Oregon Pediatric Improvement Partnership (OPIP) Semi-Annual Call with Front-Line Providers

May 10th, 2017 @ 7am-8:30am
Phone: 1-866-366-9319
Webinar Site: https://ohsu.adobeconnect.com/opip

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OPIP Mission

• OPIP supports a meaningful, long-term collaboration of stakeholders invested in child health care quality, with the common purpose of improving the health of the children and youth of Oregon.

• OPIP staff and projects are focusing on building health and improving outcomes for children and youth by:
  1) Collaborating in quality improvement activities across the state;
  2) Collaborating in quality measurement activities across the state;
  3) Supporting evidence-guided quality activities in clinical practices;
  4) Incorporating the patient and family voice into quality efforts; and
  5) Informing policies that support optimal health and development for all children and youth.
Why Are We Having These Semi-Annual Calls for Front-line Practices Invested in Child Health in Oregon?

Provide Updates, Spread Innovation:

• Key part of OPIP’s mission is to support practice-level quality improvement and implementation, and to facilitate the spread of innovations across the state.
  – GOAL FOR THIS CALL: Provide update on key projects so you can let us know if you want more information, and share tools or methods that may be useful

Policy-Level Work:

• A component of OPIP’s mission is focused on informing policies that support optimal health and development for all children and youth.
• A critical component of this work is providing actionable and meaningful information to policymakers that is informed by the front-line.
• Conversely, for the policy-level efforts that we are involved in, provide you with an update and potential implications for front-line practices
  – GOAL FOR THIS CALL: Provide updates on key policy-relevant activities

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Agenda for Today’s Call


• Area #1: Children with Health Complexity; Guest Spotlighting Opportunities Related to EDIE/PreManage

• Area #2: Developmental Screening- You’ve now screened, what to do next for children identified at-risk

Part 2: Update on Key Policy-Level Activities

• Multi-payer Learning Collaborative (SB 231)
• Health Plan Quality Metrics Committee (SB 440)
• SB 934

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Asking Questions and Getting Information

• Slides are available to be downloaded. We will also post on our website along with a recording.

• Call line will be muted due to the number of people on the call.

• If you have a question, TYPE the question in the CHAT function on the lower right corner of the webinar screen.
  – After the call, we will follow-up with you to make sure that we answer the question.
  – If you want more information or want to be kept in the loop on a project, send an email to OPIP@ohsu.edu

• When we get to policy-discussions, we will unmute the call line so people can participate verbally.
Agenda for Today’s Call


- Area #1: Children with Health Complexity; Guest Spotlighting Opportunities Related to EDIE/PreManage

- Area #2: Developmental Screening- You’ve now screened, what to do next for children identified at-risk

Part 2: Update on Key Policy-Level Activities

- Multi-payer Learning Collaborative (SB 231)
- SB 934
- Health Plan Quality Metrics Committee (SB 440)
OPIP Efforts Focused on CYSHCN and/or Health Complexity

• OCCYSHN’s Enhancing Systems of Services for CYSHCN Project
  – OPIP Serves on the State Implementation Team
  – OPIP Subcontractor to lead efforts focused on Enhanced Quality of Medical Home for CYSHCN across four sites
  – System-Level:
    o Kaiser Permanente North West
  – Practice-Level:
    o OHSU – General Pediatrics Clinic
    o Salem Pediatric Clinic
    o Pediatric Specialists of Pendleton

• Proposals OPIP Has Submitted
  – Lucile Packard Children’s Health Foundation Proposal
  – National Improvement Partnership Network Application for COINN on Children with Medical Complexity; OPIP and Oregon proposed as one of the ten states
Some Definitions:

• CYSHCN – A definition from the Maternal & Child Health Bureau
  – CYSHCN defined as “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.”
  – Three key points in this definition:
    ✓ There must be the presence of a condition (not necessarily a diagnosis)
    ✓ They utilize more services than would be expected normally
    ✓ Includes “At-risk”

• In system-level work focused on addressing children with needs for complex care managements and/or enhanced coordination, need for a refined definition for which children to prioritize limited resources.

• The term health complexity takes into account the importance of recognizing and understanding two different factors that can impact a child’s health and how the health care system can best meet their needs, and ensure high quality care that addresses costs
  – Medical complexity
  – Social complexity
Some Definitions:

• **Medical Complexity**
  - Current method OPIP working with KPNW and OHA is utilizing the Pediatric Medical Complexity Algorithm (PMCA)
    - Takes into account: 1) Utilization, 2) Diagnoses, 3) Number of Body Systems Impacted
    - Assigns child into three categories: a) Complex with chronic conditions; b) Non-Complex, with chronic conditions; or c) Healthy.

• **Social Complexity:**
  - Defined by The Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN) as “A set of co-occurring individual, family or community characteristics that can have a direct impact on health outcomes or an indirect impact by affecting a child’s access to care and/or a family’s ability to engage in recommended medical and mental health treatments”.
  - 14 factors identified by COE4CCN as predictive of a high-cost health care event (e.g. emergency room use).
WA Medicaid Study

- Identified 12 SC risk factors from literature review related to worse outcomes
  1. Parent domestic violence
  2. Parent mental illness
  3. Parent physical disability
  4. Child abuse/neglect
  5. Poverty
  6. Low English proficiency
  7. Foreign born parent
  8. Low parent educational attainment
  9. Adolescent exposure to intimate partner violence
  10. Parent substance abuse
  11. Discontinuous insurance coverage
  12. Foster care
WA Medicaid Study

• Hypothesized 6 additional SC risk factors that may be associated with worse outcomes:
  1. Parent death
  2. Parent criminal justice involvement
  3. Homelessness
  4. Child mental illness
  5. Child substance abuse
  6. Child criminal justice involvement
What have we concluded from this study?

