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

Tillamook Stakeholder Meeting 10/4/17

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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
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

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). 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

Early Learning

Coordinated Care Organizations & Primary Care

Early Intervention

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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

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
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 (Tillamook: December 6th)
  – 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
  3. Opportunities
  4. Barriers
  5. Capacity within the region

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## Stakeholder Engagement in Tillamook 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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</thead>
<tbody>
<tr>
<td>• Mimi Haley (Executive Director)</td>
<td>• TCCHC</td>
<td>• Nancy Ford</td>
<td>• Dorothy Spence (Hub Director)</td>
<td>• Community Action Team: Head Start</td>
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<td>• Safina Koreishi (Medical Director)</td>
<td>• TCCHC</td>
<td>• Tina Meier-Nowell (Special Education Council Chair)</td>
<td>• Rob Saxton</td>
<td>– Joyce Ervin</td>
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<td>• Elicia Miller (Clinical Integration Manager)</td>
<td>• Adventist</td>
<td>• Vicki Schroeder (EI Data, NWRESD)</td>
<td>• Elena Barreto (Community Navigator)</td>
<td>• CARE; Healthy Families Home Visiting</td>
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<td>• Maranda Varsik (Practice QI)</td>
<td>• Adventist</td>
<td>• EI/ECSE Program Coordinator</td>
<td>• Eva Manderson (Preschool Promise Manager/CCR&amp;R&amp;Director)</td>
<td>– Erin Skaar</td>
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<td>• Joell Archibald (Innovator Agent)</td>
<td>• Interdisciplinary teams that include health care:</td>
<td>• El Referral Intake Coordinator</td>
<td>• Public Health/CaCoon/BabiesFirst</td>
<td>– Julie Lusby</td>
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<tr>
<td>• Nicole Jepeal (Metrics/QI Analytics Supervisor)</td>
<td>• Community Connections</td>
<td>• – Kim Lyon</td>
<td>– Colleen Schwindt</td>
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<tr>
<td>• Jeanne McCarty &amp; Leslie Ford (GOBHI)</td>
<td>• Mental Health</td>
<td>• – Misty Burris</td>
<td>– Stacey Lorette</td>
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<tr>
<td>• Staff that oversee services for children</td>
<td>• Tillamook County Family Counseling</td>
<td>• – Mary Anderson</td>
<td>– Amy Youngflesh</td>
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<td></td>
<td>• Interdisciplinary teams that include health care:</td>
<td>• – Frank Hanna Williams</td>
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<td>• – Sheila Zerngast</td>
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<td>• • TCCHC</td>
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### Mental Health
- Tillamook County Family Counseling
  - Frank Hanna Williams
  - Sheila Zerngast
  - Robyn Herrick

### Home Visiting & Head Start/Early Head Start
- Community Action Team: Head Start
  - Joyce Ervin

### Child Care and Parenting Supports
- CCR&R
  - Tara Mestrich
- Childcare Centers conducting screening
  - Preschool Promise & SPARK 3 Star & above
  - Amanda Cavitt (Tillamook Early Learning Center)
- NW Parenting
  - DeAnna Pearl
  - Jill VanSant
- DHS
  - Amy Youngflesh
Community Asset Mapping and Pathway Identification in Marion and Polk Counties

**KEY STEPS**

1. **Part 1:** Children Identified At-Risk via Developmental Screening
   - Some Primary Care Practices (Pediatric & Family Medicine): Recommended: All Children in Practices
   - ASQ Screening Database (MPELH, WVCH)
   - Community-Based Providers: E.g., Early Head Start, Head Start, Home Visiting Programs, Public Health
   - Child Care Programs ASQ Online (Outside Scope of Project)

2. **Part 2:** Referral of Child Identified At-Risk
   - WESD - Early Intervention (EI)
   - EL Evaluation
   - EL Eligible
   - EL Ineligible
   - EI Feedback Form Based Evaluation
   - Common Referral Form
   - EI Ineligibility Report
   - Direct Referrals to Programs in Family Link
   - Pilot PIP Sites Only: Not Sites within Pathways Project, but could be opportunity for this project

