs, screening and assessing most vulnerable and high-risk populations
    **Head Start is for ages 3 and up, meaning it is outside the scope of the project

- **Group 3: Childcare (Early Learning Silo):** Screening happening for children over 3 in multiple sites, there may be some smaller sites screening or implementing screening for a small group of children

- **Sharing** of screening results is not standardized or routinely in place ACROSS stakeholders
**Stakeholder Interviews Findings Re: Developmental Screening – OPIP’s Perceptions About Implications for this Project**

- While developmental screening rates are at around 67.5% in this community, a significant number of young children are still not being screened
  - Referral rates and needs for services are based on current screening rates; likely **BELOW** what they will be if the standard of care provided
  - If increases in screening rates occur, the need for services will also increase
  - Children 2-3 are less likely to go in for a well-visit and therefore less likely to be screened (we will show you data on this later)

- **There are significant strengths to build off of for this project**
  - The pilot primary care site (CMH-Astoria) is screening at fidelity.
    - Since screening is occurring we can focus on follow up
      - It should be noted in the project report to CPCCO and NWELH leadership that despite the enhanced screening driven by CCO Incentive Metric, there would still be value in enhancing:
        - Access to care for insured children and
        - Developmental screening in sites not screening to fidelity
**Stakeholder Interviews Findings:**

**Referral of Children Identified At-Risk Based on Screening Tool**

**Group #1: Primary Care Sites Referral of Children Identified At-Risk on Developmental Screening**

- **Need for improved and standardized processes** (work flows & tracking) in practices which impacts who is referred and the quality of the referral
  - Value of a clear decision tree diagram based on screening tool used (ASQ most common), and other factors known about the child/family
  - Concerns about kids who flag as at-risk, but may not be at-risk (e.g. cultural, lack of exposure)
  - Lack of understanding about the parts of the EI Referral Form and why
  - Value in resources to address social determinant impacting child’s development
  - Perception that there is a lack of some resources (Parenting support, mental health)

- **Lack of educational materials** to parents of children identified at-risk. Materials also may help providers facilitate these important conversations

- **Perception that the entities they refer to are already at a capacity** and have a **long wait list**, so PCPs triage and prioritize who gets referred.

- **Barriers to referral to developmental pediatricians** located in Portland
  - Transportation and time commitment (multiple visits)
  - Wait lists for those referred to developmental pediatrician
Stakeholder Interviews Findings: Referral of Children Identified At-Risk Based on Screening Tool

Group #1: Primary Care Sites Referral of At-Risk Children Continued.

- **Perceptions about EI** and evaluation processes impact **whether and who they refer**
  - Difference between who should be referred vs. EI eligibility
  - Perception that EI is not able to provide robust enough services, refer to private if the family can afford

- **Potential under-utilization of behavioral health (Clatsop Behavioral Health)**
  - At time of interview, CMH was not referring to CBH for infant and early childhood mental health
  - Lack of awareness around capacity to serve this age group
  - Lack of awareness about optimal referral process
  - PCPs need better understanding of CBH’s eligibility protocol and intake/assessment processes

- Lack of **awareness of community-based providers** to address the specific risks identified OR **how and when** to refer to early learning providers

- Lack of **AVAILABLE resources** to address some of the risks identified
Stakeholder Interviews Findings: Referral of Children Identified At-Risk Based on Screening Tool

Group #2: Home-visiting programs, Head Start, Public Health

• Knowledge of early learning providers enhances their referral, more contact with families to help them navigate the referral
  o Seem to have better knowledge of community resources and individual relationships with other providers
  o See the children/families often and can gauge develop and support receipt of referred services
  o Leverage strategies to enhance timing of evaluation, parents calling EI directly; Multiple referrals over time

• That said, not all children identified at-risk are referred
  o Use different thresholds based on their own experience with at-risk children who are not eligible

• Potential secondary referrals for EI ineligible children
  o May be worth looking into, but EI doesn’t always have a good sense of the family risk factors

• Lack of AVAILABLE resources to address risk identified
Referral—Current Systems and Processes
OPIP’s Perceptions About Implications for this Project

• Best-match referrals of children identified at-risk should be a primary focus of the project
  o This is the first part of the pathway AND it is where some children are lost.
  o Improving workflows and processes for quality referral among primary care practices doing developmental screening was identified as key:
  ✓ WHO: Clear pathways and referrals based on risks identified including the ASQ and other family factors that may be known. This includes Medical/Therapy Services that may be covered, EI and Community-Based Providers
  ✓ WHAT: Better understanding of the different resources available
  ✓ HOW: Referral forms that support two-way communication, Parent education materials to provide at the time of referral, Standardized methods and processes to support families in the referral process

• Coordination and Communication for children referred about whether children get into referral, critical to understanding other referrals (more on this later)

• Important note to consider now: Increases in referral rates will result in an increased need for the resources to which children are referred – think about capacity now
  o Past literature has shown that 19-22% of children will be identified at-risk
Stakeholder Interviews Findings:
Ability of Referred Agency to Contact Families

• **Difficulty connecting** when the entity to which the child/family is referred tries to connect over the phone

• **General difficulty engaging some families in referrals meant to support delays, promotion tied to kindergarten readiness**
  - Numerous stakeholders reported difficulty engaging families in these referrals and noted hesitance to engage with government offices and systems.