• 9 SC risk factors identifiable in state data are associated with ↑ ED utilization which may indicate poor access to outpatient primary care and need for care coordination:
  • Severe Poverty
  • Limited English proficiency
  • Parent mental illness
  • Parent criminal justice involvement
  • Child welfare system involvement (child abuse/neglect)
  • Homelessness
  • Child mental illness
  • Child substance abuse treatment need
  • Child juvenile or criminal justice involvement
OPIP Efforts Consultation to KPNW to Identify Children with Health Complexity for Complex Care Management

- Region-level activities to impact all children enrolled in KPNW
  - N=93,637 paneled to pediatrician. N= 115,500 in systems (includes FM)
  - 17,254 pediatric Medicaid patients
- Team Based Care (TBC) exists for adults, not children
- Initial pilot-level activities focused on children in Mt. Scott (MTS) and new pediatric Team Based Care for Complex Care Management, with potential to spread clinics across region

Three Parts to the OPIP Learning Curriculum & Support

<table>
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<tr>
<th>#1</th>
<th>Support for Pilot of Complex Care MTS: Developing tools, strategies and care coordination methods</th>
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<tr>
<td>#2</td>
<td>Based on MTS learning, support to develop standardized team-based care tools for CYSHCN that will be spread around KPNW</td>
</tr>
<tr>
<td>#3</td>
<td>Develop System-Level Methods to Identify CYSHCN that Would Benefit from Complex Care Management</td>
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OPIP Efforts Consultation to KPNW to Identify Children with Health Complexity for Complex Care Management

- **Pilot established at Mt Scott**
  - Intake assessment
  - Care plans
  - Team resources allocation
- **Spreading to two additional sites**
- **Proactively using an approach anchored to HEALTH Complexity to identify which children should be prioritized**
  - **Medical** Complexity
    - Using Pediatric Medical Complexity Algorithm
  - **Social** Complexity
    - Part 1: System-Level available to them now tied to Predictive Factors of ER Use
      - Data from enrollment and program eligibility, services provided to the youth, EMR documentation. Poverty (4 indicators), Limited English Proficiency (2 indicators), Parent mental health services use (4 indicators), Foster Kids (1 indicator), Child Mental Health Service (3 indicators), Child Substance Abuse treatment need (2 indicators)
    - Part 2: Surveys that will be administered on the front-line to capture information about social complexity
      - Prioritized six items they don’t have data on

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Figure 1: Overview of System-Level and Primary Care-Level Methods Within KPNW to Identify Children with Health Complexity and Assign Pediatric Team-Based Complex Care Management Resources

**System-Level KPNW Data** Used to Identify Children with Health Complexity for Team-Based Care (TBC) Complex Care Management

**Part 1:** Medical Complexity

Classifies children in three categories:
1. Complex Chronic Disease
2. Non-Complex Chronic Disease
3. Children without Chronic Disease

**Part 2:** Social Complexity

Social Complexity Score that summarizes total number of social risk factors identified in the system-level data.

**Part 3:** Health Complexity

Combines Medical Complexity Score and Social Complexity Score into one Health Complexity Score. This score is used to determine:
1. WHO Should Receive TBC
2. Proposed LEVEL of TBC resources
3. Proposed Best Team for the Intake Assessment

**Primary Care-Level Information** Collected by the Primary Care Provider (PCP) and Team-Based Care (TBC) Team to Determine Child/Family Needs for TBC Resources

**Part 1:** PCP Gestalt

PCP provides input on presence of other social risk factors and care coordination needs

**Part 2:** TBC Team

Intake and Assessment to Determine Full Complex Care Management Needs

**Part 3 (FINAL):** Tailored TBC Resources & Best Match Team Identified for Child

Assigned to TBC and:
1. LEVEL of Complex Care Needed – Levels 1-4
2. BEST MATCH TBC TEAM -- Within TBC, Specific Lead Person Identified

**OR**

Assigned to care coordination in existing programs (Within Primary Care Exceptional Needs Care Coordination, Within Spec. Services)

**System-level Flags**

Flag of TBC Patients with a High Cost Event (ER, Urgent Care, Hospitalization)

**Primary Care-Level Information to Supplement System-Level Data**

Surveys Administered at Routine Well-Visits

On standard surveys given at select well-child visits, supplemental items will be added to gather information about priority social complexity risk factors not currently available in system-level data. In this way, these data enhance the quality of information available at the system-level to identify children with Social Complexity

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1. Based on the Pediatric Medical Complexity Algorithm (PMCA), which assesses the types of services received, diagnosis, and number of body systems impacted. Claims and utilization available within the KPNW system used. Service provided outside of KPNW or in the past for children when they were not covered by KPNW is not included.

2. Based on system-level data KPNW is able to assess the child and family that relate to social risk factors. Data sources include program eligibility (Medicaid, Subsidized Exchange) and fields within the electronic medical record highlighting patient need (e.g. Translation) or results of parental/youth screening (Depression screening, Substance abuse screening).
Prioritize complex care management for children with medical and social complexity and/or

Use information to determine the best "match" team
• Support development of novel and generalizable approaches to identify, and design complex care management programs for children with health complexity.

  1) Facilitate KPNW on the development of a pediatric team-based care (TBC) program in order to summarize learnings related to: 1) use of KPNW-level medical and social complexity data to identify children with health complexity for TBC; and 2) tools for administering a pediatric TBC program.

  2) OPIP will facilitate OHA on novel methods for using state-level medical and social complexity data for identifying children with health complexity.

    – Facilitate OHA on how to share child-level data about health complexity with the CCOs it contracts with for publicly insured children, in order to inform their pediatric complex care management programs.

    – Share child-level data about health complexity with the CCOs it contracts with for publicly insured children, in order to inform their pediatric complex care management programs.

  3) OPIP will facilitate conversations with CCOs around how to use the OHA data for identifying children with health complexity, and around care management methods, tools, and strategies from KP that can be applied. Regional variations used by CCOs, given differing internal resources, community resources, and patient demographics, will be examined.

• Informed by these efforts, OPIP will develop summary briefs distilling the generalizable models gathered for: 1) Health Systems and 2) Medicaid agencies. Interactive webinars, utilizing flipped classroom methodologies, will then be conducted.
Figure 2.0: Overview of System-Level Data used to Identify Children with Medical and Social Complexity, with the goal of Classifying Children with Health Complexity Who Would Benefit from Complex Care Management and Novel Data Sharing to CCOs/Health Systems

**Children with Medical Complexity**

Children Identified & Classifications Used:
A Medical Complexity Score will be used, which incorporates utilization, diagnosis, and number of body systems impacted. The three categories of complexity are:
1. Children with Complex Chronic Disease
2. Children with Non-Complex Chronic Disease
3. Children without Chronic Disease

Standardized Scoring & Reporting Method:
Pediatric Medical Complexity Algorithm (PMCA)

Data Source: Based on Oregon Health Authority (OHA) medical claims related to utilization and diagnosis. Examines all claims for publicly insured children, across all providers, in the last three years, regardless of lapse in insurance or changes to the CCO to which the child is assigned.

