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

Clatsop Stakeholder Meeting 5/1/18
Agenda

1. Project Overview Refresher
2. Update on Improvement Pilots Within Priority Pathways
   a) Primary Care- CMH Astoria, Pediatrics Office
      • Baseline data collection completed
      • QI improvement: Training on medical decision tree, parent supports, and deep dive on specific referrals pathways
      • Facilitated Discussion:
         1. Review Tools Created
         2. Pilot of “Early Learning Resource Connection”
   b) Early Intervention
      • Update on quality improvement activities focused on new referral form, communication feedback loops
   c) Clatsop Behavioral Health (CBH)
      • Facilitated Discussion: Deep dive- GOBHI RFA
3. Next Steps
Pathways from Developmental Screening to Services for Young Children Identified At-Risk

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

• Two-year project – August 2017-July 2019

• Aim: To improve the receipt of services for young children who are identified at-risk for developmental and behavioral delays.

• The project supports:

  – **Phase 1:** Across-sector stakeholder engagement and baseline data collection about current processes and where children are lost to follow-up (Complete)

  – **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. Within Clatsop, you picked Mental Health (Clatsop Behavioral Health)
Aim of the Improvement Pilots is to Increase the Proportion of At-Risk Children that Receive Best-Match Follow-Up

• Sites piloting the improved processes are:
  1. One primary care practice: CMH Astoria-Pediatrics Office, including their internal behavioral health staff
  2. Early Intervention – Northwest Regional Education Service District
  3. External Specialty Infant and Early Childhood Mental Health: Clatsop Behavioral Health

• Each site receiving improvement and transformation tools, monthly implementation support, and refinements to the improvement tools will be made based on lessons learned and barriers identified
Focus in Clatsop County

Pilot Primary Care Site (CMH-Astoria, Pediatric Office)
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 leveraging internal behavioral health & 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
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.
• Pilot ways EI could children for infant and early child hood mental health
Context on Primary Care Pilot Site

• Pediatric Office within the Multi-Specialty Site
  – N=5 Providers at time of baseline chart review, Currently have N=4 providers and they are recruiting for a 5th.
  – Currently have internal behavioral health to support pediatrics, supported by CPCCO
  – Provide approximately 1500 well visits with ASQs administered for children in priority age focus for project (6 months- 35.99 months), Approximately 64% insured by Medicaid
• Electronic Medical Record (EMR)
  – Cerner Community Works
• Developmental Screening Processes
  – Screen at Well-Visits
    • Before 1: 2, 4, 6 and 9 month well-visit
      – For comparability with other pilot sites, our data starts at 6 months
    • Before 2: 12 and 18 month well visit
    • Before 3: 24 months well-visit and 30 month well-visit
      (Also screen at 36 month well visit - outside scope of data)
  – Only Offer 30 month visit to Medicaid patients
Key Areas of Focus to Support Primary Care Pilot to Improve Follow-Up

- Baseline Data Collection on Current Levels of Follow-Up, Quarterly tracking throughout rest of project

OPIP Development of Tools to Support Enhanced Follow-Up Aligned with Resources in the Community:

- Medical Decision Tree
- Parent Education/Shared Decision Making Tool
- Phone Follow-Up Script
- CPCCO Summary of Services

OPIP Implementation Support of Tools with CMH Astoria QI team

- Baseline workflow assessment in site
- Monthly site visit by OPIP Practice
- Training on tools
- Identification of barriers
Designing the Baseline Data Collection in CMH-Astoria

- No searchable data to validly get at:
  - Numerator: Children identified at-risk that received follow-up
  - Denominator: Children identified at-risk on ASQ
- Information is within chart note
- Required manual chart review
- However, it was not feasible to do manual chart reviews on ALL charts given they conduct approximately N=1500 ASQs annually for young children
  - Panel of Children Under 3: N=1383
    - Children Who had a Well-Visit in Last Year: N=780
    - Approximately 64% children with Medicaid
  - Developmental Screens for Children Under 3
    - Number of Screens Completed in last year: N=1493
- Therefore, we had to come up with a feasible sampling strategy and CMH-Astoria invested internal resources
Designing the Baseline Data Collection in CMH-Astoria

