Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk for Developmental, Behavioral and Social Delays Receive Best Match Services

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Presentation to the State Advisory Council for Special Education

Colleen Reuland, MS Director – Oregon Pediatric Improvement Partnership
Dorothy Spence, Director – Northwest Early Learning Hubs
Ensuring Follow-up to Developmental Screening: Community-Based Approaches With Primary Care, Early Intervention, and Early Learning
Agenda

• Part 1: Setting the Landscape for the Community-Based Improvement Effort
• Part 2: Data Identifying Where Children Fall out of Pathways, Community Asset Mapping, Improvement Priorities

Community-Based Improvement Effort
• Part 3: Improving Follow-Up in Primary Care
• Part 4: Improving Follow-Up in Early Intervention
• Part 5: Improving Follow-Up to Home Visiting & Parenting Education
Setting the Landscape for the Community-Based Improvement Project: Fertile Ground in Oregon for an Effort Focused on Early Childhood
Transformation within Health Care in Oregon that Created a Fertile Landscape for This Project

1. Development of Coordinated Care Organizations
   – Incentive Metrics

2. Focus on Patient-Centered Primary Care Homes (PCPCH)
Coordinated Care Model

• Coordinated Care Organizations (CCOs)
  o Network of all types of health care providers (physical health care, addictions, mental health care, dental care) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).
  o 16 CCOs operating in communities around Oregon
  o 93% of children in Oregon Health Plan are enrolled in a CCO

• Key Levers within Coordinated Care Model
  o Global budget
  o Performance Improvement Projects
  o **Performance Metrics – Incentive Metrics**
2017 Incentive Metrics

1. Adolescent well-care visits
2. Ambulatory care: Emergency department utilization
3. CAHPS Composite: Access to care
4. CAHPS Composite: Satisfaction with care
5. Childhood immunization status
6. Colorectal cancer screening
7. Controlling high blood pressure
8. Dental sealants on permanent molars for children
9. Depression screening and follow-up plan
10. Developmental screening in the first 36 months of life
11. Diabetes: HbA1c Poor Control
12. Effective contraceptive use among women at risk of unintended pregnancy
13. EHR Adoption
14. Follow-up after hospitalization for mental illness
15. Mental, physical and dental health assessments within 60 days for children in DHS Custody
16. Patient Centered Primary Care Home (PCPHC) Enrollment
17. Prenatal and postpartum care: Timeliness of prenatal care
Oregon’s Patient-Centered Primary Care Home (PCPCH) Program

- State-specific definition and accreditation
  - General definition, not specific to certain populations
  - Scoring used to identify practices within “Tiers”, with Tier 5 being the highest
    - 11 “must-pass” criteria that every clinic must meet in order to be recognized
      - Developmental screening is included in a global “Must Pass Measure”
        - Measure: 3.C.0 - PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site and local referral resources
  - Other criteria worth varying amounts of points. Harder concepts = Higher # of points
  - Total points determines clinic’s overall tier on the PCPCH recognition.
- Incentives related to PCPCH
  - CCOs get incentive monies based on number of members who go to a PCPCH
    - High variability within CCO on use of PCPCH tiers for alternative payment reform to clinics
  - Some incentive to privately insured OHA members who go to a PCPCH, reduction in copays

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Transformation within Early Learning in Oregon

Within *Early Learning*:

• Development of Early Learning Division
• Development of Early Learning Hubs
• High Quality Child Care
• In 2011, legislature established the Oregon Education Investment Board (OEIB) and Early Learning Council (ELC).
• Established 16 Early Learning Hubs to bring together Human Services, Health, Early Learning, K-12 Education and Business Sectors.
• First Hub started in 2014.
• Collective Impact philosophy.

1. Children arrive more ready for kindergarten
2. Families are stable and attached
3. Services are coordinated and aligned
What is an Early Learning Hub?

• Early Learning Hubs support underserved children and families in their region to learn and thrive by making resources and supports more available, more accessible and more effective.

• Hub functions:
  1. **Identify the populations** of children most at-risk of arriving at kindergarten unprepared for school.
  2. **Identify the needs** of these children and their families.
  3. **Work across sectors** to connect children and families to services and support that will meet their needs.
  4. **Account for outcomes** collectively across the system.

• Hubs are not direct providers of services.

• Currently there are 16 Hubs across the Oregon - not necessarily aligned with regions of the CCOs.
Marion & Polk Early Learning Hub

Connection with Coordinated Care Organization:

- Connecting clinics with early learning system work:
- Developmental Screening work – desire to share Ages & Stages Questionnaires with Medical providers
- Reach Out and Read
- Parent Education
- Immunization book project
Yamhill CCO & Early Learning Hub

- Yamhill CCO received contract for ELH in May 2014
- Two Early Learning Council members (including the ELC founding chair) sit on CCO Board
- CCO goal = better care for more people at a lower cost
- Shared strategy
  - Prevent Adverse Childhood Experiences (ACEs)
  - Address social determinants of health
  - Invest in upstream prevention/early intervention
Opportunity to NOW Focus on Follow-Up to Developmental Screening that is the Best Match for the Child & Family

• Oregon one of the highest states for developmental screening.

Goals of screening:
– Identify children **at-risk** for developmental, social and/or behavioral delays
– For those children identified, **provide developmental promotion, refer to services** that can further evaluate and address delays

• Follow-up services live within a variety of settings. For example:
  Health Care

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**Children Identified “At-Risk” on Developmental Screening**
are identified “at-risk” for developmental, behavioral or social delays on standardized developmental screening tools. In the communities of focus for this work, a majority of providers are using the Ages and Stages Questionnaire (ASQ)³. Therefore the children of focus are those identified “at-risk” for delays based on the ASQ domain level findings.
From Developmental Screening to Services: Opportunity to Connect the Fantastic Individual Silos in Oregon

Coordinated Care Organizations (Including Primary Care)

Early Learning

Early Intervention

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Key Components of Community-Based Improvement Efforts

1. Community-level Stakeholder **Engagement** Across Seven Sectors & with Parent Advisors:
   - **Understand** current pathways,
   - **Identify** existing **community assets**
   - **Prioritize** **where** to focus pilots of improved follow-up

2. **Pilots to improve** the number of children who receive follow-up and coordination of care.

