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

Columbia Stakeholder Meeting 10/9/17
Agenda

1. Refresher on Key Elements of the Project in Clatsop, Columbia and Tillamook Counties
2. Overview of Stakeholder Interviews, Get Your Input
3. Overview of Baseline Quantitative Data Being Collected
4. VERY Preliminary Emerging Themes, Get Your Insight and Perspective Given Impact on Pilots
5. Preview of the Future and Improvement Pilots, Get Your Reactions
6. Next Steps

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

- Increased Focus on developmental screening across the state
  - Within primary care
  - Within home visiting
  - Within child care
- Goals of screening
  - Identify children **at-risk** for developmental, social/or behavioral delays
  - For those children identified, **provide**
    1) developmental promotion,
    2) refer to services that can further evaluate and address delays
  - Many of these services live outside of traditional health care

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

This report is focused on **children identified “at-risk”** that should receive follow-up services. These are children that are identified “at-risk” for developmental, behavioral or social delays on standardized developmental screening tools. In the communities of focus for this work, a majority of providers are using the Ages and Stages Questionnaire (ASQ)³. Therefore the children of focus are those identified “at-risk” for delays based on the ASQ domain level findings.
From Developmental Screening To Services: Opportunity to Connect the Fantastic Individual Silos

Health Care

*Coordinated Care Organizations & Primary Care*

Early Learning

Early Intervention
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 support:
  - **Phase 1**: Across-sector stakeholder engagement and baseline data collection about current processes and where children are lost to follow-up;
  - **Phase 2**: Develop, pilot implementation, and evaluate improved follow-up processes, including referral to and coordination of processes meant to ensure early receipt of services that help at-risk young children to be ready for kindergarten.
    - Pilots of improvement in the three “silos” – Primary Care, EI, Early Learning.
- NWELH has included OPIP has a key partner in this project
  - Support the stakeholder engagement
  - Support the evaluation data collection and summary
  - Support the improvement pilots within primary care clinics meant to enhance follow-up and care coordination for children identified at-risk.
  - Builds off previous efforts OPIP has led in other communities and described on their website: [http://www.oregon-pip.org/focus/FollowUpDS.html](http://www.oregon-pip.org/focus/FollowUpDS.html)
Improvement Pilots

• **Priority areas for follow-up** and early learning resources where improvements will be identified for pilots improved processes

• The sites that will **pilot the improved processes** are:
  
  1. **Three primary care practices** serving a large number of publicly insured children residing in these counties;
  2. **Early Intervention** – Northwest Regional Early Service District; and
  3. Priority **Early Learning Providers** within the NWELH that are identified as priority pathways in the community

• Key component of the December meeting

• 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
  
  NWELH → EI and Early Learning
Community-Based Improvement Opportunity: Pilot Sites Implementing Efforts to Improve Follow-up to Developmental Screening: Preview of What is Coming

Primary Care Practices
Part 1: Develop a follow-up medical decision tree that is based on ASQ and child and family factors and goes beyond developmental evaluation and EI
Part 2: Developmental Promotion Provided at Time of Screening
Part 3: Develop Parent supports in navigating referral process
Part 4: Summary of CCO Services Covered Related to Follow-Up

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

Early Learning
Within identified early learning, pilots of referrals & connections
Need to clarify this in December 2017
Phase 1: Stakeholder Engagement & Baseline Data Collection

• Engage stakeholders across six sectors within health care, Early Intervention (EI), and early learning focused on developmental screening and/or who provide follow-up services for children identified at-risk for delays on developmental screening tools.

• Baseline qualitative and quantitative data will be collected in order to:
  1. **Understand the current pathways** from developmental screening to services in each of the three counties (Clatsop, Columbia, and Tillamook), and the community-level assets and resources that exist to support follow-up services; and
  2. **Understand where and how children are falling out** of these pathways and not receiving services to address the identified risks, including where there is a lack of capacity to serve children identified.