**Goal:** To collect standardized, representative baseline data on follow-up to screens implemented at well-visits that identify a child at-risk between 6 months-35.99 months. Baseline Time Period: 7/1/16- 6/30/17

**Descriptive Data Collected to Inform Options for Sampling and Chart Review:**

1. **Well-Visits & Developmental Screening for Children Under 3:** Well Visit Claims: CPT: 99381, 99382, 99391, 99392 and Dev. Screen Claim (CPT: 96110)

2. **Population:**

<table>
<thead>
<tr>
<th>Well Visits: Children 6-35.99 Months:</th>
<th>Of this group: Well Visits with 96110 Claim: N=1395 (93%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=1493</td>
<td>Number of Well-Visits by Provider:</td>
</tr>
<tr>
<td></td>
<td>Caldwell: N=229; Ramchander: N=521;</td>
</tr>
<tr>
<td></td>
<td>Martin: N=590; McCall: N=96; McPherson: N=57</td>
</tr>
</tbody>
</table>

**Standardized Factors to Consider:**
1) Randomized across year given seasonal variations; 2) Normal Distribution Across Providers Given Likely Provider-level Variation; 3) Enough sample of charts reviewed that have children screened (some well-visits won’t have it) and, of those screened, identified at-risk (Usually 20% of screens); 4) Feasibility of the number of charts to review

3. **Sample of the Population To Review Medical Charts:**

<table>
<thead>
<tr>
<th>Sample of Visits in 1st Five Days of the Month Over the Course of the Year, N=321 Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caldwell: N=40</td>
</tr>
<tr>
<td>Ramchander: N=113</td>
</tr>
<tr>
<td>Martin: N=135</td>
</tr>
<tr>
<td>McCall: N=27*</td>
</tr>
<tr>
<td>McPherson: N=6</td>
</tr>
</tbody>
</table>

4. **Medical Chart Review.**

**Detailed charts reviewed for children identified at-risk.**

- Chart Review for Components of Care Not in Searchable Fields in the EMR: OPIP will create a standardized data entry form to enter results from the chart review that will allow for documentation of the following:
  1) Whether Screen Identifies the Child At Risk (ASQ Domain Level Scores -> One or more in Black and/or 2 or more in the Grey;
  2) ONLY for those screens that identify the child at risk, specific follow-up:
     - Provision of Targeted Developmental Promotion Specific to the Domain of Risk Identified, Specifically the ASQ Learning Activities
     - Referral for Follow-Up Services: Early Intervention, Occupational Therapy/Physical Therapy, Speech Therapy, Developmental Behavioral Pediatrician, Referrals to CaCoen/Babies First/Home Visiting, Referral to External Mental Health
CMH Astoria Baseline Data: Punchline

• Lower rates of children identified at-risk than OPIP has ever seen in collecting this data
  • Examining potential reasons and potential reasons related to sampling
  • CMH collecting data for ALL screens identified at risk as part of “follow-up data collection”. We will examine data for all those screens once 3 full months of data collected

• Findings from Small Sample Related to Follow-Up:
  o Great strengths in referrals to EI, OT/PT and Speech
  o Opportunity enhance and build of these strengths for the pilot to focus on referrals:
    ✓ Developmental promotion across all providers
    ✓ Secondary referrals for children NOT eligible for EI
    ✓ Referral to Developmental Behavioral Pediatrician (Bright Futures Recommendation)
    ✓ Referral to Internal Mental Health
    ✓ External mental health
    ✓ Referral to CaCoon/Babies First/Home Visiting