*Key partners in implementing these pilots within each of those silos:*
A. Primary Care Practices
B. Early Intervention
C. Early Learning
Spotlight on Two OPIP Projects

http://oregon-pip.org/focus/FollowUpDS.html

1. **Oregon Health Authority** contracted with OPIP to provide consulting and technical assistance to **Yamhill Early Learning Hub** and **Yamhill CCO** on a community pilot focused on ensuring children identified at-risk for developmental, behavioral, and social delays receive follow-up services. (January-December ‘16)
   • *Supported by Funding Opportunity Number CMS-1G1-12-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services*

2. **Willamette Education Service District** contracted with OPIP to lead efforts in Marion, Polk and Yamhill County (May ‘16-June ‘17)
   • In 2015 the Oregon Legislature directed Oregon Department of Education (ODE) to identify pathways from developmental screening to appropriate early learning services
Three Communities, Two CCOs, Two Early Learning Hubs and One Early Intervention Contractor

Three Communities: Marion, Polk and Yamhill Counties

Coordinated Care Organizations:
1) Willamette Valley Community Health
2) Yamhill Coordinated Care Organizations

Early Intervention Contractor
Serving All 3 Counties:
Willamette Education Service District

Early Learning Hubs
1) Marion and Polk Early Learning Hub
2) Yamhill Early Learning Hub

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Stakeholders Engaged in Community-Based Efforts

1. Identified over 60 stakeholders across the 3 communities that had a role in a) conducting developmental screening and/or b) providing follow-up to developmental screening
   - Engaged people across seven sectors

2. Parent advisors
   - Recruited four parent advisors whose children had experienced an early learning system(s)
   - Engaged the Early Learning Hub parent advisory group
Stakeholder Engagement in Marion, Polk, and Yamhill Counties to Inform Community Asset Mapping

1) CCOs (WVCH, YCCO)
- Medical Director
- Metrics Staff
- Practice Support Staff
- Mental Health Director
- Staff that oversee services for children
- Liaison to Early Learning Hubs
- OHA Innovator Agent

2) Primary Care
- Practices that see large number of children and are doing developmental screening
- Practice staff engaged included:
  - Physician
  - Care Coordinator
  - Referral Coordinator
  - Practice Manager

3) EI & Education
- EI/ECSE Program Coordinator
- EI Referral Intake Coordinator
- School District Representative

4) Early Learning Hub (Yamhill Early Learning Hub, Marion and Polk Early Learning Hub)
- Director or Executive Director
- Community Engagement Staff
- Staff involved in efforts around developmental screening

5) Home Visiting and Head Start/Early Head Start
- Centralized home visiting referral programs
- Public Health/ CaCoon/BabiesFirst
- Healthy Families
- Other community services that provide home visiting
- Early Head Start and Head Start

6) Child Care and Parenting Supports
- Childcare Resource and Referral Center
- Childcare Centers conducting screening
- Oregon Parenting Education Collaborative entities

7) Infant and Early Childhood Mental Health
- Clinic director
- Staff who conduct child and parent psychotherapy
- If available, Parent and Child Interaction Therapy
Stakeholders We Have Here Today

Let’s learn about who we have here to today to help us tailor the rest of the session

**Raise Your Hand If You Are From:**

1. Health system
2. Primary care
3. Early Intervention
4. Early learning – which for now will include Home Visiting, Early Head Start, Head Start
5. Childcare
6. Infant and early childhood mental health
7. Parent advocate
8. What group did we miss?
Momentum Around Follow-Up to Developmental Screening:
What Levers Do You Have In Your Own State?

In Oregon, these levers create fertile ground:

**Within Health Care:**
- CCO Incentive Metric – Developmental Screening
- Oregon PCPCH Standards

**Within Early Learning:**
- Early Learning Hub Metrics
  - 1st wave included CCO Developmental Screening Incentive Metric
- High quality child care – part of highest level designation

**Self Reflection:**
- What levers do you have your own state to focus on follow-up to developmental screening?
- Did your state Title V Agency pick Developmental Screening as a priority area?

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Stakeholders Important to Engage in Your Communities

• Self Reflection – As you focus on follow-up to developmental screening, who are the stakeholders across the seven sectors that you will engage?

1. Health System
2. Primary Care
3. Early Intervention
4. Early Learning – which for now will include Home Visiting, Early Head Start, Head Start
5. Childcare
6. Infant and early childhood mental health
7. Parent advocate
8. What group did we miss?
Agenda

• Part 1: Setting the Landscape for the Community-Based Improvement Project. Overview of Improvement Strategies Developed

• Part 2: Data Identifying Where Children Fall out of Pathways from Screening to Services, Community Asset Mapping, Improvement Priorities

Community-Based Improvement Effort

• Part 3: Improving Follow-Up in Primary Care
• Part 4: Improving Follow-Up in Early Intervention
• Part 5: Improving Follow-Up in Home Visiting & Parenting Education Supports
Qualitative & Quantitative Data Gathered to Inform Priority Pathways to Focus Community-Based Improvement Efforts

- Baseline **qualitative and quantitative** data collected in order to:
  1. **Understand the current pathways** from developmental screening to services in each of the three counties, and the community-level assets and resources that exist to support follow-up services.
  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 **group-level meetings** to share the baseline qualitative and quantitative findings:
  1. To **understand current pathways**
  2. **Confirm priority areas** to pilot improvements
Key Building Blocks of the Pathways for Developmental Screening, Referral and Follow-Up

Part 1: Developmental Screening

Part 2: Referral of Child Identified At-Risk

Part 3: Referred Agency Ability to Contact Referred At-Risk Child/Family

Part 4: Number of Children Evaluated and Deemed Eligible for Referred Service

Part 5: Secondary Processes (Referrals and Follow-Ups) for Ineligible Children

Part 6: Communication and Coordination Across Services

Children that don’t make it to next part of the process
Qualitative Data: Stakeholder Interviews

- Interviewed people from organizations that either:
  - Conduct developmental screening and are responsible for follow-up AND/OR
  - Provide follow-up for children 0-3 identified on developmental screening
- Purpose of Interview
  1. Current follow-up process
     - When refer
     - How refer – what form, how tracked
     - Feedback loops – child able to be contacted, eligible, services received
  2. Current services to inform the Asset Map, which may include places where assets are needed but not yet present
  3. Opportunities
  4. Barriers
  5. Capacity within the region
Community Asset Mapping and Pathway Identification in Marion and Polk Counties

Pathway for Developmental Screening & Referral and Triage Pathways for Children Identified At-Risk in Marion and Polk County

Some Primary Care Practices (Pediatric & Family Medicine): Recommended: All Children in Practices

ASQ Screening Database (MPELIH, WCH)

Community-Based Providers: E.g. Early Head Start, Head Start, Home Visiting Programs, Public Health

Child Care Programs ASQ Online (Outside Scope of Project)

WESD - Early Intervention (EI)

Medical Services (DB Peds)
Therapy Services (OT, PT, Speech)

EI Eligible
EI Ineligible
Receiving Services

For Children Referred to EI/CBP

Some Primary Care Practices

EI Feedback Form Based Evaluation

Common Referral Form

Pilot PCP Sites Only - Not Sites within Pathways Project, but could be an opportunity for this project

Direct Referrals to Programs in Family Link

Family Link (Early Learning & Family Support Network)

Receiving Service
Waistlisted for services
Unable to serve child's family, or services were refused

Community Action Head Start of Marion and Polk

Additional Community-Based Services within Marion and Polk Addressing Children/Families Identified at Risk

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 South, 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 South, Children's Health Center, Children's Behavioral Health, Salem Valley AHC, Valley Mental Health, Inter-Cultural (Do Not Psychology, Polk Mental Health-Child, Legacy Silvana Health)

TYPE OF ARROW:
- Method and/or tool has been developed, exists, but is not standardized or improvements in process could be made
- Communication
- Referral to Early Intervention (EI) services
- Referral to Early Learning and Family Support Referral Form
- Referral to Community-Based Agencies
- Referral to Medical or Therapy Services
- Communication mechanism not able to be contacted, not eligible, or not served.