3. **Part 3:** Referred Agency Ability to Contact Referred At-Risk Child/Family
   - Medical Services (DB Peds) Therapy Services (OT, PT, Speech)
   - EI Evaluation
   - EI Eligible
   - EI Ineligible
   - Receiving Services
   - For Children Referred to EI/CBP
   - CoCron/ BabiesFirst Healthy Families (Polk and Yamhill)
   - Salem/Keizer Head Start
   - Family Building Blocks-Marion and Polk
   - Oregon Child Development Coalition-Marion and Polk
   - Community Action Head Start of Marion and Polk
   - Additional Community-Based Services within Marion and Polk Addressing Children/Families Identified at Risk

4. **Part 4:** Children Evaluated and Deemed Eligible/Ineligible for Referred Service
   - Secondary Medical & Therapy Services to help ensure robustness of services
   - Covered by Public Insurance (WVCH)
   - Covered by Private Insurance
   - Self-Pay for Services
   - Mental Health Services
   - Private Ins.
   - Options Counseling North, Valley Mental Health, Salem Psychiatry (List may not be complete, currently obtaining information about services)
   - Public Ins.
   - Providers within BCN Network, Use SIM Referral
   - Options Counseling North, Children’s Behavioral Health, Mark Valley BCN, Yellow Mental Health, Inter-Cultural Ctr for Psychology, Polk Mental Health - Child, Legacy Shattering Health
**Health Care**
Follow-up within Sites That Could be Enhanced:
-- Developmental Promotion
-- Retest Child
-- If internal services

1) Tillamook County Community Health Center (Pilot Site)
   -- Internal behavioral health
2) Adventist Health
3) The Rinehart Clinic

**Referrals**
- Adventist Health – OT/PT
- OHSU, Providence – Developmental Behavioral Pediatrician

**EI & Education**
- Tillamook EI/ECSE Program

**Home Visiting & Head Start/Early Head Start**
- Community Action Team-Tillamook Head Start Center (If eligible, older age group)
- Maternity Case Management (If mom already seen, communication about child)
- CARE Inc.-Healthy Families
- CaCoon/Babies First (If child has med dx)

**Mental and Behavioral Health**
- Tillamook County Community Health Center Internal Behaviorist
- Tillamook Family Counseling Center
- Shasta Counseling Services (Does not take insurance, out of pocket only)

**Child Care and Parenting Supports**
- Tillamook Early Learning Center
- NW Parenting (2-3 classes per year)
- Lower Columbia Hispanic Council (2-3 classes per year)
- Tillamook Family Counseling Center

**Other Potential Resources**
- Community Connections-Tillamook (interdisciplinary team MAY be able to help with best match services)
- Library System – Stories Hours and Parent Groups for Moderately Delayed Kids

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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

   Medical Services

   Early Intervention

2. Other Factors Considered as Part of Pilot
   - Provider Concern
   - Medical Risk Factors
   - Adverse Childhood Events (ACEs)

   Mental Health

   CaCoon/Babies First
   Centralized Home Visiting
   Parenting Classes

   • Social Risk Factors
   • Family Income
   • County of Residence

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# Tillamook County Community Asset Mapping - 10/3/17

## Preliminary List Based Interviews

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

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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 are getting screened
  - Variation in the follow-up that happens in the PCP sites and by provider within sites
  - Importance to consider now how to spread follow-up methods from TCCHC to other sites

- **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
PRELIMINARY Emerging Themes – Gut Check from Community

• Potential Lack of Capacity & Funding for Existing Services to Serve this 0-3 Population, Especially those moderately delays
  – EI
  – Home Visiting
  – Mental Health

• Potential lack of resources to support families
  – Number of parenting classes and supports
  – Mental health providers, PCIT that families will access

• Hesitancy/Push Back on Referrals Based on Complex Factors
  – Developmental and behavioral pediatrician in Portland
    • Complex process
    • Intense process
  – 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 to 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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<tr>
<th>DATA ELEMENTS:</th>
<th>DATA SOURCES:</th>
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<tbody>
<tr>
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<td>CCO Data Based on Claims</td>
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<tr>
<td>Developmental Screening</td>
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<td>Of those screened in Primary Care:</td>
<td></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></td>
</tr>
<tr>
<td>Outcome of referral (i.e. Were they able to contact and evaluate?)</td>
<td></td>
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<tr>
<td>Outcome of evaluation/assessment (i.e. Did child get a service?)</td>
<td></td>
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<tr>
<td>Follow-up steps of ineligible</td>
<td></td>
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</tbody>
</table>