• Given new providers and provider-level variation, opportunity to standardize supports and processes
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.
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   c) CPCCO summary of follow-up services and providers who see children 0-3
   d) Pilot new methods for leveraging internal behavioral health & refer to specialty mental health (CBH)
Follow-Up to Screening Decision Tree: Determining the “Best Match” Follow-up Services to Create The Medical Decision Tree

• It is not as a simple as “at-risk” or not based on the ASQ (1 in the Black, 2 in the Grey)
  ‒ Not all children identified “at-risk” should be referred to EI and medical evaluation in Oregon
  ‒ Parents may push back on specific referrals
• It is not as simple as knowing about the resources, provider need to know WHICH kids and HOW to engage families and HOW to refer
• Decision tree guides follow-up, including internal services.
Decision Tree Anchored to Services within Primary Care and External Referrals and Supports

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) 2) Providence Seaside

Primary Practices Who Appear Not to be Screening to Recommendation: 1) Coastal Family Health Center 2) Providence Seaside

Community-Based Providers: 1) Home Visiting Programs 2) Public Health

Screening Fairs (Children 2-6)

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-CDRC 2) Providence

OT/PT/Speech CMH Rehab Clinic

EI NW Regional ESD Clatsop EI/ECSE

CaCoon/ Babies First

Child/Parent Psychotherapy Clatsop Behavioral Health (CBH)

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

NW Parenting Maternity Case Management

Community Connections Network NW Regional Childcare Resources & Referral

Clatsop Community Action

Head Start Potentially CAT Inc.

Healthy Families Community Action Team (CAT) Inc.

Options, Inc. WIC

The Harbor Women’s Center

Child Welfare, DHS

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.

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

**ASQ Screen- Child Identified At-Risk**

Targeted Developmental Promotion Materials for Areas of Development Identified: ASQ Learning Activities

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

1. **Traditional Factors for Referral**
   - Child medical issues
   - Age of Child
   - ASQ Scores by Domain
   - Provider Concern
   - Parental Concern

2. **Other Factors to Consider, Family Supports**
   - Child behaviors
   - Adverse Childhood Events
   - Family Risk Factors
   - Family Factors
   - Family Income
   - County of Residence

**El PEDS Medical Therapy CaCoon/Babies First**

**Internal Behavioral Health Mental Health**

**No Referral - Retest**

**Community-Based Supports Addressing Social Determinant of Developmental Promotion**

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Follow-Up to Screening Decision Tree

Factors that will drive the best match follow-up service

• Easy as 1, 2, 3, 4
  1) Age of the child
  2) ASQ domain scores – number of domains and specific domain results
  3) Parent or provider concern
  4) Child/family risk factors

• All children identified at-risk receive developmental promotion
Follow-Up to Developmental Screening: Priority Referrals that Address Specific Delays

Based on asset map, priority follow-up referrals include:

1. Early Intervention (EI)
2. Developmental Behavioral Pediatrics (DBP)
3. Medical and Therapy Services
4. CaCoon/Babies First
5. Child-Parent Psychotherapy (CPP) at CBH (We will discuss this pilot later)
Follow-Up to Screening Decision Tree
Medical Decision Tree- Updates and Review

The revised Medical Decision is based on previous project work, and experience with other pilots. Since making these changes we have had the following people review:

- Developmental Behavior Pediatricians
- ASQ Developers
- Oregon Department of Education
- EI Evaluators (including an Evaluator from Clatsop)

Today we also would like to get your feedback.
After needs are identified, how do we help families get to needed follow-ups?

- Parent Education/ Shared Decision-Making Tool to Support Conversations with the Family
- Phone follow-up regarding referrals
- Use of communication back from referred entities to inform next steps and family supports
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
- CaCoon
- Medical and Therapy Services

What to expect if your child was referred to EI:
- NWEEDO 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 503-339-3399.

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

Contact Information:
NWEEDO Early Intervention
503-339-3399 | www.nwweed.org

Who is CaCoon?
CaCoon is a public health nursing program serving children. CaCoon 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.