• **Early Intervention**
  - **Ability to Contact:**
    - Ability to contact referred children (data on this later)
    - Communication when can’t contact or parent doesn’t want to come in

• **Mental Health**
  - It is difficult in general to get this age group in
  - Especially difficult when stigma is at play, or if the family has had a previous experience that may influence their decision to go to the referral

• **Home Visiting Programs:**
  - Ability to contact referred children/families can be a barrier
  - Coordination with referring entity depends and varies
Stakeholder Interviews Findings: 
Getting to Referrals and Eligibility Considerations

This is a key area where the data will show children drop off

- Early Intervention
  - Getting to referrals
    - Transportation is a consistent barrier
    - While home evaluations can be offered, they present other challenges
    - Given the level of services, lack of parental engagement given the effort and time needed on their part to get to the evaluation
  - Eligibility, Services Provided
    - EI Eligibility criteria not widely known, and misconceptions may exist within PCPs
      - Screening vs. eligibility / Medical vs. Education Attainment
    - Perceptions about restrictive eligibility criteria in general
    - Perceptions about the lack of robustness of services given funding available
- Mental Health
  - Same general barriers exist (transportation etc.)
  - Referral is actually to an assessment to determine eligibility (as per Medicaid standards)
  - A warmer handoff would be helpful
- Home Visiting Programs:
  - Currently have some capacity, but not limitless. Eligibility has not been a big issue with referrals to date
  - That said, there aren’t many referrals from primary care for some programs
Referred Agency Ability to Contact and Eligibility Considerations

OPIP Perceptions of Implications for Pathways

• Important to improve provider understanding of EI referral and eligibility processes
• Important component of the Medical Decision Tree is processes and methods for coordination when the family can’t be contacted or denies evaluation
  o Communication about lack of contact or family refusal
  o Partnership-centered methods for primary referral agency reaching out
  o Models to leverage established relationships- primary care provider, home visitor etc.
• Value of tracking and evaluation data to inform how many children are lost and community resource capacity included in this project
  o PCP tracking of referral and follow-up to referral
  o Early Intervention: Tracking of who referred, proportion able to be contacted, and of those contacted how many are eligible
  o Pilot Early Learning Provider referral and ability to contact
    o If mental health chosen, explore pilots of more family-centered methods of engagement to enhance uptake
Stakeholder Interviews Findings:
Secondary Referral and Follow-Up & Coordination/Communication

• Early Intervention
  o Secondary Referral for Ineligible Children
    ✓ Provide a packet with preschool/ head start resources and developmental promotion materials, but not currently a standardized process for referral.
    ✓ Connect families to CBH when concern is known
    ✓ Need more specific information about resources available for the risk identified
    ✓ If secondary referral addressed, need educational information for parents to explain the processes
    ✓ Value of PCP engagement and support in helping the family
  o Coordination/Communication
    ✓ Currently send information back to referring provider when requested and have correct contact information, but not sure they are sending what providers actually want (there is wide confusion about what the feedback options are on the universal referral form)
    ✓ Opportunity for improved coordination/communication with primary care, both eager to pilot

• Community-Based Providers:
  o Value of more specific information about resources available, based on risk identified
  o Community Connections Network may be a secondary option to explore
Stakeholder Interviews Findings:  
Secondary Referral and Follow-Up Care Coordination  

OPIP Perception of Implications for Pathways Related to Referral and Follow-Up

Overall:

- No clear standardized processes and models used – depends on risk and knowledge of systems
- Stakeholders noted *value of enhanced communication and feedback loops* between each other
- Stakeholders noted value of *community asset mapping specific to ASQ domain & other known factors*

- **PCP - Secondary Referral and Follow-Up**
  - Could use *better and more specific information about EI services child is receiving* in order to identify supplemental services that they could refer to
  - Need *better knowledge and awareness of secondary follow-up services* available for the child and WHAT can be covered
  - Many of the *services available are for children experiencing poverty*, which is only a part of the population the practice serves
  - *Timely and meaningful communication and coordination* a primary hope for this project
Using Data to Inform Our Discussions and Proposed Priority Areas to Focus Our Community-Based QI Project:
Examining Quantitative Data to Understand
The Pathway of Screening to Services for Young