**Children with Social Complexity**

Children Identified & Classifications Used:
A Social Complexity Score (indicating the number of social complexity risk factors identified) will be created based on "a set of co-occurring individual, family, or community characteristics that have a direct impact on health outcomes or an indirect impact by affecting a child's access to care and/or a family's ability to engage in recommended medical and mental health treatments.*

Standardized Scoring & Reporting Method:
None currently exists. This project supports development of a scoring algorithm.

Data Source: Integrated Client Services (ICS) Data Warehouse for the child and their parents. Data across the Oregon Department of Human Services (DHS) and OHA client-based services. Includes data from the following DHS Programs: Aging and People with Disabilities, Child Welfare, Developmentally Disabled, Self-Sufficiency, Vocational Rehabilitation. Includes data from the following OHA Programs: Alcohol and Drug (AD), Contraceptive Care (C-Care), Family Health Insurance Assistance Program (FHIAF), Healthy Kids Connect (HKC), Medical Assistance Programs (MAP), Mental Health (MH), Women Infants Children (WIC). Includes data from the following external agencies: Department of Corrections (DOC), Oregon Housing and Community Services.

**Data Sharing Through Project:**

For children assigned to the CCO/KPNW, child-level PMCA classifications (see three categories above).

Periodicity:
Data are currently being run, and sharing to CCOs is expected within 2017. It is currently expected that there will be annual sharing of this information.

**Children with Health Complexity**

Children Identified & Classification Used:
A Health Complexity Score will be created that combines the Medical Complexity Score and Social Complexity Score. This project supports the facilitation of conversations across public and private stakeholders about the scoring algorithms that will be used and the final classification to be made for each child.

Standardized Scoring & Reporting Method:
None currently exists. This project supports these data being combined for the first time.

Data Source:
Medical Complexity & Social Complexity Information at a child level for children insured by Medicaid.

**Data Sharing Through Project:**

For children assigned to their CCO/KPNW, Health Complexity Score.

Periodicity:
To be determined through the project's facilitated discussions. Goal is to implement data sharing by Fall 2018.

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* Social Complexity as defined by The Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN)
Opportunities to Provide Input if LPCHF Proposal is Funded

• Engaging public and private stakeholders on data sharing
  – Let Colleen Reuland know if you would like to be engaged (reulandc@ohsu.edu)

• Engagement of Your CCO
  – A key part of the discussion with CCOs will be on how they may use and share this data with the primary care practices the child is attributed
  – We can share on future calls the CCOs that are engaged, and you can let us know if you are interested in conversations on the use of the data
National Improvement Partnership Network Application for COINN on Children with Medical Complexity

• Health Care Delivery System Innovations for Children with Medical Complexity
• Five-year grant, starting September. Funding announcement expected late August
• Purpose:
  – Children with medical complexity (CMC), a subgroup of children and youth with special health care needs (CYSHCN), have generally been characterized as “children with substantial family-identified needs, characteristic chronic and severe conditions, functional limitations, and high health care use” (Cohen et al. Pediatrics 2011).
  – The purpose of this initiative is to develop and implement innovative care and payment models for such children and youth, using a Collaborative Improvement and Innovation Network (CoIIN) approach.
  – Through collaborative learning, a CoIIN made up of teams of families of CMC, pediatric primary and specialty care clinicians, leaders of integrated health care delivery systems and/or freestanding children’s hospitals, state Title V CYSHCN and Medicaid leaders, and other relevant stakeholders from participating states will work together to test strategies and build evidence for optimizing high quality, cost-effective, family-centered care for CMC.
• OPIP and Oregon are included as one of the ten states
  – Supports Learning Collaborative of ten practices focused on CMC
  – Let Colleen Reuland (reulandc@ohsu.edu) know if you are interested
Figure 1: Overview of **System-Level** and **Primary Care-Level** Methods Within KPNW to Identify Children with Health Complexity and Assign Pediatric Team-Based Complex Care Management Resources

**System-Level KPNW Data** Used to Identify Children with **Health Complexity** for Team-Based Care (TBC) Complex Care Management

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**System-level Flags**

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EDIE/PreManage Overview

Susan Kirchoff RN, MBA
Oregon Health Leadership Council

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EDIE in Oregon

2013

• OHLC Evidence Based Best Practice Committee identified ED utilization as a major focus area

• Identified the Emergency Department Information Exchange (EDIE) as a promising approach based on the success in Washington State

• OHLC formed a voluntary partnership with the Oregon Health Authority (OHA), the Oregon Association of Hospitals (OAHHS), and the Oregon Chapter of the American College of Emergency Physicians (OCEP)
What is EDIE?

- Real-Time ED Information Exchange
- Notifies on High Utilizer/Complex Needs Patients
- Proactive, Concise, Actionable Data at Point of Care
- Push Technology - Notices/Alerts Within Care Provider Workflow
  - Anticipates provider needs (no need to look up a patient)
- Can include patient specific care recommendation
Why EDIE?

• Identify high utilization patients that present to ED
• Provide ED’s with critical information in real time to improve care outcomes
• Identify patients at risk for hospital readmission
• Reduce burdensome duplication of tests
• Reduce reliance on costly ED’s through better coordination of care
EDIE—Success to Date

All 59 hospitals are receiving EDIE notifications including ED and inpatient activity

• ED physicians report significant value in knowing all patient utilization—particularly when accompanied by a care recommendation

• ED physicians also report information provided enables them to reduce unnecessary testing and reconnect patients to their primary care home

• Legislation passed which will permit Prescription Drug Monitoring Program information to be incorporated into EDIE notifications to support efforts in reduction of opioid prescribing in the ED (Q2 2017)
What is PreManage?

• Complementary product for health plans, clinics, group practices, etc.
• Expands real-time notifications to health plans and providers etc. to better manage their members and coordinate care
• If a patient triggers a pre-set rule, which can be dynamically determined or based on rules developed by health plan or provider or based upon static rules defined by the health plan, PreManage notifies the health plan
• Notifications available: ED Visits, Inpatient Admission, Discharge & Transfers (ADT), and DC Summaries
# Notifications in PreManage