COLOR OF ARROW:
- Communication
- Referral to Early Intervention (EI) services
- Referral to Community-Based Agencies
- Referral to Medical or Therapy Services
- Communication mechanism not able to be contacted, not eligible, or not served.

TYPE OF BOX:
- Existing group, site, organization, or function
- Groups of different services
Key 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 who are referred will not be eligible impacts if and when they refer
- 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 or HOW to refer to them
- Parent push-back on referrals, cultural variations

Early Intervention
- Value in communication back to referring provider
- Value in understanding who is eligible and what services receiving to inform secondary follow-up
- Follow-up steps for ineligible children

Need for Parent Supports
- Developmental promotion that could in occur in the home when referral not available
- Education about referrals when provided, parent support in navigation
Parent Advisor Input

#1: Need for Better Communication and Supports → What does a Positive Developmental Screening Mean?
- Need printed and verbal information
- Information should include: Why screening was done, what the screening results mean, what they can expect moving forward, who they can call if they have questions
- Who will be calling them and why
- For EI, explanation that you are being referred for further evaluation → not for services
- How the information will be shared across the different providers
- Materials need to take into account different social contexts

#2 Multiple providers and multiple entities can be overwhelming and scary
- Understand the value and importance of each team
- That said, it can make a parent feel overwhelmed and scared about the “seriousness”

#3: Home visitors are extremely helpful in translating the different services and providing support
- Understand that some parents don’t allow someone to come to the home
- Value of co-location at their PCP or partnership with Head Start

#4: Better communication between multiple entities working with the same family is necessary and appreciated
- Burden is on the parent to update the multiple providers their child sees, can be overwhelming
Quantitative Data Collected to Inform Baseline & Evaluation Data

<table>
<thead>
<tr>
<th>Focus of Metrics</th>
<th>CCO Data Based on Claims (Health System for Publicly Insured)</th>
<th>Primary Care Practice Data: Based on EMR</th>
<th>Early Intervention Data: Based on Data in ECWeb, Manual Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Screening</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Of those screened in Primary Care:</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td># at-risk, Types of Risk</td>
<td></td>
<td></td>
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<tr>
<td>Referrals</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provision of other follow-up (i.e. rescreen, developmental promotion)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Outcome of referral</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>(i.e. Were they able to contact and evaluate?)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome of evaluation/ assessment</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>(i.e. Did child get a service?)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up steps of ineligible</td>
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<td>X</td>
</tr>
</tbody>
</table>

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Developmental Screening Rates in the First Three Years of Life for Publicly Insured Children in Willamette Valley Community Health (WVCH): As Tracked by 96110 Claims Submitted

Source: WVCH Developmental Screening Rates, Based on 96110 Claims Submitted for Children Continuously Enrolled for 12 Months
Variation in Developmental Screening Rates for Practices to Whom WVCH Children Are Attributed

Of the 50 practices WVCH contracts with, majority are NOT screening to fidelity of Bright Futures Recommendations: (86% of practices are below 50% of attributed children screened)

Source: Based on 96110 Claims Submitted for Children Continuously Enrolled for 12 Months and Who WVCH Attributed to the Practice

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Primary Care Practice Data

**Highlight of Findings:**

- Majority of children who come in were screened
  - Children who do not come in, not screened
  - Most likely for children 2-3 years old
- Across three practices, 19-28% of developmental screens conducted in the first three years of life identified a child at-risk for delays
- However, for those children identified at-risk for delays, referrals to EI ranged from 20-35%
An Applied Example from One of Our Primary Care Pilot Sites

Number of ALL Children in Clinic (Publicly and Privately Insured) **WHO RECEIVED A DEVELOPMENTAL SCREEN IN ONE YEAR:**
N=1431

- Number of children who were **identified at-risk and SHOULD HAVE BEEN TO REFERRED TO EI:**
  N=401

- **NUMBER REFERRED TO EI based on their developmental screen:**
  N=76

- **81% NOT REFERRED**

Of the children who received a developmental screen, **28% identified at-risk for delays for which developmental promotion should occur.**

Data Source: Data provided by Childhood Health Associates of Salem, Aug. & Jan 2017

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Baseline Data from Early Intervention Referral and Evaluation Outcomes

#1: Indication of Follow-Up to Developmental Screening
- Child find rates
- Numbers of referrals
- Number of referrals able to be contacted AND evaluated
- Outcome of referrals (Eligible, Ineligible)

#2: Data to Inform Processes for At-Risk, But EI Ineligible Children
- Evaluation outcome results by referral and child characteristics
Number of CHILDREN referred to Early Intervention

![Graph showing the number of children referred to Early Intervention from 2013 to 2015.]

- **Marion**
  - 2013: 93
  - 2014: 81
  - 2015: 101

- **Polk**
  - 2013: 141
  - 2014: 165
  - 2015: 151

- **Yamhill**
  - 2013: 581
  - 2014: 575
  - 2015: 607
2015 WESD EI Referral Outcomes in Marion, Polk, & Yamhill Counties

Percentage of Referrals
- Evaluated
- Parent Delay
- Not Able to Be Contacted
- No Parental Concerns
- Other Reason for No Evaluation

Marion, Polk & Yamhill Counties
- Total N=353 (39%)
- N=7 (1%)

Total: N=915
- 562 (61%)
- 170 (19%)
- 154 (17%)
- 22 (2%)
Outcomes of Evaluation For WESD Referrals from Physicians: Marion, Polk, and Yamhill Counties (2015)
Number of CHILDREN Receiving EI Services

![Chart showing the number of children receiving EI services from 2013 to 2015, with data points for Marion, Polk, and Yamhill counties. The chart indicates an increase in the number of children eligible for EI services across the years, with Marion county having the highest numbers.](chart.png)
The Punchline: Opportunity and Need to Focus on Follow-Up to Developmental Screening that is the Best Match for the Child & Family