• Population of Focus for the Project: Children 0-3 identified on developmental screening tools as at-risk for developmental, behavioral or social delays

Data

• Data Available That will be Examined

  1. **Census Data** – How many children 0-3
  2. **Columbia Pacific Coordinated Care Organization (CPCCO) Data for Publicly Insured (Funder)**
     • Children covered, Continuously enrolled
     • Children who have a visit
     • Children who receive a developmental screening, according to claims submitted
  3. **Primary Care Practice Data (Next Meeting): Pilot Site**
     • Children practice identifies as their patient; Of those, number seen
     • Children who received a developmental screening
     • Children identified at-risk on developmental screen
     • Children identified at-risk who received follow-up
  4. **Early Intervention: According to Bright Futures Data, A Referral for All Children Identified At-Risk (A Pilot Site)**
     • Referrals
     • Referred children able to be evaluated
     • Of those evaluated, eligibility
  5. **Early learning providers (Tracking data will be collected for pilot sites to evaluate pilot)**
Children 0-3 in Clatsop County

2016 Census Data **under 3 years:**

- Children 0-3: Clatsop: 1250
- N=828 Children Covered by CPCCO in Clatsop
  - Proportion of children 0-3 Publicly Insured: 66%
- N= 452 Children Who Had Turned 1, 2 and 3 Who were Continuously Enrolled for 12 months (Denominator for Accountability Measures)

*Sources: ACS and OHA birth records, Census estimate is for a 5-year average 2012-16*
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Publicly Insured Children Under Three Years Old: Number Continuously Enrolled; Proportion Who Received a Well Visit & Developmental Screen

- **Continuously Enrolled Children**
  - FY 15-16 (7/1/15-6/30/16): 496
  - FY 16-17 (7/1/16-6/30/17): 452

- **Well Visits**
  - FY 15-16 (7/1/15-6/30/16): 366 (74%)
  - FY 16-17 (7/1/16-6/30/17): 338 (75%)

- **Developmental Screens (96110 Claim)**
  - FY 15-16 (7/1/15-6/30/16): 346 (70%)
  - FY 16-17 (7/1/16-6/30/17): 305 (67%)

*Data Source: Provided by CPCCO for Publicly Insured Children, October 2017*

*Do not reproduce without proper OPPI citation*
Proportion of Continuously Enrolled, Publicly Insured Children Who had a Well-Visit and Developmental Screen in the Last Year

Data Source: Provided by CPCCO, October 2017 – FY16-17 ONLY

Do not reproduce without proper OPIP citation
Developmental Screening Rate for **Clatsop County** and the **Tri-County CPCCO Regions (Clatsop, Columbia, Tillamook)**

- **Clatsop County**
  - **FY 15-16** (7/1/15-6/30/16): 69.7% (N=346)
  - **FY 16-17** (7/1/16-6/30/17): 67.5% (N=305)

- **Tri-County**
  - **FY 15-16** (7/1/15-6/30/16): 53.6% (N=689)
  - **FY 16-17** (7/1/16-6/30/17): 61.0% (N=749)

Data Source: Provided by CPCCO, October 2017

*Do not reproduce without proper OPiP citation*
Developmental Screening Rate for Clatsop County and the Overall CPCCO Region for **NON-Continuously** Enrolled Children

**Important Note:** N=451 Children Under 3 Screened in One Year

- **Clatsop County**
  - FY 15-16: 56.5% (N=490)
  - FY 16-17: 54.5% (N=451)

- **Tri-County**
  - FY 15-16: 42.0% (N=1014)
  - FY 16-17: 48.6% (N=1134)

Data Source: Provided by CPCCO, October 2017. Developmental Screens according to 96110 Claims.
Developmental Screening Rates by Age of Child

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<tr>
<th>Age of Child</th>
<th>Percentage of Developmental Screens</th>
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<tr>
<td>Turned 1yr</td>
<td>77.2% (N=122)</td>
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<tr>
<td>Turned 2yrs</td>
<td>66.3% (N=108)</td>
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<tr>
<td>Turned 3yrs</td>
<td>57.3% (N=75)</td>
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Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

Do not reproduce without proper OPIP citation
Developmental Screening Rates by Race/Ethnicity – CONTINUOUSLY ENROLLED CHILDREN

Data Source: Provided by CPCCO, October 2017

Do not reproduce without proper OPIP citation
Annual Number of Developmental Screens Conducted in CPCCO Clinics in Columbia, Clatsop & Tillamook Counties

Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY

Do not reproduce without proper OPIP citation
Number of Continuously Insured Children Assigned to Clinic vs. Clinic’s Developmental Screening Rate