## Notification Criteria for US Health Plan

<table>
<thead>
<tr>
<th>Name</th>
<th>Met</th>
<th>Inception</th>
<th>Destinations</th>
<th>Description</th>
<th>Criteria Filters</th>
</tr>
</thead>
</table>
| 0/15 Readmission              | 5x  | 07/01/2013      | • Social Worker SMS  
• MedLink Case Manager  
• WA DOH (Foster Case)  
• Child Welfare Case Worker | • Triggered on an Inpatient encounter type  
• Patient has been encountered at 2 different facilities in 15 days to any participating facility | Deceased                  |
| 2 In-Patient Visits in 90 Days| 5x  | 07/01/2013      | • EPIC EMR                                        | • Triggered on a Inpatient encounter type  
• Only tally encounters of type Inpatient  
• Has had 2 encounters in 3 month(s) | Dx Name  
Dx Coded  
Event                  |
| 3 ED Visits in 12 Months      | 68x | 07/01/2013      | • EPIC EMR                                        | • Patient has had 3 encounters in 365 days | Group  
Guidelines  
Insurance  
Patient  
Referral |
| Asthma                        | 40x | 07/01/2013      | • joyce@ushp.com                                  | • Patients age is less than 15 years old  
• Dx contains the phrase ‘Asthma’ | Facility Count  
Visit Count  
Visit to Facility |
| Behavioral Health             | 300x| 07/01/2013      | • Child Welfare Case Worker                       | • Triggered on a Behavioral encounter type | Visit Type  
WA PRC  
PDHP  
Age |
| Congestive Heart Failure      | 135x| 07/01/2013      | • USHP Care Manager                               | • Patient has a referral at US Health Plan  
• Dx contains the phrase ‘Congestive Heart’ | Zip Code  
Destination Filters |
| Dental Visits                 | 50x | 07/01/2013      | • EPIC EMR                                        | • Dx contains the phrase ‘RE:RX:- (Tooth | teeth | dent | *’  
• When a New Diagnosis event is triggered | Destination Filters  
Dr. Jones Fax  
Dr. Jones Printer  
(Disabled)  
EPIC EMR  
MedCenter  
Malone Case Manager  
Paging System  
Social Worker SMS  
USHP Case Manager  
WA DOH (Foster Care)  
Joyce@ushp.com  
maternity@ushp.com |
| Diabetes Trigger              | 35x | 07/01/2013      | • Dr. Jones Fax                                   | • The dx is coded as one of the following:  
• Drug or chemical induced diabetes mellitus with hyperosmolality with coma  
• Type 1 diabetes mellitus with unspecified complications  
• Other specified diabetes mellitus with foot ulcers  
• Other specified diabetes mellitus with other diabetic kidney complications  
• Unspecified diabetes mellitus in pregnancy, childbirth and the puerperium  
• More... | |
| Guidelines Have Been Added    | 25x | 07/01/2013      | • Social Worker SMS  
• Paging System                                   | • Has care guidelines in the Mental & Behavioral category | USHP Care Manager  
USHP Case Manager  
WA DOH (Foster Care)  
Joyce@ushp.com  
maternity@ushp.com |
| In-patient Geriatric Admit with Pneumonia | 6x  | 07/01/2013      | • MedCenter                                       | • Triggered on an Inpatient encounter type  
• Patients age is greater than 70 years old  
• Dx contains the phrase ‘Pneumonia’ | |

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## PreManage Onboarding - Health Plans/CCO’s

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<th>CCOs Live</th>
<th>In Process</th>
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</thead>
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<tr>
<td>• Kaiser Permanente NW</td>
<td>• FamilyCare</td>
<td>• Umpqua Health Alliance</td>
</tr>
<tr>
<td>• Humana</td>
<td>• PacificSource Central OR</td>
<td>• AllCare</td>
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<td>• PacificSource</td>
<td>• PacificSource Gorge</td>
<td>• Cascade Health Alliance</td>
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<td>• Regence-Cambia</td>
<td>• Yamhill CCO</td>
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<td>• Providence Health Plan</td>
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<td>• Moda Health</td>
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# PreManage Onboarding - Providers

## Clinics (sample)
- Providence Medical Group
- Legacy Medical Group *(by May 2017)*
- Silverton Health
- NW Primary Care
- Tuality Clinics
- Portland Clinic
- St. Charles Family Care
- Santiam Medical Group
- Pacific Medical Group

## FQHCs:
- Mosaic Medical
- Virginia Garcia
- Central City Concern
- Outside In
- Wallace
- One Community Health

## Behavioral Health & Specialty
- GOBHI
- Options Counseling (Salem area)
- Cascadia Behavioral Health
- Lifeworks NW
- Morrison Child & Family Services
- Western Psychological
- ACT Teams

### Community Paramedicine:
- Mercy Flights
- Tri-County 911

### Specialty:
- Compass Oncology
- Hematology Oncology of Salem *(Spring)*

### Long-Term Care:
- OHA AAA/APD Pilot (6 sites) now live
State coordinated efforts

• OHA is leveraging enhanced federal match (75/25) to fund a (voluntary) PreManage subscription for the Medicaid program

• Current subscription runs through July 31, 2018

• Subscription covers:
  • CCOs, including behavioral health and dental partners
  • Fee-for-service contractor (KEPRO)
  • Assertive Community Treatment (ACT) teams
  • Other OHA/DHS Care Managers, current pilot for long-term care (e.g., APD, AAA offices)
Community Collaboration

Regional Adoption of PreManage

- Create shared goals and areas of focus across CCO’s, Health Plans, Hospitals, Primary Care and other provider organizations in a specific community
- Clarify roles and responsibilities to reduce duplication and increase cross organizational care coordination
- Develop agreements on standard workflows across the community

Communities of Practice

- Opportunities for specific user groups (e.g. Behavioral Health, Dental) to share best practices, develop workflows and align efforts
EDIE/PreManage—Success to Date

• EDIE widely viewed by ED providers as a very useful tool
• Commercial health plans and CCO’s are finding the notifications very helpful to their internal care management processes as well as coordination with their provider network
• Behavioral health adoption has spread rapidly and the information is being utilized to manage ED and IP transitions in care
• Community adoption is accelerating cross organizational care coordination for high risk high utilizing individuals
Current Priorities

Decrease ED visits for high utilizing patients

- Increase use of care recommendations
- Expand cross organizational care coordination

Enhance dissemination of information and resources to support improvement efforts

- Analyze and distribute aggregated data reports
- Increase sharing of EDIE/PreManage best practices and workflows

Leverage use of EDIE/PreManage Technology to support healthcare transformation

- Integrate PDMP/EDIE notifications
- Expand cross organizational care coordination for mental health transitions in care
OHLC EDIE/PreManage Learning Community

• **Information Sharing**
  Broad dissemination of technical tips, events calendar, training resources and educational materials

• **Collaboration**
  Promote community-driven conversations regarding adoption, implementation and standard use of EDIE and PreManage

• **Networking**
  Statewide peer to peer communication and sharing of ideas and workflows across use cases