While there are increases in screening, most children identified at-risk are not receiving follow-up aligned with recommendations

– Primary care providers are not referring children identified at-risk
  • 60-80% of children identified at-risk for delays on the ASQ not referred for EI Services

– Referral rates to EI have not increased at a rate that is proportional to screening rates

– Number of children served by EI has not increased in a way aligned with early identification through screening
  • 2 in 5 children referred by PCP to EI not ever able to be evaluated, no communication back to referring entity
  • Of those evaluated, 62% were found to be eligible for services, meaning 38% were ineligible for services (Rates lower for PCP-based referrals)
Community-Level Stakeholder Meetings to Confirm Priority Areas for Improvement Pilot

• Convened stakeholders who were interviewed for this project in a group-level meeting to review findings and confirm community-level priorities about areas of focus

  o Leveraged shared table and relationships created within Early Learning Hubs (Yamhill Early Learning Hub & Marion and Polk Early Learning Hub)

  o Meeting within regions that shared Early Learning Hub and Coordinated Care Organizations

    ✓ Marion and Polk
    ✓ Yamhill

  o Review the asset maps and prioritized which “boxes” to focus on and which “arrows” to focus on
Three Priorities Areas Identified for WHERE to Focus Improvement Pilots

1) **Enhance follow-up** processes for children identified at **primary care practices** conducting developmental screening
   - At a population-level, this is where the most “car seats” for children age 0-3 are parked

2) For **Early Intervention**:
   - Enhance coordination and communication with the entity that referred the child
   - Follow-up steps for EI ineligible

3) **Within** identified **early learning sites**, **pilots of referrals & connections**
   - Home visiting (Pilot of PCP to Centralized Home Visiting Referral)
   - Parenting classes (PCP Info about OPEC-supported

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Questions about Qualitative & Quantitative Data

• Questions about data presented?

• Do the findings resonate with what you are finding in your own communities?
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• Part 2: Data Identifying Where Children Fall out of Pathways, Community Asset Mapping

Community-Based Improvement Effort

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• Part 5: Improving Follow-Up with Home Visiting & Parenting Education Supports
Community-Based Improvement Opportunity: Improvement Efforts Implemented by Pilot Sites

**Primary Care Practices**
1) Develop follow-up medical decision tree anchored to:
   - A) ASQ scores,
   - B) Child and family factors,
   - C) Resources within the community
2) Parent education when referred to other services
3) CCO summary of follow-up services and providers who see children 0-3
4) Care coordination based on whether eligible for services and which services receiving

**Early Intervention**
1) Enhanced communication and coordination for children referred & not evaluated
2) Communication about evaluation results
   - For Ineligible Children: Referral to Early Learning supports
   - For Eligible Children: Communication about EI services being provided
3) Examination of EI Eligibility and Presenting ASQ Scores

**Early Learning**
1) Enhanced developmental promotion using tool supported by the HUB (e.g. VROOM, ACT Early, ASQ Learning Activities)
2) NEW referrals from PCP/EI to:
   - Centralized home visiting referral
   - Evidence based parenting classes
Community-Based Improvement Opportunity: Improvement Efforts Implemented by Pilot Sites

**Primary Care Practices**

1) Develop follow-up medical decision tree anchored to:
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2) Parent education when referred to other services
3) CCO summary of follow-up services and providers who see children 0-3
4) Care coordination based on whether eligible for services and which services receiving
Development of Decision Support Tools for Primary Care Providers to Identify Best Match Services in Community

• Based on data and community engagement, **six priority referrals** were identified and collaborative partnerships established.
• Created a medical decision tree for providers about WHICH kids to refer and WHERE:

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 Which Included Promotion FIRST and Then, Where Applicable, Referral

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

2. Other Factors Considered as Part of Pilot
   - Child Medical Factors
   - Adverse Childhood Events
   - Family Risk Factors

- Early Intervention
- DB PEDS
- Mental Health
- No Referral - Rest

- ASQ Screen- Child Identified At-Risk

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

CaCoon/Babies First
Centralized Home Visiting
Parenting Classes

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Pathways for Follow-Up to Developmental Screening for Children 0-3 in Marion and Polk County

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

KEY:
- ASQ Domain Scores
- Developmental Promotion
- Referral
- Child Factors
- Family Factors
- Family Income
- County
- Referral

Follow-Up Based on Total Score Across Domains:

**GROUP A**
- 2 or More in Black
- N = 111
- Developmental Promotions:
  1. ASQ Learning Activities for Specific Domains Identified at-Risk
  2. Information on Vaccination
  Refer to Early Intervention for an Evaluation

**GROUP B**
- "At-Risk": 1 in Black; OR 2 or more in Grey
- And could benefit from EI
- N = 299
- Developmental Promotions:
  1. ASQ Learning Activities for Specific Domains Identified at-Risk
  2. Information on Vaccination
  Refer to Early Intervention for an Evaluation

**GROUP C**
- "Watchful Waiting" Borderline: 2 or more Grey or 1 in Black but Not Ready to Refer to EI
- Re-Screen in 3-6 Months. Set up a Follow-Up if Child Does Not Move a Visit

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

**GROUP D**
- In Black on Social Emotional Domain

Three Community Resources To Consider for Groups A-D:

**Resource #1**
- Child has a Medical Dx or Medical Risk Factors (ex: Fe, delayed lead, seizure disorder)
- Social Risk Factors (Ex: parent with inadequate knowledge/supports, alcohol/substance abuse, or mental illness; teen parent)
- Refer to CoCoon/ Hablon First
  Use CoCoon 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
  Child Lives in Marion/Polk County

**Resource #3**
- Support developmental promotion by addressing issues such as literacy/reading, parenting skills, food insecurity
  Could benefit from parenting classes?
  Mid-Valley Parentline
  www.midvalleyparentline.org
  ParentResource@co.polk.or.us
  www.earlylearninghub.org
  Parentinghub@earlylearninghub.org

Developed and Distributed by the Oregon Pediatric Improvement Partnership for Childhood Health

Do not reproduce without proper OPIP citation
Left Side:
- Anchored to ASQ Scores
- 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

Right Side
- Anchored to Child and Family Factors and Potential Needs
- Referral to early learning services to support child and family
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 crayons, or markers. You can also try puzzles, blocks, and other soft, small toys. Talk and enjoy the time together.

When writing or drawing, set up clear rules. “We draw only on the paper, and only on the table. It will help you remember.”

- Flipping Pancakes
- Macaroni String
- Homemade Orange Juice
- Draw What I Draw
- Bath-Time Fun
- My Favorite Things
- Sorting Objects

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.

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

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!

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 zigzag patterns and spirals. Use a crayon and paper, a stick in the sand, markers on newspaper, or your fingers on a streamside bathroom mirror.