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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 to Consider an Early Childhood Health Dashboard

• 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

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

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

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

Follow-Up Based on Total Score Across Domains:

**GROUP A**
- 2 or More in the Black
  - Developmental Promotion:
    1. ASQ Learning Activities for Specific Domains Identified At-Risk
    2. Information on Vroom
  - Refer to Early Intervention For An Evaluation
  - Consider Referral to Developmental/Behavioral Pediatrician
  - Consider Supplementing Medical and Therapy Services Under Insurance Coverage, Medical & Therapy Services (See One-Page Summary of WVCH Providers and Coverage)

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

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

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

**GROUP D**
- In Black on Social Emotional Domain
  - Provide: 1) Providing ASQ Learning Activities for SE Domain
  - Behavior/Impulsivity with significant functional impact (e.g., expelled from Child Care)

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)
- 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
- Family Link Include Info on EI Referral
- Mid-Valley Parenting www.midvalleyparenting.org
  - Email: parentresources@co.polk.or.us
- Mariner & Polk Early Learning Hub www.carlylearninghub.org
  - Email: parenthub@earlylearninghub.org

**Resource #3**
- Support developmental promotion by addressing issues such as literacy/reading, parenting skills, food insecurity
- Could benefit from parenting classes?
- Refer to Marion County Child. Behav. Health for PCT
  - Options Counseling North, Valley Mental Health, Salem Psychiatry
  - Options Counseling North-Child, Marion County Children’s Behavioral Health, Mid Valley SCD, Valley Mental Health, Inter-Cultural Qr for Psychology, Polk Mental Health -Child, Legacy Shilohers Health
Developmental Promotion

ASQ Learning Activities for the Specific Domains

Fine Motor
Activities to Help Your Toddler Grow and Learn

Your toddler’s eyes and hands are working together well. He enjoys taking apart and putting together small things. He loves using any kind of writing or drawing tool. Provide scrap paper, washable markers, or markers. You can also try puzzles, blocks, and other safe small toys. Talk and enjoy the time together. When writing or drawing, set up clear rules. “You draw only on the paper, and only on the table. I will help you remember.”

- **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.
- **Macaroni String**: String a necklace out of dried peas 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 shoehorn. You can also tape the ends of a piece of yarn so that it is easy to string.
- **Homemade Orange Juice**: Make orange juice with your toddler! Have him help squeeze the fruit using a handheld juicer. Show him how to use the fruit juice 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. You take a turn. Then your child takes a turn. Try drawing patterns and spirals. Use a crayon and paper, a block in the sand, markers on newspaper, or your fingers on a soapy 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 your hands and fingers.
- **My Favorite Things**: Your child can make a book of 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. Stickering can be fun, too. You can write what he says about each page, and let him “write” his own name. It may only be a mark, but that’s a start!
- **Sorting Objects**: 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 succeeded.

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.

Vroom!

Brain Building Basics
5 things to remember for building your child’s brain

1. **Look**
   - Make eye contact so you and your child are looking at each other.

2. **Chat**
   - Talk about the things you see, hear and do together and explain what’s happening around you.

3. **Follow**
   - Take your child’s lead by responding to their sounds and actions, even before they are old enough to talk. When they do start talking, ask follow-up questions like, “What do you think?” or “Why did you like that?”

4. **Stretch**
   - Make each moment longer by building upon what your child does and says.

5. **Take Turns**
   - With sounds, words, faces and actions, go back and forth to create a conversation or a game.

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Phone Follow Up within 36 Hours

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

At your appointment, Dr. XX recommended that your child go to (Insert EI program Name 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.
  - EI focuses on helping young children learn skills. EI services enhance language, social and physical development through play-based interventions and parent coaching.
  - There is no charge (it is free) to families for EI services.

- **Family Link**
  - Family Link connects families with early childhood family support programs in Marion and Polk Counties. There is no charge (it is free) to families for Family Link services.
  - What to expect if your child was referred to Family Link:
    - The Family Link Referral Coordinator will call you to learn more about your child and family. They will work with you to find available services that best meet your needs, and link you to them.
  - Contact Information:
    - WESD Intake Coordinator
      - Phone number: (503) 355-4714
    - The results from their assessments will be used to determine whether or not EI can provide services for your child.