*To join the Learning Community contact:*
[ali@orhealththleadershipcouncil.org](mailto:ali@orhealththleadershipcouncil.org)
Agenda for Today’s Call


• Area #1: Children with Health Complexity; Guest Spotlighting Opportunities Related to EDIE/PreManage

• Area #2: Developmental Screening- You’ve now screened, what to do next for children identified at-risk

Part 2: Update on Key Policy-Level Activities

• Multi-payer Learning Collaborative (SB 231)
• SB 934
• Health Plan Quality Metrics Committee (SB 440)
OPIP Efforts: Community-Based Pathways From Developmental Screening to Services

- OPIP has been working in three communities on a project focused on the full pathway from a child being identified at-risk on developmental screening to receiving services
  - Marion, Polk, and Yamhill Counties

- Two sources of funding
  1) Oregon Health Authority – Transformation Center and Overlap in CCO & Early Learning Hub goals (*ended December ‘16*)
  2) Willamette Education Service District (WESD)
    - WESD received funds to improve referral to EI and follow-up processes focused on young children. Includes a specific focus on EI Ineligible children (*ends June ‘17*)
    - OPIP a subcontractor

- Currently exploring funding to spread this work to other communities

Do not copy or reproduce without proper OPIP citation.
OPIP Efforts: Community-Based Pathways From Developmental Screening to Services

• Resources:

  – OPIP Website
    • [http://www.oregon-pip.org/focus/FollowUpDS.html](http://www.oregon-pip.org/focus/FollowUpDS.html)
    • Will be updated and enhanced when Yamhill Final Report is able to be publicly shared and when the WESD contracts end this summer

  – Webinar for the Patient Centered Primary Care Institute
    • On call today I will highlight a few key new approaches
Opportunity to NOW Focus on Follow-Up to Developmental Screening that is the Best Match for the Child & Family

• Goals of screening:
  – Identify children at-risk for developmental, social, or behavioral delays
  – For those children identified, provide 1) developmental promotion, and 2) refer to services that can further evaluate and address delays
    • Many of these services live outside of traditional health care

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.

Do not copy or reproduce without proper OPIP citation.
Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening.

If follow-up to developmental screening is occurring, shouldn’t the slope of the lines be similar?

Number of Children 0-3yrs Screened (According to 96110) in WVCH

- **2013 vs. 2015:** Total Improvement: 79% (N=2440 Children)

Number of Children Found Eligible To Receive EI Services in Marion & Polk Counties

- **2013 vs. 2015:** Total Improvement: 10% (N=26 Children)
  - Marion: 10% (N=21)
  - Polk: 11% (N=5)

Do not copy or reproduce without proper OPIP citation.
In Marion & Polk Counties during this time period, 747 referrals were made to WESD. If just this practice were to refer ALL identified children, the total referrals to WESD could have been about 44% higher - or about 1072
For Those Children Identified “At-Risk” and Referred to Early Intervention Services, Improvement Opportunities Exist

• Within pilot primary care practices, a majority of children identified “at-risk” had no documented follow-up
  – 60-70% of those identified “at-risk” were not referred to Early Intervention (Bright Futures Pathway)

• Of children identified as “at-risk” that were referred to Early Intervention (n=915):
  – 562 (61%) children were able to be evaluated.
    • Reasons for the 39% of referrals not being evaluated:
      Parental delay (18.6%), an inability to contact the family (16.8%), and the family declining the evaluation (2.4%).
  – Of the children able to be evaluated (n=562), 347 (62%) children were found to be eligible for services, meaning 38% were ineligible for services.

Do not copy or reproduce without proper OPIP citation.
Qualitative Findings Related to Follow-Up to Developmental Screening for Young Children

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

• **Need for parent supports**
  – Developmental promotion that could in occur in the home
  – Education about referrals when provided
  – Parent support in navigation
Priority Areas Identified for WHERE to Focus Improvement Pilots in Primary Care

1. For primary care practices conducting developmental screening, enhance follow-up for children identified
   - 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

2. Pilots of referrals from primary care to home visiting programs, parenting classes, and other supports

Do not copy or reproduce without proper OPIP citation.
Part 1: Primary Care Providers Need a Follow-Up Medical Decision Tree To Identify Best Match for the Child/Family and is Anchored to Services in the Community

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

1. Medical and Therapy Services (developmental evaluation and therapy services)
2. Early Intervention (EI)
3. CaCoon/Babies First
4. Centralized Home Visiting Referral (Includes Early Head Start and Head Start)
5. Parenting Classes
6. Mental Health
Example Follow-Up Medical Decision Tree for a Practice in Marion and Polk County

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

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

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

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

**GROUP D**
- **In Black on Social Emotional Domain**
  - Provide:
    1. Providing ASQ Learning Activities for SE Domain
    2. Information on Vroom
  - Refer to Internal Behavioral Health Staff for further assessment and support

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

**Resource #1**
- **Child has a Medical Dx or Medical Risk Factors** (ex: parent with inadequate knowledge/supports, alcohol/substance abuse, or mental illness; teen parent)
- **AND**
- Social Risk Factors
  - *CaCoon/Babies First*
  - Use CaCoon Program Referral Form

**Resource #2**
- Family Risk Factors Present or Exposure to Adverse Childhood Events & would benefit from Home Visiting and/or Head Start
- **Publicly Insured**
  - **YES**
  - Child Lives in Marion/Polk 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.earlylearninghub.org
  - Email: parentinghub@earlylearninghub.org

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

**GROUP D**
- **In Black on Social Emotional Domain**
  - Behavior/Impulsivity with significant functional impact (e.g. expelled from child care)

  **And/or**
  - Exposure to Adverse Childhood Events (ACES) in Family Environment
  - If YES:
    - **Privately Insured**
      - **Child Lives in Marion County**
      - Refer to Marion County Child. Blv. Health for PCIT
    - **Child Lives in Polk County**
      - Options Counseling North, Valley Mental Health, Salem Psychiatry
    - **Options Counseling North-Child, Manzanita Children’s Behavioral Health, Mid Valley BCN, Valley Mental Health, Inter-Cultural Ctr for Psychology, Polk Mental Health-Child, Legacy Silverton Health**
    - **Child Lives in Marion/Polk County**
      - **Option Counseling North-Child, Manzanita Children’s Behavioral Health, Mid Valley BCN, Valley Mental Health, Inter-Cultural Ctr for Psychology, Polk Mental Health-Child, Legacy Silverton Health**

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Developed and Distributed by the Oregon Pediatric Improvement Partnership for Childhood Health
**Left Side:**
- Anchored to ASQ Scores
- Developmental promotion that should happen that day
- When and who to refer to **Early Intervention (EI)**
- When and who to refer to a **Developmental Pediatrician** for evaluation
- When and who to refer to **Mental Health**

**Right Side:**
- Anchored to Child and Family Factors and Potential Needs
- Referral to early learning services to support child and family: **Babies First!/CaCoon**, Home Visiting, Parenting Classes
Developmental Promotion: Options to Provide to All Children Identified at Risk

Vroom!