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

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 out 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 that’s a start!

Find an egg carton or muffin pan. Put some common objects such as nuts, shells, or cotton balls into a plastic bag. Let your toddler use a little spoon or fork to pick up the objects and put them in different sections of the egg carton. Give her a little hug when she has success!

Vroom!

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

1. Look
   - Make eye contact as 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 as early as they are old enough to talk. When they do start talking, ask them questions like: “What did 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.
Family Supports in Navigating Referrals

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

- **Education sheet** for parent and to support shared decision making
- **Phone follow-up** for children referred
- **Communication back from Early Intervention** when child can’t be contacted, Care Coordination support from practice to reach out to the family
Follow-Up to Screening: How We Can Support Your Child

Why did 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 parents improve their child’s development, such as when you complete this tool. This tool helps identify kids who may be at-risk for delays. It is important to identify these delays early, as there are services that can address them.

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

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

2) Phone follow-up within two days
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, e.g. 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 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].
# Services Covered by WVCH

**Version 1.0**

WVCH Coverage of Medical and Therapy Services for Children with Developmental, Behavioral or Social Delays

<table>
<thead>
<tr>
<th>Type of Medical or Therapy Service Addressing Developmental Delays</th>
<th>Covered (Y/N)</th>
<th>Benefit Coverage, Any Requirements for Service to be Approved</th>
<th>Providers in WVCH Contract That are Able to Provide Services</th>
<th>Serve Children aged 1 month – 3 years old?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy Services</td>
<td>Yes</td>
<td>Authorization required for therapy visits beyond the initial evaluation/ re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.</td>
<td>Creating Pathways, Mighty Oaks Therapy Center (Albany), PT Northwest, Salem Hospital Rehab</td>
<td>Yes</td>
</tr>
<tr>
<td>Physical Therapy Services</td>
<td>Yes</td>
<td>Authorization required for therapy visits beyond the initial evaluation/ re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.</td>
<td>Capital PT, Keizer PT, Pinnacle PT, PT Northwest, Salem Hospital Rehab, Therapeutic Associates, Creating Pathways</td>
<td>No</td>
</tr>
<tr>
<td>Speech Therapy Services</td>
<td>Yes</td>
<td>Authorization required for therapy visits beyond the initial evaluation/ re-evaluation for all dx. Each request for continued therapy is reviewed for line placement and medical appropriateness.</td>
<td>Chatterbucks, Creating Pathways, Mighty Oaks Therapy Center (Albany), PT Northwest, Salem Hospital Rehab, Sensible Speech</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychological Testing Services</td>
<td>Yes</td>
<td>Authorization required</td>
<td>Valley Mental Health, Willamette Family Medical Center, Intercultural Psychology Services</td>
<td>Yes - 18 months and up</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Yes</td>
<td>Enrolled in services</td>
<td>Marion County Child Behavioral Health*, Polk County Mental Health*, Inter-Cultural Center for Psychology</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Bilingual provider

Do not reproduce without proper OPIP citation
Key Findings from the Pilot: Successes

• Improved primary care knowledge and awareness of follow-up pathways
  – High value in the medical decision tree..but we to plan to revise it
  – High value in the ASQ Learning Activities
  – High value in the parent education sheets from provider perspective

• Findings related to referrals for follow-up:
  – Increase in the number of at-risk children receiving targeted developmental promotion
  – Increase in referrals to early intervention of the more delayed children
    • Across the three sites, referral to EI increased by 22%
    • In Marion and Polk, two pilot practices contributed to over 50% of the increased number of referrals in the community
  – Increase in referrals to home visiting
Findings from Primary Care Pilot Sites: Barriers

- Increases in referrals didn’t necessarily mean increase in services received
- Not all children received follow-up in alignment with the medical decision tree
  - Lack of EI eligibility impacted their referral to EI, need to revise the medical decision tree
  - Provider lack of experience with talking about parenting classes and home visiting services, “clumsy referral”
  - Lack of knowledge about family risk factors to inform referrals to home visiting programs
  - No increase in mental health referrals for these young children.
  - Parent reluctance or push back on the follow-up steps
- Cultural variations in expectations around child development, value of accessing services early to intervene
- Competing priorities for practices on where to focus, especially for multi-specialty practice
  - Two pediatric practices implemented all components of the project to fidelity
  - Third practice was a multi-specialty practice and experienced barriers to robust participation
    - Lead physician-level champion, who also served as the primary liaison at community-level events, transitioned from the practice
    - Significant competing demands with adult-focused efforts
    - Given the lack of incentive metrics related to follow-up to developmental screening and because young children are a relatively small proportion of their total population, difficult to prioritize this topic area
- Barriers to feasibility of meaningful and relevant evaluation data collection in the EMR
Reflections from My Early Learning Hub Partners

• From your perspective, what part of the innovations piloted were most relevant and meaningful to you in your role as a HUB?

• What learnings did you gather about opportunities and needs to spread to other practices in your region?
Questions about Primary Care Provider Improvement Efforts

- Questions?
- What have you learned from your own efforts?
Agenda

• Part 1: Setting the Landscape for the Community-Based Improvement Project. Overview of Improvement Strategies Developed
• Part 2: Data Identifying Where Children Fall out of Pathways, Community Asset Mapping

Community-Based Improvement Effort
• Part 3: Improving Follow-Up in
• Part 4: Improving Follow-Up in Early Intervention
• Part 5: Improving Follow-Up with Home Visiting & Parenting Education Supports
Community-Based Improvement Opportunity:
Improvement Efforts Implemented by Pilot Sites

Early Intervention
1) Enhanced communication and coordination for children referred & not evaluated
2) Communication about evaluation results
   • For Ineligible Children: Referral to Early Learning supports
   • For Eligible Children: Communication about EI services being provided
3) Examination of EI Eligibility and Presenting ASQ Scores
Focus of Improvement Efforts
Within Willamette Education Service District (WESD)

**Implement new processes focused on:**

1. Improved communication and coordination
   - A) For children *not evaluated*
   - B) For children *evaluated and found eligible*

2. Follow-up steps for those found *El ineligible*
   - A) Provision of Act Early materials
   - B) Referral of ineligible children to centralized home visiting

*Do not reproduce without proper OPIP citation*
Pilots of New Processes to Improve Communication and Coordination by WESD - Early Intervention

GREEN - new process implemented
Early Intervention Universal Referral Form

### 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: 
- Country: 
- Primary Phone: 
- Secondary Phone: 
- E-mail: 
- Primary Language: 
- Interpreter Needed: Yes / No 
- Type of Insurance: 
- Private: Yes / No 
- Other: 
- Other (Specify): 
- No Insurance: 
- Child’s Doctor’s Name, Location And Phone (If Known): 

#### Parent Consent for Release of Information

Consent for release of medical and educational information, as directed by the parent/guardian, to share any and all pertinent information regarding my child, 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 health provider who referred me to EI/ECSE to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: 
Date: / / 

#### Office Use Only Below:

**Reason for Referral to EI/ECSE Services**

Provider: Complete all of the applicable boxes. Please attach a completed screening tool.

- Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):
  - Social/Emotional: 
  - Language: 
  - Motor: 
  - Fine Motor: 
  - Visual: 
  - Hearing: 
  - Speech: 
  - Other: 
- Concerns related to the child’s medical condition: 
- Concerns related to the child’s mental health: 
- Concerns related to the child’s socio-emotional: 
- Other: 

Provider Signature: 
Date: / / 

#### Provider Information and Request for Referral Results

- Name and title of provider making referral: 
- Address: 
- Phone: 
- Fax: 

Did you name the child’s primary care physician? 
Date: / / 

Request the following information to include in the child’s health record:

- Evaluation Report: 
- Individualized Family Service Plan (IFSP): 
- Early Intervention/Early Childhood Special Education (EI/ECSE): 

#### ECSE Evaluation Results to Referring Provider

- Date: / / 
- Provider Signature: 

Provider agrees to complete the referral process, attach required information, and return the referral status below.

- Family contacted: 
- Child evaluated: 
- EI/ECSE capacity: 

References or attachments are required above.

**Do not reproduce without proper OPPE citation**
Leveraging the EI Universal Referral Form to Communicate Whether Children Referred But NOT Evaluated

Completed Example:
Pilots of New Processes to Improve Communication and Coordination by WESD - Early Intervention

**GREEN - new process implemented**

Referral Using URF → Phone Call Attempt #1

Phone Call Attempt #2 → Send Letter → Provider Feedback - Bottom of EI Form → Close Referral (After 60 Days)

Schedule Evaluation → Made contact → Close Referral

Evaluation (to begin within 45 days) → Eligible?

Yes → Provider Feedback → Top of Summary of Services → Determine Services

No → Act Early Packet

Additional Follow Up Identified → Refer to Centralized Home Visiting

Refer to Mental Health

Provider Feedback - Bottom of EI Form

*Do not reproduce without proper OPIP citation*
One-Page Summary of Services

Willamette
EDUCATION SERVICE DISTRICT
Marion Center • 2611 Pringle Rd, Salem, OR 97302 • Phone 503.383.4575 • Fax 503.340.4173
Yamhill Center • 2043 SW Hwy 18, McMinnville, OR 97128 • Phone 503.425.5903 • 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 03/12/16 to determine if she is eligible for Early Childhood Special Education Services.

Additional remarks: 2/15/17: Eligible for Hearing Impairment
A new Individual Family Service Plan (IFSP) was developed for ____________ on 11/15/16. These services will be reviewed again no later than 03/01/17.

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

- 1x/2 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.

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

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Focus of Improvement Effort Within Willamette Education Service District (WESD)

Implement new processes focused on:
1. Improved communication and coordination
   A) For children not evaluated
   B) For children evaluated and found eligible
2. Follow-up steps for those found EI Ineligible
   A) Provision of Act Early materials
   B) Referral of ineligible children to centralized home visiting
CDC Act Early Materials

If you have concerns about your child’s development please contact:

Marion, Polk & Yamhill Counties
Toll Free Number (888)660-4666
sandra.gibson@wesd.org

Milestone Moments

Learn the Signs. Act Early.

www.cdc.gov/milestones
1-800-CDCINFO


Special thanks to Tina F. Rauge, MD, Penny Lorentz, MD, and Wendy Charney, MD.

You can follow your child’s development by watching how she or he plays, learns, speaks, and acts.

Look inside for milestones to watch for in your child and how you can help your child learn and grow.

Department of Health and Human Services
Centers for Disease Control and Prevention

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Successes in WESD Efforts

• Review of EI data internally and sharing of EI data helpful to inform community conversations, identify the priority pathways
• Refined internal data collection processes, development of standardization of processes
• In October 2017, Statewide EI adopted
  o Use of the Bottom of the Universal Referral Form to Communicate for children referred by not evaluated
  o One page Summary of Services for children eligible
From Our Perspective: Barriers to Our Efforts

- Staffing bandwidth to ensure these communications are sent in a timely manner
- Ensuring all practices use the Universal Referral Form & complete FERPA release
  - Without proper use and inclusion of signatures, communication between entities is difficult and time consuming
- Ability of programs to serve EI Ineligible children
  - EI referrals have less context about family risk factors given they don’t have an established relationship with the child/family; May impact the number of priority risk factors that are listed on referral form
  - Large number of EI Ineligible are privately insured and/or may not have risk factors that prioritize them

75

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Over Course of Project: Increase in Referrals to Early Intervention

Overall Increase in Referrals to EI: Jul-15-May-16 vs Jul-16-May-17

<table>
<thead>
<tr>
<th></th>
<th>Jul-15-May-16</th>
<th>Jul-16-May-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Overall</td>
<td>652</td>
<td>834 (+22%)</td>
</tr>
<tr>
<td>Yamhill Overall</td>
<td>179</td>
<td>164 (-8%)</td>
</tr>
<tr>
<td>Marion Overall</td>
<td>118 (+9%)</td>
<td></td>
</tr>
<tr>
<td>Polk Overall</td>
<td>107</td>
<td></td>
</tr>
</tbody>
</table>

Number of Referrals

Do not reproduce without proper OPIP citation
Over Course of Project:
Increase in Physician Referrals to EI Largely Driven by Pilot Sites

Overall Increase in Physician Referrals to EI:
Jul-15-May-16 vs Jul-16-May-17

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marion PCPs</td>
<td>412</td>
<td>523</td>
</tr>
<tr>
<td>Polk PCPs</td>
<td>51</td>
<td>60</td>
</tr>
<tr>
<td>Yamhill PCPs</td>
<td>51</td>
<td>79</td>
</tr>
<tr>
<td>Total PCPs</td>
<td>58 (+12%)</td>
<td>79 (+24%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>564 (+27%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>701 (+25%)</td>
</tr>
</tbody>
</table>
Over Course of Project: No Increase in Number of Children Eligible for EI

Children Found Eligible for EI Services: Jul-15-Apr-16 VS Jul-16-Apr-17

- **All Counties**
  - Baseline: 280
  - Follow-Up: 251 (-10%)

- **Marion/Polk**
  - Baseline: 211
  - Follow-Up: 211 (0%)

- **Yamhill**
  - Baseline: 69
  - Follow-Up: 40 (-42%)

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Examining Presenting ASQ Domain-Level Scores Provided by Referral and EI Eligibility