• Convene stakeholders in county-level meetings to share the baseline qualitative and quantitative (**Columbia: 12/11**)  
  – To understand current pathways  
  – Confirm priority areas to pilot improvements

• Convening of tri-county stakeholders
Phase 1: Stakeholder Interviews

- Interviewing people from organizations that either:
  - Conduct developmental screening and are responsible for follow-up AND/OR
  - Provide Follow-up for Children 0-3 Identified on Developmental Screening

- Purpose of Interview
  1. Current follow-up process
     - When refer
     - How refer – what form, how tracked
     - Feedback loops – child able to be contacted, eligible, services received
  2. Current services to inform the Asset Map, which may include places where assets are needed but not yet present
  3. Opportunities
  4. Barriers
  5. Capacity within the region
## Stakeholder Engagement in Columbia County
### Informing Community Asset Mapping

<table>
<thead>
<tr>
<th>CPCCO</th>
<th>Primary Care</th>
<th>EI &amp; Education</th>
<th>NW Early Learning Hub</th>
<th>Home Visiting &amp; Head Start/Early Head Start</th>
<th>Child Care and Parenting Supports</th>
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</table>
| Mimi Haley (Executive Director) | OHSU Scappoose  
- Brigit Hatch  
- Joe Skariah  
- Nicole Hoyt  
- Aubrey Bridges  
- Rachel Sircar | Nancy Ford (Director of Birth to Age 5 Services, NWRESID)  
Tina Meier-Nowell (Special Education Coordinator, NWRESID)  
Vicki Schroeder (EI Data, NWRESID)  
EI/ECSE Program County Coordinators  
- Cindy Jaeger  
EI Referral Intake Coordinators  
- Mary Akin  
EI Lead Evaluators  
- Mary Dorry | Dorothy Spence (Hub Director)  
Rob Saxton (Governance Council Chair)  
Elena Barreto (Community Navigator)  
Eva Manderson (Early Learning Program Specialist/Preschool Promise Manager) | Community Action Team (Head Start & Healthy Families Home Visiting)  
- Joyce Ervin  
- Sunday Kamppi | CCR&R  
- Elaine Parsons  
Childcare Centers conducting screening  
(Preschool Promise & SPARK 3 Star & above)  
- Martine Barnett  
(Cubs Corner/ St. Helens HS)  
NW Parenting  
- Julianne Cullen  
DHS  
- Amy Youngflesh |
| Safina Koreishi (Medical Director) | Legacy St. Helens  
- Naiyar Azhar |  |  |  |
| Elicia Miller (Clinical Integration Manager) | |  |  |  |
| Maranda Varsik (Practice QI) |  |  |  |  |
| Joell Archibald (Innovator Agent) |  |  |  |  |
| Nicole Jepeal (Metrics/QI Analytics Supervisor) |  |  |  |  |
| Jeanne McCarty & Leslie Ford (GOBHI) |  |  |  |  |
| Staff that oversee services for children |  |  |  |  |

**Mental Health**

- CCMH  
  - Roland Migchielsen  
  - Beth Owens  
  - Jill VanWormer

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### Health Care
Follow-up within Sites That Could be Enhanced:
- Developmental Promotion
- Retest Child
- If internal services

1) OHSU Scappoose (Pilot Site)
   - Internal behavioral health
2) Legacy
3) Potentially Peace Health/ Longview Peds
4) Potentially SBHCs

### EI & Education
- Columbia EI/ECSE Program

### Home Visiting & Head Start
- CAT Inc.- Healthy Families
- CaCoon/Babies First/Maternity Case Management (*If meeting eligibility requirements*)
- Potentially CARE Inc.- Head Start (*older kids and parenting workshops*)

### Mental and Behavioral Health
- Columbia Community Mental Health (CPP and PCIT)
- Amani Center – when abuse is a factor
- Options - under specific circumstances

### Child Care and Parenting Supports
- NW Parenting (2-3 classes per year)
- Potentially Sunnyside Daycare and Learning Center and other child care providers
- St. Helens High School Child Development and Teen Parent Program