ASQ Learning Activities for the specific domains

**Fine Motor**

Activities to Help Your Toddler Grow and Learn

- **Flipping Pancakes**
  - Trim the corners from a simple sponge to form a “pancake.” Give your child a small frying pan and a spatula. Show him how to flip the pancake.

- **Macaron String**
  - String a necklace out of dried pasta with big holes. Tube-shaped pasta, such as rigatoni, works really well. Your child can paint the pasta before or after stringing it. Make sure she has a string with a stiff tip, such as a shoelace. You can also tape the ends of a piece of yarn so that it is easy to string.

- **Homemade Orange Juice**
  - Make orange juice or lemonade with your toddler. Have him help squeeze the fruit using a handheld juicer. Show him how to twist the fruit back and forth to get the juice out. To make lemonade, you will need to add some sugar and water. Let him help you stir it all up. Cheers!

- **Draw What I Draw**
  - Have your child copy a line that you draw, up and down and side to side. Take a turn. Then your child takes a turn. Try zigzag patterns and spirals. Use a crayon and paper, a stick in the sand, markers on newspaper, or your fingers on a steamy bathroom mirror.

- **Bathtime Fun**
  - At bath time, let your toddler play with things to squeeze, such as a sponge, a washcloth, or a squeeze toy. Squeezing really helps strengthen the muscles in her hands and fingers. Plus it makes bath time more fun!

- **My Favorite Things**
  - Your child can make a book about all of his favorite things. Clip or staple a few pieces of paper together for him. He can choose his favorite color. Let him show you what pictures to cut from magazines. He may even try cutting all by himself. Glue pictures on the pages. Your child can use markers or crayons to decorate pages. Stickers can be fun, too. You can write down what he says about each page. Let him “write” his own name. It may only be a mark, but it’s a start!

- **Sorting**
  - Find an egg carton or muffin pan. Put some common objects such as nuts, shells, or cotton balls into a plastic bowl. Let your toddler use a little spoon or tongs to pick up the objects and put them in different sections of the egg carton. Give her a little hug when she has success!
Referral Pathways by **TOTAL** Score Across Five Domains

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

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

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

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

- Consider Referral to [Developmental/Behavioral](#) Pediatrician
  (See DB Peds Referral Cheat Sheet)

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

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

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

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

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

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

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

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

---

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GROUP A

2 or More in the Black

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

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

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

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

Universal Referral Form
for Early Intervention/Early Childhood Special Education (EI/ECSE) Providers

CHILD/PARENT CONTACT INFORMATION

Child’s Name: __________________________ Date of Birth: ______/____/_____
Parent/Guardian Name: __________________________ Relationship to the Child: __________
Address: __________________________________ City: __________ State: ______ Zip: ______
County: __________ Primary Phone: __________ Secondary Phone: __________ Email: __________

Primary Language: __________________________ Interpreter Needed: □ Yes □ No

Type of Insurance:
□ Private □ CHIP/Medicaid □ TRICARE/Other Military Ins. □ Other (Specify) __________
□ No Insurance

Children’s Doctor’s Name, Location And Phone If Known:

PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)

Consent for release of medical and educational information

I, __________________________________________ (print name of parent or guardian), give permission for my child’s health provider
__________________________________________ (print provider’s name), to share any and all pertinent information regarding my
child, __________________________________________ (child’s name), with Early Intervention/Early Childhood Special Education
(EI/ECSE) services. I also give permission for EI/ECSE to share developmental and educational information regarding my
child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: __________________________ Date: ______/____/_____

Your consent is effective for a period of one year from the date of your signature on this release.

Concise for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

□ Speech/Language __________ □ Gross Motor __________ □ Fine Motor __________
□ Adaptive/Self-Help __________ □ Hearing __________ □ Vision __________
□ Cognitive/Problem Solving __________ □ Social-Emotional or Behavior __________ □ Other: __________
□ Clinician: concerns but not screened __________ □ Family is aware of reason for referral.

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

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

□ Family contacted on ______/____/______ The child was evaluated on ______/____/______ and was found to be:

□ Eligible for services □ Not eligible for services at this time, referred to:

□ EI/ECSE County Contact/Phone: __________________________ Notes:

EI/ECSE County Contact/Phone: __________________________ Attachments as requested:

□ Unable to contact parent □ Unable to complete evaluation □ EI/ECSE will close referral on ______/____/______

* The EI/ECSE Referral Form may be duplicated and downloaded at: http://www.ohsu.edu/kdf/outreach/loccshn/programs-projects/dev-screening-and-referrals.cfm

* The EI/ECSE Referral Form may be duplicated and downloaded at: http://www.ohsu.edu/about/ohsu-biohov/programs-projects/who-are-we-screening-referrals.cfm

Form Rev: 10/9/2013

Do not copy or reproduce without proper OPAP citation.
Pilot of EI Communication When Unable to Evaluate:
Goal is to Reduce the 2 in 5 Children Referred by Not Evaluated

Feedback to Referring Provider
• When they sent the “closure” letter
• If they referred to FamilyLink

Completed Example:

Do not copy or reproduce without proper OPIP citation.
New Pilot Feedback Form from EI on Summary of Services (Instead of Evaluation Summary and IFSP)

Willamette Education Service District
Marion Center • 2611 Pringle Rd, Salem, OR 97302 • Phone 503.385.4675 • Fax 503.540.4473
Yamhill Center • 2045 SW Hwy 18, McMinnville, OR 97128 • Phone 503.435.5900 • Fax 503.435.5920

---

**Early Intervention Referral Feedback**

Child's Name: ___________________________ Birthdate: ________

Your patient, ________, was found eligible for Early Intervention services on: 11/02/16

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

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

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

A new Individual Family Service Plan (IFSP) was developed for ________ on 11/16/16. These services will be reviewed again no later than 05/15/17.