CaCoon Services
- Speech Language Pathologist: Specializes in speech, voice, and swallowing disorders
- Audiologist: Specializes in hearing and balance concerns
- Developmental Behavioral Pediatrics: Specializes in the following, post-development areas: learning delays, feeding problems, behavior disorders, delayed development in speech, motor, or cognitive skills.
- Autism Specialist: Specializes in planning a diagnostic and treatment plan for children with symptoms of Autism
- Occupational Therapy: Specialist in performance activities necessary for daily life
- Physical Therapy: Specializes in range of movement and physical coordination

Any Questions?
At Columbia Memorial Hospital – Pediatrics, we are here to support you and your child. If you have questions about this process, please call us.

Phone Number: 503-325-3337

We would also like your feedback for future iterations of this tool

Shared Decision Making Tool
Improved engagement with families around decisions related to follow ups and referrals
Phone Follow Up within 36 Hours

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

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

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

Answer questions (frequent questions or concerns highlighted in blue)

- 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?

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

If no further questions: Great. You should be getting a call from the Early Intervention Coordinator, her name is Laura to schedule an appointment. If you would like to call to schedule at a time that works for you, the best number is 503.338.3368.

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

• Comments/questions?
• Any future considerations for modifications?

Family Supports

• What have you learned is key to helping support families to navigate referrals and follow-up?
• What words do you use to describe these services?
• Are there words or ways to describe the services that you have found you need to use for different cultures or educational levels?
Resources and Connection to the Family: What are ways to operationalize best match supports?

*Interest in developing a process for connecting children and families to additional family supports that exist in the community*

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

**KEY STEPS**

1. **Part 1:** Children 0-3 Identified At-Risk via Developmental Screening
   - Primary Practices Conducting Screening at Recommended Periodicity:
     - CMH Pediatrics (Pilot Site)

2. **Part 2a:** Developmental Supports to Address Delays Identified By Entity Who Screened
   - Developmental Promotion Activities
   - Internal Behavioral Health

3. **Part 2b:** Referral to Agency to Address Delays Identified
   - Developmental Behavioral Pediatrician
     - OHSU-CDRC
     - Providence
   - OT/PT/Speech CMH Rehab Clinic
   - EI NW Regional ESD Clatsop E/PCSE
   - CaCoon/Babies First/ Maternity Case Management
   - Child/Parent Psychotherapy Clatsop Behavioral Health (CBH)

4. **Part 3:** Additional Family Supports That Address Child Development and Promotion
   - NW Parenting
   - Community Connections Network
   - NW Regional Childcare Resources & Referral
   - Clatsop Community Action
   - Head Start Potentially CAT Inc.
   - Healthy Families Community Action Team (CAT) Inc.
   - Options, Inc.
   - The Harbor Women’s Center
   - Child Welfare, DHS

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PLACE HOLDER FOR EARLY LEARNING SERVICE INTEGRATION PROPOSAL

DOROTHY AND ELENA
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Early Learning
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.
• Pilot ways EI could children for infant and early child hood mental health
Modifications to Universal Referral Form (URF)

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

The goals of the updates were to:

1. Help facilitate improved communication between EI/ECSE and the referred family
2. Streamline Communication between referring providers and EI/ECSE
3. Support enhanced timely communication so that PCPs can assist with outreach and engagement of families
4. Inform follow-up steps for EI ineligible and EI eligible
Component of the QI Work Related to Primary Care and EI Impacted by the New URF

Pilot Primary Care Sites
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   c) CPCCO summary of follow-up services
   d) Pilot new methods for connection to mental health

Training on the new URF, standardized use and completion part of QI process, training & implementation supports

Use of the information EI provides back is part of the PCP QI process and supports for:
1) Children not able to be evaluated
2) Children ineligible
3) Children eligible

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   • For Eligible Children:
     Communication about EI services being provided to inform secondary steps