- **Medical/Therapy Services**
  - Your child’s health care provider referred you to the following:
    - Speech Language Pathologist: Specializes in speech, voice, and swallowing disorders
    - Audiologist: Specializes in hearing and balance concerns
    - Occupational Therapist: Specializes in performance activities necessary for daily life
    - Physical Therapist: Specializes in range of movement and physical coordination

- **Developmental-Behavioral**
  - Pediatrician: Specializes in child development areas including learning delays, leading problems, behavior changes, delayed development in speech, motor, or cognitive skills

- **Child Behavioral Health**
  - Services: Specializes in mental health assessments, individual/family/group counseling, skills training and crisis intervention

- **Autism Specialist**: Specializes in providing a diagnosis and treatment plan for children with symptoms of Autism

**Parenting Support**

- Classes located in Marion County
  - Phone number: (503) 623-9664
  - Website: mikawalearning.org

- Classes located in Polk County
  - Phone number: (503) 723-9664
  - Website: mikawalearning.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) 334-3170

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# 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**  
2/14/2017

<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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupational Therapy Services</strong></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 Yes, Mighty Oaks Therapy Center (Albany) Yes, PT Northwest No, Salem Hospital Rehab Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Physical Therapy Services</strong></td>
<td>Yes</td>
<td>Authorization required for therapy visits beyond the initial evaluation/re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.</td>
<td>Capitol PT No, Keizer PT No, Pinnacle PT No, ProMotion PT No, PT Northwest No, Salem Hospital Rehab Yes, Therapeutic Associates No, Creating Pathways No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Speech Therapy Services</strong></td>
<td>Yes</td>
<td>Authorization required for therapy visits beyond the initial evaluation/re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.</td>
<td>Chatterboks Yes, Creating Pathways Yes, Mighty Oaks Therapy Center (Albany) Yes, PT Northwest No, Salem Hospital Rehab Yes, Sensible Speech Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Pediatric Psychological Testing Services</strong></td>
<td>Yes</td>
<td>Authorization required</td>
<td>Valley Mental Health Yes - 18 months and up, Willamette Family Medical Center Yes - 18 months and up, Intercultural Psychology Services Yes - 18 months and up</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td></td>
<td>Enrolled in services</td>
<td>Marion County Child Behavioral Health Yes, Polk County Mental Health Yes, Inter-Cultural Center for Psychology Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Bilineural provider*
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

<table>
<thead>
<tr>
<th>Child/PARENT CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong> _____________________</td>
</tr>
<tr>
<td><strong>Date of Birth:</strong> <strong>/</strong>/____</td>
</tr>
<tr>
<td><strong>Parent/Guardian Name:</strong> ______</td>
</tr>
<tr>
<td><strong>Relationship to the Child:</strong></td>
</tr>
<tr>
<td><strong>Address:</strong> __________________</td>
</tr>
<tr>
<td><strong>City:</strong> ___________</td>
</tr>
<tr>
<td><strong>State:</strong> ___________</td>
</tr>
<tr>
<td><strong>County:</strong> ___________</td>
</tr>
<tr>
<td><strong>Primary Phone:</strong> _____________</td>
</tr>
<tr>
<td><strong>Secondary Phone:</strong> ___________</td>
</tr>
<tr>
<td><strong>E-mail:</strong> ___________________</td>
</tr>
<tr>
<td><strong>Primary Language:</strong> __________</td>
</tr>
<tr>
<td><strong>Interpreter Needed:</strong> _____</td>
</tr>
<tr>
<td><strong>Type of Insurance:</strong> ( ) Private ( ) OHP/Medicare ( ) TRICARE/Other Military Ins. ( ) Other ( ) No insurance</td>
</tr>
<tr>
<td><strong>Child’s Doctor’s Name, Location And Phone (if known):</strong> __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent for release of medical and educational information</td>
</tr>
<tr>
<td>I, ________, (print name of parent or guardian), give permission for my child’s health provider</td>
</tr>
<tr>
<td>(print provider’s name), to share any and all pertinent information regarding my child</td>
</tr>
<tr>
<td>(print child’s name), with Early Intervention/Early Childhood Special Education (E/ECSE) services. I also give permission for E/ECSE to share developmental and educational information regarding my child with the health provider who referred my child to ensure they are informed of the results of the evaluation.</td>
</tr>
<tr>
<td><strong>Parent/Guardian Signature:</strong> ___________________</td>
</tr>
<tr>
<td><strong>Date:</strong> <strong>/</strong>/____</td>
</tr>
</tbody>
</table>