**IFSP Services**

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

<table>
<thead>
<tr>
<th>Services Provided by:</th>
<th>Frequency</th>
<th>Current Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Early Intervention Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Occupational Therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Physical Therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☑ Speech Language Pathologist</td>
<td>1x/2 weeks; 45 minutes</td>
<td>Marie Sellke</td>
</tr>
<tr>
<td>☑ Other</td>
<td>1x/month; 45 minutes</td>
<td>Ann Stevenson- hearing services</td>
</tr>
</tbody>
</table>

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

• The ASQ domains which put the child “at-risk” matter in terms of whether you should refer to Developmental Behavioral Pediatrician

• After consultation with experts in the field, the children most likely to be delayed in getting a medical evaluation and/or will not receive robust enough services from EI to address their needs:
  1. Intellectual disability
  2. Autism

• Flags for these under-identified children are
  – Delays in communication (always one of the factors)
  And
  – Delays in problem solving or social emotional
Consider Referral to Developmental Behavioral Pediatrician

- Kid “In the BLACK” in the Communication domain AND either the Personal-Social domain or Problem Solving Domain
- Or if the child is in the Black on 2 or more other domains and has any of the following presenting concerns:
  - Kids with overall DD (or intellectual disability) or ASD who do not have identified cause (may be seen initially by genetics instead)
  - Kids who are not progressing in services as expected or recent increase in symptoms
  - Kids who have challenging behaviors with inadequate response to behavioral interventions or medication.
  - Kids with secondary medical issues that are not responding to usual treatments (including feeding and nutrition)
  - Kids with rare/unusual genetic/chromosomal disorders (after initial visit with medical genetics)
  - Kids with other chronic conditions that require inter-disciplinary team management (eg, child with CP, TBI etc)
  - Kids who may be experiencing traumatic events

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**GROUP B**

"At-Risk":
1. In Black; OR
2. 2 or more in Grey
And could benefit from EI

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

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

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

**GROUP C**

‘Monitoring’:
2. or more Grey or 1 in Black But Not Ready to Refer to EI

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

- Re-Screen in 3-6 Months, Set up a Follow-Up if Child Does Not Have A Visit
Referral Pathways Based on Score to Just Social-Emotional Domain

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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

Privately Insured
- Child Lives in Marion County
- Child Lives in Polk County

Publicly Insured
- Child Lives in Marion/Polk County

Options Counseling North, Valley Mental Health, Salem Psychiatry

Options Counseling North-Child, Marion County Children’s Behavioral Health, Mid Valley BCN, Valley Mental Health, Inter-Cultural Ctr for Psychology, Polk Mental Health - Child, Legacy Silverton Health

Behav. Health for PCIT
• Right Side of Medical Decision Tree

• For ALL children identified at-risk, consideration of three community-level resources
### Child and Family Factors Listed on the Back of the Decision Tree: Tied to Eligibility and Priority Criterion Within This Community

<table>
<thead>
<tr>
<th>Child Factors: Based on PCP Gestalt</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of Prenatal Care</td>
</tr>
<tr>
<td>• Support with Breastfeeding</td>
</tr>
<tr>
<td>• Support with Infant Care</td>
</tr>
<tr>
<td>• Drug-Exposed Infant/Pregnancy</td>
</tr>
<tr>
<td>• Support with Attachment/Bonding</td>
</tr>
<tr>
<td>• Has Disability</td>
</tr>
<tr>
<td>• Born Premature</td>
</tr>
<tr>
<td>• Home Environment Concerns</td>
</tr>
<tr>
<td>• Development Concerns</td>
</tr>
<tr>
<td>• Social/Emotional Concerns</td>
</tr>
<tr>
<td>• Behavior Concerns</td>
</tr>
<tr>
<td>• Feeding Concerns</td>
</tr>
<tr>
<td>• Health Concerns</td>
</tr>
<tr>
<td>• Weight Concerns</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Factors: Based on PCP Gestalt</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feels Depressed or Overwhelmed</td>
</tr>
<tr>
<td>• Isolation/Lack of Support</td>
</tr>
<tr>
<td>• Support with Parenting</td>
</tr>
<tr>
<td>• Has Disability</td>
</tr>
<tr>
<td>• Teen/Young Parent</td>
</tr>
<tr>
<td>• First Time Parent</td>
</tr>
<tr>
<td>• Tobacco Use</td>
</tr>
<tr>
<td>• Domestic Violence (present or history of)</td>
</tr>
<tr>
<td>• Alcohol/Drug Use</td>
</tr>
<tr>
<td>• Lack of Food/Clothing/Housing</td>
</tr>
<tr>
<td>• Incarceration/Probation</td>
</tr>
<tr>
<td>• Low Income</td>
</tr>
<tr>
<td>• Migrant/Seasonal Worker</td>
</tr>
<tr>
<td>• Unemployed</td>
</tr>
<tr>
<td>• Homeless</td>
</tr>
<tr>
<td>• Receives TANF/SSI/SNAP</td>
</tr>
</tbody>
</table>

*Domain Scores*
Part 2: Care Coordination Supports to the Family

Informed by parent advisors, developed tools and processes to better support families

1. Information Sheet (developed through this project). Providers ended up using this to ensure shared decision making on referrals

2. Phone Follow-up (developed through this project)
Follow-Up to Screening: How We Can Support Your Child

Why did we have you complete a questionnaire about your child's development?

Our goal is to help young brains and bodies develop and grow to their fullest potential. These support services can help prepare your child for kindergarten and beyond. National recommendations call for specific tools to be used to assess a child’s development, such as the one you completed. This tool helps identify kids who may be at risk for delays. It is important to identify these delays early, as there are services that can address them.

Based on the results, we are referring your child to the services checked below:

- Early Intervention (El)
  El helps babies and toddlers with their development. In your area, Willamette Education Service District (WESD) runs the El program. El focuses on helping young children learn skills. El services enhance language, social and physical development through play-based interventions and parent coaching. There is no charge (it is free) for services for El.
  What to expect if your child was referred to El:
  - 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 (503) 885-2714.
  - The results from the assessment will be used to determine whether or not El can provide services for your child.
  Contact Information:
  WESD Intake Coordinator
  503-585-4714 | www.wesd.org

- Family Link
  Family Link connects familes with early childhood family support programs in Marion and Polk Counties. There is no charge (it is free) to families for Family Link services.
  What to expect if your child was referred to Family Link:
  The Family Link Referral Coordinator will call you to learn more about your child and family. They will work with you to find available services that best meet your needs, and link you to them based on eligibility.
  Contact Information:
  Inette Dillman, Referral Coordinator
  503-990-7411 x122
  familylink@familybuildingblock.org

- CaCoon
  CaCoon is a public health nursing program serving families. CaCoon public health nurses work with your family to support your child’s health and development. A CaCoon nurse will meet with you in your home, or wherever works best for you and your child. There is no charge (it is free) to families for CaCoon services.
  Contact Information:
  Judy Creave, Program Supervisor
  503-951-7655
  www.ohsu.edu/ed/reachout/coreys/m/programs/projects/cacoon.cfm

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

Why did you sign a consent form?