Data Source: Provided by CPCCO, October 2017- FY 16-17 ONLY

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Examining Quantitative Data to Understand
The Pathway of Screening to Services for Young

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Primary Care Practice Data to be Collected in Pilot Primary Care Site

• Primary Care Provider Data to be Collected
  – Screening (Claims, Documentation in EMR)
  – Proportion of children identified at-risk (Documentation in EMR on domain-level scores)
  – Follow-up steps (Documentation in the EMR)

Highlight of Findings from Practice-Level Collected In Other Counties: Note, In order to be a Pilot Site Had to be Doing Screening to Fidelity

• Majority of children who come in were screened
  – Children who do not come in, not screened
  – Most likely for children 2-3 years old

• Across three practices, 19-28% of developmental screens conducted in the first three years of life identified a child at-risk for delays. (19.9, 21%, 28%).
  – Past study was 21%

• However, for those children identified at-risk for delays, referrals to EI ranged from 20-35%
  – Meaning 65-80% of children identified at-risk not referred to Early Intervention
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5. Early learning providers (Tracking data will be collected for pilot sites to evaluate pilot)
Value of Data from NWRESD on Early Intervention to Inform This Pilot

#1: Indication of Follow-Up to Developmental Screening
• Bright Futures (BF) recommends that all young children identified at-risk for developmental, behavioral and social delays on a developmental screening tool (aka the focus of this project) should be referred to Early Intervention at a minimum
  o EI referrals & children served by EI is an indication of referral and follow-up
    ▪ If increases in developmental screening and follow-up are occurring, then an indication of this would be:
      ✓ Increase in referrals and/or
      ✓ Increase in referred children found eligible (indication of better of referrals)
  o Acknowledgement of issues with the BF Recommendation, given realities of administration in primary care practice AND Oregon’s EI eligibility criterion
    ▪ Value of descriptive data about kids that fail the ASQ that are then found ineligible for EI

#2: Data to Inform Processes for At-Risk Children, But EI Ineligible
• A proportion of at-risk children referred to EI, will be found ineligible
  – The goal for this project is to ensure that at-risk children receive follow-up
  – Therefore, a focus of this project is secondary referrals of EI ineligible children
    • Value of descriptive information about these ineligible in order to inform secondary and follow-up services
#1: Indication of Follow-Up to Developmental Screening

- Numbers of Referrals
- Number of Referrals Able to be Contacted AND Evaluated
- Outcome of referrals (Eligible, Ineligible)

#2: Data to Inform Processes for At-Risk, But EI Ineligible Children

- Evaluation Outcome Results by Referral and Child Characteristics
Number of Early Intervention Referrals in Clatsop & NWRESD Tri-County Region (Tillamook, Clatsop and Columbia)

<table>
<thead>
<tr>
<th>SY 15-16 (7/1/15-6/30/16)</th>
<th>SY 16-17 (7/1/16-6/30/17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clatsop Referrals</td>
<td>Tri-County Referrals</td>
</tr>
<tr>
<td>281</td>
<td>336 (+16%)</td>
</tr>
<tr>
<td>112</td>
<td>144 (+22%)</td>
</tr>
</tbody>
</table>

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017
Number of Early Intervention Referrals in Clatsop VS. Number of CHILDREN Referred in Clatsop

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation
Clatsop Early Intervention (EI) Referrals by Age of Child

**Data Source:** Provided by NWRESD from Data Available in ECWeb, October 2017

<table>
<thead>
<tr>
<th>Age</th>
<th>SY 15-16 (7/1/15-6/30/16)</th>
<th>Total N=112</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 0-1yr</td>
<td>38% (N=43)</td>
<td></td>
</tr>
<tr>
<td>Ages 1-2yrs</td>
<td>26% (N=29)</td>
<td></td>
</tr>
<tr>
<td>Ages 2-3yrs</td>
<td>36% (N=40)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>SY 16-17 (7/1/16-6/30/17)</th>
<th>Total N=144</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 0-1yr</td>
<td>25% (N=36)</td>
<td></td>
</tr>
<tr>
<td>Ages 1-2yrs</td>
<td>35% (N=51)</td>
<td></td>
</tr>
<tr>
<td>Ages 2-3yrs</td>
<td>40% (N=57)</td>
<td></td>
</tr>
</tbody>
</table>

*Do not reproduce without proper OPIP citation*
Clatsop EI Referrals by Referral Source
As Documented in EC Web

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation
Clatsop EI Physician Referrals by Specific Clinics – Both School Years Combined

- 66% (N=88) for Columbia Memorial Hospital
- 19% (N=25) for OHSU
- 15% (N=21) for Other Provider
- 3% for each of the following: Providence, The Children’s Clinic, Coastal Family Health, Unknown