**OFFICE USE ONLY BELOW:**

**Reason for Referral to E/ECSE Services**
Provider: Complete all that applies. Please attach completed screening tool.

**Concerning area:** ( ) ASD ( ) ASQ:SE ( ) PEDI ( ) PEDI-DM ( ) MCHAT ( ) Other

**Concerns 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 Development
- Social/Emotional Behavior
- Other

**Clearance concerns but not present:**

**Family is aware of reason for referral:**

**Provider Signature:** ___________________  |
| **Date:** __/__/____ |

**Provider Information and Request for Referral Results**

**Name and title of provider making referral:** ___________________  |
| **Office Phone:** ______ |
| **Office Fax:** ______ |
| **Address:** ___________________  |
| **City:** ___________            |
| **State:** ___________           |
| **Zip:** ___________             |

**Prior to the child’s Primary Care Physician (PCP) ? y N**

**E/ECSE Services:**

- Please complete this portion, attach requested information, and return to the referral source above.

- **Family contacted:** /___/____ The child was evaluated on /___/____ and was found to be:

- **Eligible for services** /___/____
- **Not eligible for services at this time** /___/____

**E/ECSE County Contact:** Phone: ___________________  |
| **Notes:** ___________________  |
| **Attachments as requested above:** ___________________  |

The E/ECSE Referral Form may be duplicated and downloaded at: [http://www.oregon.gov/ohs/services/ehd/programs/project/early-intervention-and-referrals.cfm](http://www.oregon.gov/ohs/services/ehd/programs/project/early-intervention-and-referrals.cfm)
| Form Rev: 10/2/2013 |
Leveraging the Early Intervention Universal Referral Form to Communicate Whether Children Referred But NOT Evaluated

**Completed Example:**

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:</td>
</tr>
<tr>
<td>Notes:</td>
</tr>
<tr>
<td>Attachments as requested above:</td>
</tr>
<tr>
<td>□ Unable to contact parent □ Unable to complete evaluation EI/ECSE will close referral on <em><strong><strong>/</strong></strong></em>/____</td>
</tr>
</tbody>
</table>


Form Rev. 10/22/2013

OCT 11 2016

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

Early Intervention Referral Feedback

Child's Name ___________________________________________ Birthdate: __________

Your patron 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: 2/18/17: Eligible for Hearing Impairment.

An Individual Family Service Plan (IFSP) was developed for her on 11/18/16. These services will be reviewed again no later than 03/18/17.

IFSP Services

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

Services Provided by:

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

Frequency Current Provider

1x2 weeks; 45 minutes Marie Selke
1x/month; 45 minutes Ann Stevenson - hearing services

This form is submitted annually and any time there is a change in services. Please contact Marie 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) 354-4415
Next Steps

• Baseline Quantitative Data
  – Collect
  – Sensemake of the data relative to the project
  – Summarize for the 12/6 Tillamook Meeting

• Complete Stakeholder Interviews
  – Finish remaining interviews
  – Summarize themes for 12/6 Tillamook Meeting relative to:
    • Strengths
    • Opportunities for pilots
    • Special populations of consideration
    • Barrier to consider now

• Onboard work with the pilot primary care site (TCCHC)
• December 6th Stakeholder Meeting
Quarterly Tillamook Stakeholder Meetings: Getting Your Insight and Input on Timing

• Proposal is to align with Great Beginnings regular meetings (if works for primary care partners)

• First quarterly stakeholder meeting would be **12/6/2017**

  – Question for group – **Would you like to use the full meeting time of Great Beginnings or use the last half of the meeting & schedule an additional hour after Great Beginnings?**

  • Option 1: 12/6/17, 2-4PM (Using full meeting time of Great Beginnings)

  • Option 2: 12/6/17, 3-5PM (Only use 1 hr of Great Beginnings and add additional hour after)
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