### Referrals
- PT-Therapeutic Associates
- OHSU, Providence – Developmental Behavioral Pediatrician

### Other Potential Resources
- Library System – Story Hours and Parent Groups for Moderately Delayed Kids
Asset Map Developed In Order to Create a Medical Decision Tree
To Identify Best Match for the Child/Family
and is Anchored to Services in the Community

Example from Marion, Polk and Yamhill:

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

Example from Marion, Polk and Yamhill

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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Columbia County Community Asset Mapping - 10/9/17
Preliminary List Based on Interviews

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</tbody>
</table>

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Emerging Themes – Gut Check from Community

- **Primary Care Screening is Happening for Children Who Access Services**
  - Children who receive primary care in the county are getting screened
  - Some families do access primary in other counties, and even in WA
  - That said, variation in the follow-up by site and significant variation by provider
  - Practices in Columbia, often see a lot of children in other counties so can make workflow
  - PCP in the sites often don’t live in the community, may limit knowledge of local resources

- **Value in a clear asset map and summary of CCO services**

- **Opportunity to Enhance Promotion and Follow-Up within PCP Site**
  - Developmental promotion activities and guidance
  - Parent guidance and parent support in navigating process

- **Opportunity to Enhance Referral and Feedback Loops for Existing Pathways**
  - Standardization of who is referred, how and assurance of communication feedback loops
  - Excited over enhanced communication and feedback loops in EI pilot
  - Excited about exploring enhanced referral criterion for EI, consideration of pathways for children:
    - Not eligible for EI
    - Eligible, but needing additional and enhanced supports
Emerging Themes – Gut Check from Community

- Potential lack of knowledge about resources available or how to refer
  - Infant early childhood mental health
  - PCIT availability

- Potential lack of capacity & funding for existing services to serve this 0-3 population, especially those moderately delayed
  - EI
    - Sometimes referral to OHSU DB PEDS to get OT/PT Services
  - Home Visiting
  - Mental Health - recognize there is a new service, but interested in capacity. Number of PCIT slots.

- Potential lack of resources to support families
  - Number of parenting classes and supports

- Hesitancy/push back on referrals based on complex factors
  - Developmental and behavioral pediatrician in Portland
  - Mental Health

- For some families, perception of lack of shared understanding and commitment to need for early developmental promotion activities
  - Shared perception about child’s developmental status
  - Shared belief on importance of early developmental experiences
  - Shared understanding of the value of services that intervene early
  - Ability to go to the services given a number of other stressors in the family

- Need for parent to parent supports in understanding value, navigating system

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## Phase 1 – Part 2
Baseline Quantitative Data Understand Current Needs, Referrals, and Inform Conversations About Capacity and Priority Areas of Focus

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<th>DATA ELEMENTS:</th>
<th>DATA SOURCES:</th>
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<td>CCO Data Based on Claims</td>
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<td>Developmental Screening</td>
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<tr>
<td>Of those screened in Primary Care:</td>
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<tr>
<td># at-risk, Types of Risk</td>
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</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>X</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>?</td>
</tr>
</tbody>
</table>
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
Other Community-Level Data That Will be Explored Over the Course of the Project -- Early Childhood Health Dashboard

• HUB Dashboard data
  – Number of Children in Foster Care, Child Welfare Involvement
  – TANF
  – SNAP
  – Developmental Disabilities
  – Public insurance rates

• Health Care Data
  – Immunizations
  – Well-Visit Rates

• PRAMS 2013, 14, 15

• PRAMS2 2013 - (we refer to it as “2011 PRAMS2, because those children are 2 years old and were born in 2011):

• Kindergarten readiness data collected by the Oregon Department of Education

• Data You All Collect in this Region that Paints a Larger Picture
  – Home visiting data – number served, referrals and ability to access and receive services
  – Others?
Community-Based Improvement Opportunity:
Pilot Sites Implementing Efforts to Improve Follow-up to Developmental Screening: Preview of What is Coming