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation
Clatsop EI Referrals by Whether Child Has Medicaid

<table>
<thead>
<tr>
<th></th>
<th>SY 15-16 (7/1/15-6/30/16)</th>
<th>SY 16-17 (7/1/16-6/30/17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>51% (N=57)</td>
<td>38% (N=55)</td>
</tr>
<tr>
<td>Not Medicaid</td>
<td>49% (N=55)</td>
<td>62% (N=89)</td>
</tr>
</tbody>
</table>

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation
Data from NWRESD on Early Intervention Referral and Evaluation Outcomes to Be Shared Today

#1: Indication of Follow-Up to Developmental Screening

- Child find rates
- Numbers of Referrals
  - Number of Referrals Able to be Contacted AND Evaluated
- Outcome of referrals (Eligible, Ineligible)

#2: Data to Inform Processes for At-Risk, But EI Ineligible Children

- Evaluation Outcome Results by Referral and Child Characteristics
Percentage of Clatsop EI Referrals Able to Be Evaluated by EI

<table>
<thead>
<tr>
<th>Year</th>
<th>Evaluated</th>
<th>Not Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>SY 15-16</td>
<td>63% (N=71)</td>
<td>37% (N=41)</td>
</tr>
<tr>
<td>SY 16-17</td>
<td>77% (N=111)</td>
<td>23% (N=33)</td>
</tr>
</tbody>
</table>

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017

Do not reproduce without proper OPIP citation
Clatsop EI Evaluations BY Medicaid Insurance

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017  Data is from SY 16

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Data from NWRESD on Early Intervention Referral and Evaluation Outcomes to Be Shared Today

#1: Indication of Follow-Up to Developmental Screening

- Child find rates
- Numbers of Referrals
- Number of Referrals Able to be Contacted AND Evaluated
  - Outcome of referrals (Eligible, Ineligible)

#2: Data to Inform Processes for At-Risk, But EI Ineligible Children

- Evaluation Outcome Results and Characteristics of Ineligible
Examined by Age of Child, Referral Source, Medicaid Insured

• Examined referrals by:
  o Age of Child: Birth to 1, 1-2, 2-3
  o Referral Source
  o Race-ethnicity
  o Medicaid Insured

• Due to time constraints today, we don’t have time to review all findings but they have been used to inform our recommendations
Number of Children Found Eligible in **Clatsop**

**Percent Improvement from 2016 vs. 2017:** **18%** *(N=12)*

**Data Source:** Provided by NWRESD from Data Available in ECWeb, October 2017

*Do not reproduce without proper OPiP citation*
Percentage of Clatsop EI Referrals Able to Be Evaluated & Eligible for EI

**Data Source:** Provided by NWRESD from Data Available in ECWeb, October 2017

- **SY 15-16 (7/1/15-6/30/16)**
  - Total N=112
  - Evaluated & Eligible: 76% (N=54)
  - Evaluated & Did Not Qualify: 48% (N=54)
  - Not Evaluated: 37% (N=41)

- **SY 16-17 (7/1/16-6/30/17)**
  - Total N=144
  - Evaluated & Eligible: 59% (N=66)
  - Evaluated & Did Not Qualify: 31% (N=45)
  - Not Evaluated: 23% (N=33)

76% of those evaluated were eligible. 59% of those evaluated were eligible.
Clatsop EI Referral Outcomes by Medicaid Eligibility

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Total N=55</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluated &amp; Eligible</td>
<td>82% (N=45)</td>
</tr>
<tr>
<td>Evaluated &amp; Did Not Qualify</td>
<td>14% (N=8)</td>
</tr>
<tr>
<td>Not Evaluated</td>
<td>4% (N=2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not Medicaid</th>
<th>Total N=89</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluated &amp; Eligible</td>
<td>33% (N=28)</td>
</tr>
<tr>
<td>Evaluated &amp; Did Not Qualify</td>
<td>28% (N=25)</td>
</tr>
<tr>
<td>Not Evaluated</td>
<td>48% (N=43)</td>
</tr>
</tbody>
</table>

96% of those evaluated were eligible

Total: 17% (N=10)

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017 Data is from SY 16

Do not reproduce without proper OPIP citation
Clatsop EI Referral Outcomes by Age of Child

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total N</th>
<th>Evaluated &amp; Eligible</th>
<th>Evaluated &amp; Did Not Qualify</th>
<th>Not Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 0-1yr</td>
<td>36</td>
<td>28% (N=10)</td>
<td>36% (N=13)</td>
<td>43% of those evaluated were eligible</td>
</tr>
<tr>
<td>Ages 1-2yrs</td>
<td>51</td>
<td>43% (N=22)</td>
<td>55% (N=18)</td>
<td>71% of those evaluated were eligible</td>
</tr>
<tr>
<td>Ages 2-3yrs</td>
<td>57</td>
<td>60% (N=34)</td>
<td>16% (N=9)</td>
<td>24% (N=14)</td>
</tr>
</tbody>
</table>