1) Children not able to be evaluated
   • Communication BEFORE case closed to PCP can outreach
   • Communication when not able evaluate
2) Children ineligible
   • You were already doing this, new work is how PCP is using info
   • Potential EI referral (future focus)
3) Children eligible and a summary PCPs will use better
   • New Summary of Service

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Service Summary Overview

NWRESD sends the Service Summary to referring providers for children when:

- Referred children are found ELIGIBLE
- Whenever changes are made to the services being provided (annually)

Service Summary

Child's Name: SAMPLE, Willow

Birthdate: 02/01/00

Your patient, Willow was found eligible for Early Intervention services on:

Sample was found eligible under the category:

A new Individual Family Service Plan (IFSP) was developed for Willow on. These services will be reviewed again no later than.

IFSP Goal Areas
- Cognitive
- Social / Emotional
- Motor
- Adaptive
- Communication

IFSP Services Provided

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>How Often</th>
<th>Provider</th>
</tr>
</thead>
</table>

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

Date: 01/22/18
EI/ECSE Unable to Contact

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

03/22/18

George & Gigi
PO Box 123
Aloha, OR 97007

Re: Ginny Sample, birthdate 11/03/13

Dear George & Gigi

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

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

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

Thank you, and have a wonderful day!

Sincerely,

NWRESD sends this letter to referring providers noting that the ESD Coordinator was unable to contact the referred family.
Improved Referral from PCP and Documentation

Working with CMH to improve the quality of the referral by:

- Use the new URF
- Have documented ASQ domain scores
- FERPA signature

Already started DATA IMPROVEMENTS with EI to document in ECWeb:

Linking Referral to Primary Care
Will Pilot Quarterly data validations to ensure all referrals were ‘caught’
Improving Outreach in Primary Care and EI

OPIP will be working with CMH to implement 36 hour phone follow ups for children referred to Early Intervention.

Will work with NWRESD to expand and improve upon outreach techniques based on changes to the URF.
A goal of the project is to improve communication and coordination.

New workflow: If **NWRESD** faxes URF back to practice noting their inability to contact, **CMH** will work to follow up with families to help get them in.

---

**Improving Early Communication between EI and Primary Care Pilots**

- **3a. Service Center able to contact the family?**
  - **NO**
    - **Contact Attempts Unsuccessful**
      - **Before Case is Closed, After 60 days,**
        - **2a. Send Bottom of the URF to practice for this Child**
        - **2a. Send Bottom of the URF to practice for this Child**
        - **Primary Care Piloting FU with families if they get URF**

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Early Learning Provider Pathway Pilot in Clatsop County

Enhance Pathways to Infant and Early Childhood Mental Health at CBH:

• Addresses an important high-risk population that would be identified on Developmental Screening and not addressed fully in current pathways
• Have capacity and expertise for this population specifically
• Community noted significant barriers and past poor experiences with mental health

Initial Plans for the Pilot included:

• Patient-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- Primary Care** pilot an improved referral and warm hand off process between PCP and CBH, including potential models of warm handoffs at the site
  – **Secondary Referral processes- EI** pilot an improved referral and warm hand off process between EI and CBH
  – **Communication/coordination with referring entity**- models for two way communication
Enhanced Pathways for Children Referred by Primary Care to Early Intervention and Engagement in Mental Health

**Focus of Across Sector Improvement Pathways for Young Children Identified At-Risk in Clatsop County**

- **CMH Pediatric Clinic (Primary Care Pilot Site)**

  - **Internal Behavioral Staff at CMH**
    - Assessment of family
    - Engagement of family on mental health services, models for safe connection

- **New Referral/Communication Form to CBH For Young Children**

- **EI Ineligibility Report**

- **New Feedback Communication**

- **El: NW Regional ESD**
  - Columbia El/ECSE

- **EI Evaluation**
  - El Eligible
  - El Ineligible

- **EI Feedback Form Based Evaluation**

- **Universal Referral Form**

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

- Referral to Agency to Address Delays Identified

**Part 2:**

- **El: NW Regional ESD**
  - Columbia El/ECSE

- **EI Evaluation**
  - El Eligible
  - El Ineligible

- **If Applicable, Referral to CBH or CMH PCP and In-Clinic Behavioral Support**

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Pathway Pilot in Clatsop County to Internal Behavioral Health and Specialty Infant and Early Childhood Mental Health