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**Early Learning**
Within identified early learning, pilots of referrals & connections

Need to clarify this in December 2017
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

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 WCHP 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 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

Rescreen 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)

And/or Exposure to Adverse Childhood Events (ACEs) in Family Environment

Consider Use of Early Childhood Mental Health Dx Codes

Three Community Resources To Consider for Groups A-D

Resource #1
Child has a Medical Dx or Medical Risk Factors (ex: FIT, elevated lead, seizure disorder)

Social Risk Factors (Ex: parent with inadequate knowledge/supports, alcohol/substance abuse, or mental illness; teen parent)

AND

YES

Refer to CaCon/ Babies First Use CaCon 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

Child Lives in Marion or Polk County

Child Lives in Yamhill County

Refer to Family Link Include Info on EI Referral

Resource #3
Support developmental promotion by addressing issues such as literacy/reading, parenting skills, food insecurity

Could benefit from parenting classes?

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

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

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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 (EI)**
  - Helps babies and toddlers with their development. In your area, Willamette Education Service District (WESD) runs the EI program.
  - 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.

- **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:
    - WESD will set you up for 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 EI can provide services for your child.

  **Contact Information:**
  - WESD Intake Coordinator
  - 503-385-4714 | www.wesd.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 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 Chaves, Program Supervisor
  - 503-361-2693
  - www.otss.egov/outreach/ovcysghb/programs-projects/cacoon.chm

- **Parenting Support**
  - Classes located in Marion County
  - Veneta Middle School (503) 567-7183
  - Early Learning Hub

  **Classes located in Polk County**
  - (503) 622-9664
  - MikeValleyparenting.org

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 of Salem, we are here to support you and your child. If you have any questions about the process please call our Referral Coordinators: (503) 364-3170.

Education Sheet for Parents

Added a “Parenting Support” section since last meeting that sites are piloting.
## Services Covered by CCO: Example for Marion & Polk

**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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<tr>
<td><strong>Occupational Therapy Services</strong></td>
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<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</td>
<td>Yes</td>
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<td></td>
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<td>Mighty Oaks Therapy Center (Albany)</td>
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<td>PT Northwest</td>
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<td>Salem Hospital Rehab</td>
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<td><strong>Physical Therapy Services</strong></td>
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<td>Yes</td>
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<td></td>
<td></td>
<td></td>
<td>Mighty Oaks Therapy Center (Albany)</td>
<td>Yes</td>
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<td></td>
<td></td>
<td></td>
<td>PT Northwest</td>
<td>No</td>
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<td></td>
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<td></td>
<td>Salem Hospital Rehab</td>
<td>Yes</td>
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<td></td>
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<td></td>
<td>Sensible Speech</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Skills Groups</td>
<td>Yes</td>
<td>Enrolled in services</td>
<td>Marion County Child Behavioral Health*</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Polk County Mental Health*</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inter-Cultural Center for Psychology</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Bilingual provider

*Do not reproduce without proper OPIC citation*
Community-Based Improvement Opportunity: Pilot Sites Implementing Efforts to Improve Follow-up to Developmental Screening: Preview of What is Coming

Primary Care Practices
- At a population-level, this is where the most “car seats” for children age 0-3 are parked
- Part 1: Develop a follow-up medical decision tree that is based on ASQ and child and family factors and goes beyond developmental evaluation and EI
- Part 2: Develop Parent supports in navigating referral process
- Part 3: Summary of CCO Services Covered Related to Follow-Up

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

Early Learning
Within identified early learning, pilots of referrals & connections
Need to clarify this in December 2017
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**