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017  Data is from SY 16

Do not reproduce without proper OPIP citation
2017 Outcomes of Evaluation for Clatsop By: Top Referral Sources

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017  Data is from SY 16

Do not reproduce without proper OPIP citation
2017 Outcomes of Evaluations in Clatsop for Proposed PCP Pilot Site

Data Source: Provided by NWRESD from Data Available in ECWeb, October 2017. Data is from SY 16

- 23% (N=12) Not Evaluated
- 58% (N=30) Evaluated & Did Not Qualify
- 35% (N=18) Evaluated & Eligible
- 42% (N=22) Not Evaluated

Total N=52

Do not reproduce without proper OPIP citation
The Punchline for This Project Focused on **Follow-Up** to Developmental Screening that is the Best Match for the Child & Family

A majority of the population of young children are publicly insured

– That said, the practice who sees the most publicly insured children also sees a large number of privately insured patients & are screening

For publicly insured children:

– If they maintain their enrollment and access well-child care, most receive developmental screening (Population of focus for this project)

Within primary care:

• Value in **feasible, family-centered promotion for all at-risk children**, and **referral and follow-up methods** that take into account family and child risk factors and identify best match resources available in the community

For children referred to EI

– Strategies to enhance outreach to families have increased referrals able to be evaluated (3 in 4)

  • Rates lower for referrals from physicians
  • Still 1 in 4 referrals not able to be evaluated

– Of referrals able to be evaluated, 59% eligible for services

  • Eligibility rates lower for children referred from physicians
Phase 2: Improvement Pilots

• Sites that will **pilot the improved processes (as defined by CPCCO project)** are:

  1. **One primary care practice** serving a large number of publicly insured children residing in this county: **CMH Astoria**
  2. **Early Intervention** – Northwest Regional Education Service District
  3. Priority **Early Learning Provider** identified as a priority pathway in the community for this specific population (0-3 identified at-risk on screening tool)

• Sites will receive **improvement and transformation tools**, monthly **implementation support**, and refinements to the improvement tools will be made based on lessons learned and barriers identified

  OPIP → Primary Care & Referrals from Primary Care
  NWELH → EI and Early Learning

• At the end toolkits will be developed to spread to other stakeholders (**e.g. other primary care practices in the region**)

**NOTE: We know there are other pathways stakeholders wish existed. A Focus of the project is to quantify and describe needs to the funder (CPCCO) and NWELH Leadership as part of project reports.**
Proposal for Focus in Clatsop County

**Pilot Primary Care Site (CMH-Astoria)**
- Enhance provision of developmental promotion for children that families can do at home
- Enhance referrals for best match services
- Provide coordination of care and support in accessing services

**Early Intervention (NWESD-Clatsop)**
- Enhanced communication and coordination for children referred
- For Ineligible Children: Communication Back to PCP to Inform Secondary Steps; If Applicable, Referral to Early Learning supports, Pilots of referral to CBH.

**Early Learning**
- Proposed Early Learning Provider: CBH – Infant and Early Childhood Mental Health
- Pilot new ways, in collaboration with PCP practice and early learning providers (for whom children paneled to CMH-Astoria), to engage and connect families with mental health
Proposal for Focus in Clatsop County

Pilot Primary Care Site (CMH-Astoria)
1) Enhanced developmental promotion for all at-risk children
2) Enhanced follow-up to developmental screening supported by:
   a) Development of a follow-up medical decision tree, including secondary follow-up, anchored to: i) ASQ scores, ii) Child and family factors, iii) Resources within the community
   b) Parent education sheet to support shared decision making, care coordination support strategies
   c) CPCCO summary of follow-up services and providers who see children 0-3
   d) Pilot new methods for connection to mental health

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

Early Learning
Proposed Early Learning Provider: CBH – Infant and Early Childhood Mental Health
• Pilot new ways, in collaboration with PCP practice and early learning providers (for whom children paneled to CMH-Astoria), to engage and connect families with mental health
Improvement Pilot: Breadth and Depth, Components of a Pathway

**Breadth Strategies:**
- Strategies that engage the most number of children that engage with primary care practices
- General communication about value of developmental promotion
- General communication about building blocks of kindergarten readiness
- General communication about what it means to be identified at-risk on the ASQ (Parent education sheet)