- Identified children who were referred to EI and domain-level ASQ scores were provided
  - Only 26% of referrals across nearly 3 school years had domain-level scores for ASQ
- This required WESD to complete manual chart review and data entry
- WESD provided OPIP with blinded database that included:
  - ASQ scores
  - EI eligibility and for which domains
  - Other descriptive factors to inform analysis. For example: Age of child, Medicaid insurance, referral source, medical eligibility
- Primary care pilot sites also provided data on children referred to EI and their information about the child’s domain-level score
- OPIP conducted analyses to identify any trends to inform better referrals from primary care to EI
Children Identified as At-Risk on ASQ by Referring Provider & EI Eligibility

At-Risk on ASQ, Across Five Domains:
- 2 STDs from Normal on One Domain (Black)
- 1.5 STD from Normal on Two Domains (Grey)

Total N=369

- 201 (55.5%) Did Not Qualify for EI
- 168 (45.5%) EI Eligible

Do not reproduce without proper OPIN citation
Children Identified as At-Risk on ASQ by Referring Provider and EI Eligibility: By Age

![Bar chart showing the percentage of children identified as At-Risk on ASQ by age group.](chart.png)
### EI Eligibility by ASQ Scores:
by Medical Decision Tree Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Eligible</th>
<th>Does Not Qualify for EI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall At-Risk</strong></td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Red" /></td>
<td><img src="#" alt="Total" /> N=369</td>
</tr>
<tr>
<td><strong>Group A</strong> (2+ in the black)</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Red" /></td>
<td><img src="#" alt="Total" /> N=172</td>
</tr>
<tr>
<td><strong>Group B</strong> (2+ in the grey or only 1 in the black) Specific groups within Group B:</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Red" /></td>
<td><img src="#" alt="Total" /> N=197</td>
</tr>
<tr>
<td>2+ in the grey</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Red" /></td>
<td><img src="#" alt="Total" /> N=43</td>
</tr>
<tr>
<td>Only 1 in the black</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Red" /></td>
<td><img src="#" alt="Total" /> N=154</td>
</tr>
<tr>
<td><strong>Group D</strong> (Black in the Personal Social Domain)</td>
<td><img src="#" alt="Green" /></td>
<td><img src="#" alt="Red" /></td>
<td><img src="#" alt="Total" /> N=100</td>
</tr>
</tbody>
</table>

Black = 2 standard deviations from normal on ASQ
Grey = 1.5 standard deviations from normal on ASQ

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Implications to Inform Future Efforts

• Current recommendations are for all children identified “at-risk” to be referred to EI
• That said, given Oregon’s eligibility requirement for EI, we know that many of the children identified “at-risk” on ASQ will not be eligible within EI
  – If all children referred, more children will be evaluated and not eligible
  – Eligibility rates impact referral
    ✓ Providers stop referring
    ✓ Parents may not go back to referral if not found eligible at one point in time
• Modifications to the medical decision tree
  – Changing the referral guidance to EI based on data and collaborative conversations with PCPs and Local EI contractors
  – Will Vary by
    ✓ Level of parental concern
    ✓ Age of child
Reflections from My Early Learning Hub Partners

• From your perspective, what part of the Early Intervention engagement and QI work most relevant and meaningful to you in your role as a HUB?

• What learnings did you gather about opportunities and needs based on the pilots within EI?
Agenda

• Part 1: Setting the Landscape for the Community-Based Improvement Project. Overview of Improvement Strategies Developed
• Part 2: Data Identifying Where Children Fall out of Pathways, Community Asset Mapping

Community-Based Improvement Effort

• Part 3: Improving Follow-Up in Primary Care
• Part 4: Improving Follow-Up in Early Intervention
• Part 5: Improving Follow-Up in Home Visiting & Parenting Education Supports
Community-Based Improvement Opportunity: Improvement Efforts Implemented by Pilot Sites

Early Learning
1) Enhanced developmental promotion using tool supported by the HUB (e.g. VROOM, ACT Early, ASQ Learning Activities)

2) NEW referrals from PCP/EI to:
   • Centralized home visiting referral
   • Evidence based parenting classes
Referrals to Centralized Home Visiting

• Two different regions (Yamhill, Marion and Polk) created a centralized referral form for home-visiting programs

• Allows for providers to have one place to refer to

• Programs meet periodically to review the referral and identify the “best match” for the referral
  ▪ Feedback loops
  ▪ No wrong door
Examples of the Centralized Home Visiting Referral Forms in these Communities

In Yamhill:

**Family CORE**

Coordinated 0-5 years **Referral Exchange**

Referral form for prenatal, infant, and young children home visitation programs

Those with chronic medical conditions are eligible up to age 21 years.

Clients without or with insurance are eligible for programs.

Please fax this form to 503-857-0767.

The person or family being referred will be contacted.

We will provide a follow-up letter to you regarding the outcome of the referral.

For questions or mailed submissions, please call 503-776-7426.

807 NE 3rd St., McMinnville, OR 97128

Date: ____________________________

Child (or pregnant women being referred): ____________________________

Due Date (if applicable): ____________________________

Parent or Guardian names (or a child): ____________________________

Relationship: ____________________________ Date of Birth: ____________________________

Phone number: ____________________________

Home address: ____________________________

Primary Language: ____________________________

Race/Ethnicity: White O Hispanic/Latino O Black/African American O Native American O Other O

Please check all that apply:

- Medical condition
- Teen parent
- Parent with developmental delays
- Child or at risk for developmental delays
- Infant feeding/weight gain problems
- Risk of maternal depression
- Isolation/lack of support
- Child abuse/child neglect
- Additional Information:

Additional Information:

Referring Source Information:

Person (provider) to receive referral follow-up information: ____________________________

Agency/Organization: ____________________________

Phone Number: ____________________________ Fax Number: ____________________________

For Internal Family CORE use only:

- Early Intervention/Early Childhood Special Education
- Healthy Families
- Head Start/Head Start
- Early Head Start/Head Start
- MCH
- Mother/Infant
- Responsible Parent

In Marion and Polk Counties:

**Family Link**

Use this form to refer pregnant women or parenting families with children ages 0-5 to early learning and family support programs in Marion and Polk counties. Services are often delivered through home visits and/or classroom-based programs designed to improve child health and development, increase school readiness, improve maternal health, and increase parental parenting practices.