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

Any Questions?

At Childhood Health Associates 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) 364-3176

Pilot

Education Sheet for Parents To Explain Referrals

Available for download
(FollowUp to Screening_Ed Mat.pdf)

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Phone Follow-Up: Developed this because 39% of Referred children NOT able to be Evaluated

- 2 in 5 children referred to EI don’t get evaluated
- Some studies show that families make a decision on a referral in the first 48 hours
- Researchers in Illinois found that phone follow-up (not necessarily contact) within two days of the referral significantly increased follow-through
- Phone calls can also identify barriers to obtaining the evaluation
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 may have may have 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).
Preliminary Findings from Pilot Sites

1) Enhanced collaboration and coordination across Primary Care, Early Intervention, and Early Learning

2) Tools and resources have been effective in a more family-centered approach and referrals to services
   - Filled a need for specific and community-based information about WHICH kids to refer and HOW
   - More children referred to EI → More children not eligible for EI
     • A significant number of children identified on ASQ will be evaluated and not eligible for Early Intervention
     • Difference between ASQ criterion and EI eligibility criterion
     • Need to enhance referral decisions
   - Examining population identification rates and capacity of the systems to which they refer
     • Home visiting
     • Mental health services specific to early childhood mental health

3) Disparity in services available to privately insured or children/families that don’t meet the priority criterion for home visiting
Agenda for Today’s Call


• Area #1: Children with Health Complexity; Guest Spotlighting Opportunities Related to EDIE/PreManage

• Area #2: Developmental Screening- You’ve now screened, what to do next for children identified at-risk

Part 2: Update on Key Policy-Level Activities

• Multi-payer Learning Collaborative (SB 231)

• SB 934

• Health Plan Quality Metrics Committee (SB 440)
Multi-Payer Learning Collaborative (SB 231): Primary Care Transformation Initiative

SB231 Multi-Payer Learning Collaborative

- [http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx](http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx)

- Aims to ensure that sufficient resources are allocated to Oregon’s primary care system - was enacted by the 2015 legislature.

- Requires commercial insurers and Coordinated Care Organizations (CCOs) to report the **percentage of their total medical expenditures that are directed to primary care**.

**Learning Collaborative**

- OHA is required to convene a learning collaborative with the purpose of sharing best practices on primary care alternative payment methodologies and initiative alignment.

- Report to OHPB

- Met monthly - Began March 2016 and ended December 2016

- Restarted again in March 2017
  - SB 934 would extend this group through **2023**.
Primary Care Payment Reform SB 231: Recommendations Endorsed by OHPB

- [http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx](http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx)

- Document: “SB231_PCPRC_Draft-OHPB_Recommendations_110416_final”
  - Under the 11/7/16 Meeting Materials

- Title on Top of Document: Recommendations to the Oregon Health Policy Board

- November 4, 2016
  1. Collaborative Governance
  2. Technical Assistance
  3. Measurement: Recommendations for the SB 440 Process
  4. Data Aggregation
  5. Primary Care Behavioral Health Integration
  6. Payment Model Recommendation

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SB 934

• Focused on enhanced payment to primary care

• Status:
  – Proposes: Beyer, Knopp, Kruse, Monnes Anderson, Steiner Hayward
  – Status: The bill passed the Senate on 5/2, and is now in the House (first reading, referred to the House Speaker’s desk on 5/3; Referred to Health Care on 5/4)

• Summary:
  – [Link](https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureAnalysisDocument/37558)
  – Requires coordinated care organizations (CCOs), commercial insurers, Public Employees’ Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB), by January 1, 2023, to spend at least 12% of premiums on primary care.
  – Requires insurers that spend less than 12% of their premiums on primary care to develop a plan to increase spending on primary care by at least 1% each year.
  – Requires CCOs and commercial insurers that participate in a federal primary care program to offer similar payment methodologies to all state-recognized patient-centered primary care homes that serve covered enrollees.
  – Grants Oregon Health Authority (OHA) and Department of Consumer and Business Services rulemaking authority to implement provisions of the measure. Requires PEBB and OEBB to report annually to the Legislative Assembly on progress toward achieving the 12% rate.
    • Defines prominent carriers as insurers with an annual premium income of $50 million or more.
    – Authorizes OHA to convene a collaborative to advise and assist in the implementation of a Primary Care Transformation Initiative.
      • Requires collaborative to report annually to the Oregon Health Policy Board and Legislative Assembly on primary care spending targets and implementation of transformation initiative.
The Health Plan Quality Metrics Committee was established by Senate Bill 440 (2015).

Purpose of the group is to identify health outcome and quality measures that may be applied to services provided by coordinated care organizations or paid for by health benefit plans sold though the health insurance exchange or offered by the Oregon Educators Benefit Board or the Public Employees’ Benefit Board.

The committee will be the single body to align health outcome and quality measures used in Oregon to ensure that the measures and requirements are coordinated, evidence-based, and focused on a long term statewide vision.
Health Plan Quality Metrics Committee
Roster (April 2017)

Maggie Bennington-Davis, MD
Health Share of Oregon

Kristen Dillon, MD
PacificSource Community Sol.

Benjamin LeBlanc, MD
Providence Health and Services

Lynnea Lindsey, PhD
Psychologist

Jeff Luck, PhD
Oregon State University

Melinda Muller, MD
Legacy Health

Raj Mummad, MD
Kaiser Permanente

Ana Quiñones, PhD
OHSU-PSU School of Public Health

Bhavesh Rajani, MD
Yamhill Community Care

Colleen Reuland
Oregon Pediatric Improvement Project

Hannah Rosenau
Oregon Foundation for Reproductive Health

Leslie Clement
Oregon Health Authority

Berri Leslie
Department of Consumer and Business Services

Shaun Parkman
Public Employee Benefits Board

Tom Syltebo, MD
Oregon Educators Benefits Board
We appreciate you taking the time to join us today.

Next Call is October 17, 2017 @ 7-8:30 am

Thank You!

Oregon Pediatric Improvement Partnership

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