**Depth Strategies:**
- Ensuring follow-up for children identified at-risk and vulnerable
- EI Ineligible
- Children whose development impacted by trauma in the home or lack of attachment

**Component of Pathways:**
- Standardized referral
  - Who
  - How (Referral Form )
- Two-Way Communication and Feedback Loops for All Referral: Whether able to contact, whether able to serve child, general outline of services
Follow-Up Decision Tree for Primary Care Practices Will Map Best-Match Set of Services for Children and Families to These Services In Your Community

Part 2b: Referral to Agency to Address Delays Identified
- Developmental Behavioral Pediatrician*
  - 1) OHSU-CDRC
  - 2) Providence
- OT/PT/Speech CMH Rehab Clinic
- EI NW Regional ESD Clatsop EI/ECSE
- CaCoon/ Babies First/ Maternity Case Management
- Head Start Potentially CAT Inc.
- Healthy Families Community Action Team (CAT) Inc.
- Child/Parent Psychotherapy Clatsop Behavioral Health (CBH)

Part 3: Additional Family Supports that Address Child Development and Promotion
- NW Parenting
- Community Connections Network
- NW Regional Childcare Resources & Referral
- Clatsop Community Action
- Options, Inc.
- The Harbor Women's Center
- Child Welfare, DHS

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Proposed Early Learning Provider Pathway in Clatsop County

Proposal is to Enhance Pathways to Infant and Early Childhood Mental Health in CBH:

- Addresses an important high-risk population that would be identified on developmental screening and not address fully in current pathways
- Have capacity and expertise for the 0-3 population specifically
- Community noted significant barriers and past poor experiences with connection to services

Pilot would include

- Patients Centered Methods for Engagement and Referral to CBH from Pilot Primary Care Practice to CBH (Includes secondary referrals for CMH-Astoria Patients in EI):
  - Referral processes- pilot an improved referral and warm hand off process between PCP and CBH, including potential models of warm handoffs at the site
  - Referral processes- pilot an improved referral and warm hand off process between EI and CBH
  - Communication/coordination with referring entity- models for two way communication

- Implementation Support
  - Meetings with PCP, CBH and EI to confirm scope and opportunities for pilot
  - Development of engagement, referral and work flow processes, Parent input and insight
  - Data collection to assess impact of the pilot
Enhanced Pathways for Children Referred by Primary Care to Early Intervention and Engagement in Mental Health
Parent Partner

- Introduction
- Experience with navigating these processes
- Reaction to proposed pilots
Community-Level Input on the Proposed Pilot

• Primary Care Pilot
  – Any input on the current proposed tools or strategies?
  – Any barriers we should make sure to address?

• Early Intervention Pilot
  – Any input on the current proposed tools or strategies?
  – Any barriers we should make sure to address?

• Early Learning
  – Input on the proposed pilot to CBH?
    • What do you hope is addressed?
    • What barriers should we prepare to proactively address?
Early Learning Provider Pathways
Not Proposed But Valuable to Note for the Future

Additional Potential Priority Pathway Pilot (Depends on funding)-
Parenting Boot Camps
• Potential collaboration between NW Parenting and CMH
• Would potentially include monthly boot camp parenting classes for expecting parents and for parents of children identified on screening tools who may benefit.

Pilot could include:
• **Referral to/ connection to classes:** Improve workflows for connecting families to these classes
• If build and available during project, pathways to parenting supports

_Outside the scope of the project, but important to note:_
  1. Ways PCP, EI, CBH, and Home Visiting can better collaborate in identifying and serving families that may cross numerous systems in order to identify best match services
Slides Providing An Overview of Examples of Supports That Will be Provided:
We Will Prioritize Group Discussion Over Reviewing these Details
Support to Primary Care Pilot

- OPIP will develop new tools to enhance promotion and follow-up for all children identified at risk:
  - Improved developmental promotion activities at the time of the visit,
  - Education tools about concept of “kinder readiness”
  - **Referral/Getting to Referral**- Improve workflows and processes for referral, including:
    - Develop a medical decision tree anchored to score and child and family risk factors and mapped to resources in the community
    - **Develop Parent education materials** to provide at the time of referral
    - Standardized methods and processes to support families in the referral process, Care Coordination
    - Develop standardized processes related to secondary referral and follow-up steps

- **OPIP Implementation Support**
  - Improvement and implementation site visits
  - Provider and staff trainings
  - Communication and coordination with early learning providers in the community to identify success and barriers and problem solve
  - Data collection and evaluation to assess impact of the improvement efforts
Determining the “Best Match” Follow Up for the Child and Family Which Included Promotion FIRST and Then, Where Applicable, Referral

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

2. Other Factors Considered as Part of Pilot
   • Child Medical Factors
   • Adverse Childhood Events
   • Family Risk Factors
   • Family Factors
   • Family Income
   • County of Residence

No Referral - Rest

Early Intervention

DB PEDS

Mental Health

CaCoon/Babies First
Centralized Home Visiting
Parenting Classes
Example of Medical Decision Tree from Past Projects
Family Supports in Navigating Referrals

Informed by parent advisors, developed tools and practice-level work flow processes to better support families

- **Education sheet** for parent and to support shared decision making
- **Phone follow-up** for children referred
- **Communication back from Early Intervention** when child can’t be contacted, Care Coordination support from practice to reach out to the family
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.