<table>
<thead>
<tr>
<th>EI/ECSE Services: please complete this portion, attach requested information, and return to the referral source above.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Family contacted on <em><strong><strong>/</strong></strong></em> The child was evaluated on <em><strong><strong>/</strong></strong></em>/____ and was found to be:</td>
</tr>
<tr>
<td>□ Eligible for services □ Not eligible for services at this time, referred to:</td>
</tr>
<tr>
<td>□ EI/ECSE County Contact/Phone: ____________________ Notes:</td>
</tr>
<tr>
<td>Attachments as requested above:</td>
</tr>
<tr>
<td>□ Unable to contact parent □ Unable to complete evaluation EIECSE will close referral on <em><strong><strong>/</strong></strong></em>/____</td>
</tr>
</tbody>
</table>

*The EI/ECSE Referral Form may be duplicated and downloaded at: [http://www.ohsu.edu/xdo/utreach/bccysn/programs-projects/dev-screening-and-referrals.cfm](http://www.ohsu.edu/xdo/utreach/bccysn/programs-projects/dev-screening-and-referrals.cfm)*

**Completed Example:**

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

<table>
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<tr>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>□ Eligible for services □ Not eligible for services at this time, referred to:</td>
</tr>
<tr>
<td>□ EI/ECSE County Contact/Phone: ____________________ Notes: Contact attempts: 8/12/16, 8/20/16, 9/1/16 CLOSURE LETTER MAILED 9/1/16 due to no contact</td>
</tr>
<tr>
<td>Attachments as requested above:</td>
</tr>
<tr>
<td>□ Unable to contact parent □ Unable to complete evaluation EIECSE will close referral on 9/1/16 due to no contact</td>
</tr>
</tbody>
</table>

**RECEIVED**

Form Rev. 10/22/2013

OCT 11 2016

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

By: A.M.
One-Page Summary of Services

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<table>
<thead>
<tr>
<th>Willamette Education Service District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marion Center • 2611 Pringle Rd, Salem, OR 97302 • Phone 503.385.4575 • Fax 503.540.4473</td>
</tr>
<tr>
<td>Yamhill Center • 2045 SW Hwy 18, McMinnville, OR 97128 • Phone 503.435.5900 • Fax 503.435.5920</td>
</tr>
</tbody>
</table>

---

**Early Intervention Referral Feedback**

- **Child's Name:** ________________  ____ Birthdate: __________

- **Your patient:** was found eligible for Early Intervention services on: 11/02/16

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

- As required under Oregon law, she will be re-evaluated by 03/12/18 to determine if she is eligible for Early Childhood Special Education Services.

- Additional referrals: 2/13/17: Eligible in Hearing Impairment

- A new Individual Family Service Plan (IFSP) was developed for no later than 04/01/17. These services will be reviewed again on 11/10/16. Please contact Marie Selke with any questions.

---

**IFSP Services**

- **Goal Areas:**
  -  □ Cognitive
  -  □ Social / Emotional
  -  □ Motor
  -  □ Adaptive
  -  □ Communication

---

**Services Provided by:**

-  □ Early Intervention Specialist
-  □ Occupational Therapist
-  □ Physical Therapist
-  □ Speech Language Pathologist
-  □ Other

**Frequency**

-  1x2 weeks, 45 minutes
-  1x/month, 45 minutes

**Current Provider**

-  Marie Selke
-  Ann Stevenson - hearing services

---

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

---

Marie Selke, Speech Language Therapist, 2611 Pringle Rd, SE Salem, OR (503) 540-4415

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30

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Next Steps

• Baseline Quantitative Data
  – Collect
  – Sense-making of the data relative to the project
  – Summarize for next meeting in Columbia County (December 11th)

• Complete Stakeholder Interviews
  – Finish remaining interviews
  – Summarize themes for 12/11 Columbia County Meeting relative to:
    • Strengths
    • Opportunities for pilots
    • Special populations of consideration
    • Barrier to consider now

• Onboard work with the pilot primary care site (OHSU Scappoose)
• December 11th Stakeholder Meeting
Quarterly Columbia County Stakeholder Meetings:
Getting Your Insight and Input on Timing

• December 2017
  – Review Data
  – Confirm Priorities for Pilot Focus
• Spring 2018
  – Review draft pilot tools and strategies, get you input and insight for modifications and improvements
• 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

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