Work to date

• Engaging relevant teams from CMH and CBH, Meeting held with each team

• Requests for existing tools, strategies, and methods related to
  – Within Primary Care: Internal pathways to behavioral health and deep understanding of infant and early childhood mental health
  – With CBH: Referral forms, assessment, communication feedback loops

• Literature review, interviews of experts around the country, and overall search for helpful information, tools, and models that exist
  – Workflows and models
  – Talking points and information sheets
  – Assessments
  – Referral Forms
  – Communication Forms
  – Information about billing and coding in both Primary Care and Mental Health
OPIP Proposal to GOHBI to Support Needs Identified in This Project

• In preliminary discussions with the sites and gathering current processes, we identified that a number of the tools, strategies and pathways are not developed or in place.
• This development work goes beyond the scope of the current CPCCO funding.
• Submitting a proposal mid-May to GOHBI to support the tools and strategy need AND to support implementation strategies.
  – Collaborative effort with OPIP, CMH-Astoria, CBH
• Will be exploring funding to address the broader need and area of focus for pregnant moms and young children overall.
Training, Curriculum and Implementation Support Needed to Ensure a True Pathway Addressing Mental Health for Young Children

**Primary Care (Follow up to Developmental Screening)**

- **KEY TOOLS AND Quality Improvement**
  - Tools & Training
    1) Medical Decision Tree outlining decision support and considerations for internal behavioral health processes as well as referrals to mental health
    2) Training for PCPs of what CPP and PCIT are and what services look like
    3) Talking points for providers for use with families around the topic of behavioral and mental health
    4) Internal Behavioral Health: -- Capacity & workflows -- Specific assessments and care -- Coding and Billing
    5) Shared Decision Making Sheet and supplemental materials for parents around behavioral and mental health concepts and referral
  - Implementation Support, Ongoing QI
    -- Training on tools and models
    -- Implementation support and QI Coaching for Primary Care Provider
    -- Implementation support and QI for Internal Behavioral Health Staff

- **Two-way Communication**

**Mental Health (Prenatal, Infant, Early Childhood)**

- **KEY TOOLS AND Quality Improvement**
  - Improved assessments for pregnant women, children, and families
  - Improved processes around receiving referrals from these subpopulations
  - Improved processes related to pilot tools and concepts
  - Provider/team trainings around changes related to the pilot
  - Data collection related to evaluation of pilot activities
  - Coding and billing

- **Communication from Primary Care to Mental Health**
  - Concepts leading to tools
    - Improved Referral Form
    - Relevant Status Updates
  - Implementation support for tools and models

- **Communication from Mental Health to Primary Care**
  - Concepts leading to tools
    - Ability to contact family
    - Dx and Tx Plan
    - Relevant Status Updates
    - Discharge/End of Services
  - Implementation support for tools and models, ongoing QI

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New Opportunity- OPIP Proposal to GOHBI

**Hearing from you:**

- Questions or comments regarding this opportunity to expand the scope of work in this pathway?
- Any feedback or input regarding the approaches we described?
- Are there any other considerations we missed? Any challenges or barriers that exist?
Next Steps

• Follow-up to questions or needs for additional information raised today
• Focus on the priority pathways discussed today, incorporating refinements
  – Primary Care Pilot site improvement efforts
    • Including pilot of Early Learning Service Integration Pilot via NWELH
  – EI improvement efforts
  – CBH Pilot
• Presentation on this work at the Innovation Café for CCOs in June
• Next Stakeholder Meeting- September 4, 2018
Quarterly Clatsop County Stakeholder Meetings: Getting Your Insight and Input on Timing

• 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