1) Sheet for parents to explain referrals to support shared decision making between primary care provider and parent

2) Phone follow-up within two days

For children referred, better parent support and shared decision making

Early Intervention (EI)
EI helps babies and toddlers with their development. In your area, Wilmette Education Service District (WESD) 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:
- WESD will call you to set up an appointment for your 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 (303) 385-3714.
- The results from their assessment will be used to determine whether or not EI can provide services for your child.
Contact Information:
Tonya Colar, EI Program Coordinator,
503-365-4366 | www.ode.state.or.us

Parenting Support
Classes located in Marion County
Springfield, Oregon
(503) 967-2384
earlylearning.org
Classes located in Polk County
(503) 628-6362
midvalleyparenting.org

Medical/Therapy Services
Your child’s health care provider referred you to the following:
- Speech Language Pathologists
- Audiologists
- Occupational Therapists
- Physical Therapists
- Developmental Behavioral Pediatricians
- Child Behavioral Health Specialists

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. CaCoon nurses will check 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 Drake, Program Supervisor
(503) 967-1919
cacoon.uoregon.edu

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 with local services.
Contact: Erin Giavasis,
503-999-7431 ex.122
familylink@familybuildingblocks.org

Parenting Support

Care
Design and distributed by Oregon Pediatric Improvement Partnership, Version 20.10.1

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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 Le 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).
Early Intervention Support from NWELH and OPIP

• General Quality Improvement
  o Support in sharing and use of EI data for tracking, and community level conversations (This Meeting), Quarterly tracking to assess impact of the project
  o EI Participation in development of updated medical decision tree for providers
  o EI Participation in Tri-County EI QI calls around improvements in data collection and processes/workflows (shared learning from work on this project): NWELH and OPIP Participation

• Referral/Getting to Referral- Improve workflows, including:
  o Communication about whether children get into referral, and follow up steps depending on the result

• Communication/Coordination- Improve/pilot workflows and tools around evaluation results, eligibility, and services provided
  o Pilot communication workflows and tools to improve communication/coordination with primary care

• Secondary Referral- Improve/pilot workflows, tools, and processes focused on secondary steps for children that are found to be ineligible for EI services
  o Pilot enhanced processes and follow up steps for children found to be ineligible for EI services, particularly to CBH.
Proposed Early Learning Provider Pathway in Clatsop County

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- Would potentially include monthly boot camp parenting classes for expecting parents and for parents of children identified on screening tools who may benefit.

Pilot could include:

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*Outside the scope of the project, but important to note:*

  - Ways PCP, EI, CBH, and Home Visiting can better collaborate in identifying and serving families that may cross numerous systems in order to identify best match services

  Sites will receive improvement and transformation tools, monthly implementation support, and refinements to the improvement tools will be made based on lessons learned and barriers identified
Next Steps

• Follow-up to questions or needs for additional information raised today

• Focus on the priority pathways discussed today, incorporating refinements noted in our discuss
  – Primary Care Data Collection and Analysis
  – Primary Care Pilot site improvement efforts
  – EI improvement efforts
  – CBH Pilot

• Next Stakeholder Meeting- May 1st, 2018
Quarterly Clatsop County Stakeholder Meetings: Getting Your Insight and Input on Timing

- **May 1, 2018**
  - Review draft pilot tools and strategies, get you input and insight for modifications and improvements
  - Elements of proposed pilot with CBH
- **Fall 2018**
  - Update from the pilot, key learnings and implications for future spread, system-level issues and discussions
  - Obtain input and guidance on barriers and how to address
- **Late Spring 2019**
  - Update from pilot
  - Review of draft tools for Spread, Obtain Input and Guidance to Ensure Useful and Meaningful for the Community
  - Identify key learnings and implications for future spread, system-level issues and discussions
Questions? Want to Provide Input? You Are Key to the Success of This Work

• Door is always open!
• NWELH Lead
  – Dorothy Spence: dspence@nwresd.k12.or.us
  – 503-614-1682 (office)
  – 410-227-8090 (cell)
• OPIP Contract Lead
  – Colleen Reuland: reulandc@ohsu.edu
  – 503-494-0456