Child: ____________________________

Sex: M O F O DOB: ____________________________

Parent/Guardian: ____________________________

Relationship to child: ____________________________

Set: M O F O Due Date: ____________________________

Parent/Guardian: ____________________________

Relationship to child: ____________________________

Address: ____________________________

City: ____________________________ Zip: ____________________________

Cell Phone: ____________________________ Home Phone: ____________________________

Preferred Language: ____________________________ Email: ____________________________

Reason for Referral: Check ALL that apply:

- Child/Children
- Lack of Parental Care
- Support with Breastfeeding
- Dev-Exposed Infant
- Fact-Exposed Infant
- Soc-Exposed Infant
- Lack of Adequate Parenting
- Support with Attachment/Attachment
- Domestic Violence
- Support with Parenting
- Support with Bereavement
- Social Emotional Support
- Substance Abuse
- Tobacco Use
- Alcohol Use

Additional Family Information:

- Migrant/Seasonal Work
- Homeless
- Resides TANF/SNAP
- Resides SNAP

Is there anything else we should know?

Referred by: ____________________________

Contact Person: ____________________________ Agency: ____________________________

Phone: ____________________________

Parent Consent to Refer: By signing this form, I authorize Yamhill Valley Farm Workers Clinic to disclose the information listed above for the purpose of connecting my family to an early learning and family support program, to the following organizations:

- Family Building Blocks
- Mid-Columbia Valley Community Action Agency
- Marion County Public Health Department
- Polk County Public Health Department
- Yamhill Education Service District (WESD)

Parent/Member Signature: ____________________________ Date: ____________________________
YCCO Support of Family CORE

- Family CORE originally housed at Yamhill County Public Health
- As CCO staff capacity increased, Family CORE moved to CCO – BAAs signed October 2016.
- Member Engagement Coordinator continued to support, but Family CORE Leadership Team desired increased focus on home visiting
- Grant & Project Coordinator now collecting/reporting data quarterly
- New hire in July 2017: Family Engagement Coordinator
  - Service Integration Team coordination
  - Family CORE support & expansion
Pilot of Referrals in Primary Care Pilots Sites as Part of ASQ Follow-Up

Follow-Up Based on Total Score Across Domains:

- **GROUP A**: 2 or More in the Black
  - N = 111
  - 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 Peds Referral Cheat Sheet)
  - Consider Supplementing Medical and Therapy Services Under Insurance Coverage: Medical & Therapy Services (See One-Page Summary of WIC(P) Providers and Coverage)

- **GROUP B**: “At-Risk”
  - 1 in Black; OR
  - 2 or more in Grey And could benefit from EI
  - N = 290
  - 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 WIC(P) Providers and Coverage)

- **GROUP C**: ‘Watchful Waiting’
  - Borderline: 2 or more Grey or 1 in Black But Not Ready to Refer to EI

Three Community Resources To Consider for Groups A-D:

- **Resource #1**: Child has a Medical Dx or Medical Risk Factors (e.g. FTT, elevated lead, seizure disorder) AND Social Risk Factors (Ex. parent with inadequate knowledge/supports, alcohol/substance abuse, or mental illness; teen parent)
  - Refer to 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
  - Pubically Insured
  - Child Lives in Marion/Polk County
  - Child Lives in Yamhill County
  - Refer to Family Link Include Info on EI Referral
  - Refer to FamilyCORE 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?
  - Classes in Yamhill & Polk Counties
  - Classes in Marion County
  - Mid-Valley Parenting www.midvalleyparenting.org
  - Email: parentresources@co.polk.or.us
  - Marion & Polk Early Learning Hub www.earlylearninghub.org
  - Email: parentinghub@earlylearninghub.org

Do not reproduce without proper OP/IP citation
Example of Pilot of Referrals as Part of Follow-up to Screening from PCP Sites to Centralized Home Visiting

- Agreed upon criteria for referrals were as follows:
  - Children identified at-risk on the ASQ who also have Family Risk Factors, including those listed below:
    - Feels Depressed or Overwhelmed
    - Isolation/Lack of Support
    - Support with Parenting
    - Has Disability
    - Teen/Young Parent
    - First Time Parent
    - Tobacco Use
    - Domestic Violence (present or history of)
    - Alcohol/Drug Use
    - Lack of Food/ Clothing/Housing
    - Incarceration/Probation
    - Low Income
    - Migrant/Seasonal Worker
    - Unemployed
    - Homeless
    - Receives TANF/SSI/SNAP
Successes and Barriers to Pilots of PCP Follow-up to Home Visiting

Successes:

- Improved communication and understanding between both entities of each other and their services
- Increased referrals

  Example from Marion and Polk Counties and Referral to Family Link
  - Pilot primary care site referred 30 kids from February 2017-May 2017 to Family Link
  - Referral to Family Link spread to 2nd primary care pilot site
  - Early Intervention referred 70 EI Ineligible children to Family Link

Barriers:

- Not able to contact families referred by phone
  - Example from Family Link Pilot: Of the 30 kids referred in pilot primary care site, 30% unable to be reached and 7% declined conversation with Family Link when they were contacted.
- Many children who do get connected are still pending or put on waitlists
  - Reality of the capacity across organizations to catch these children
  - Example from Family Link Pilot: Of the 30 kids referred in pilot primary care site, 10% on waiting lists and 23% closed to lack of eligibility
- Stigma around home visiting
- Cultural variations and acceptance of home visiting services
Pilot to Parenting Classes
Figure 1.0: Pilot Medical Decision Tree for Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks in Marion, Polk and Yamhill 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 Domain Identified At-Risk
  2) Information on Vroom
- Refer to Early Intervention For an Evaluation
- To Determine Eligibility Use Universal Referral Form, FEIPA Signed, Indicate "Summary Evaluation Form" To Receive Summary of Services
- Consider Referral to Developmental/Behavioral Pediatrician (See DBP Referral Cheat Sheet)
- Consider Supplementing Medical and Therapy Services Under Insurance Coverage: Medical & Therapy Services (See One-Page Summary of WCHI 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 Domain Identified At-Risk
  2) Information on Vroom
- Refer to Early Intervention For an Evaluation
- To Determine Eligibility Use Universal Referral Form, FEIPA 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 WCHI 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 Domain Identified At-Risk
  2) Information on Vroom
- Bi-Screen in 3-6 Months, Set-up a Follow-Up if Child Does Not Have a Visit

Three Community Resources To Consider for Groups A-D

Resource 1
- Support developmental promotion by addressing issues such as literacy, reading, parenting skills, food insecurity
- Could benefit from parenting classes?

Resource 2
- Mid-Valley Parenting
  - www.midvalleyparenting.org
  - Email: parentresources@co.polk.or.us

Resource 3
- Marion & Polk Early Learning Hub
  - www.earlylearninghub.org
  - Email: parentinghub@earlylearninghub.org
Parenting Classes Pilots

• Extend the number of parent education courses and locations
• Mind in the Making and other new curriculums for the community
• Hold course in locations where families gather
• Doctors recommending courses helpful
• Desire to “normalize” parent education
• Partner with area medical clinics to host classes
• Partner with other area organizations to host classes
Oregon Parenting Education Collaboratives: Example Classes

Make Parenting a Pleasure (in Spanish *Haga de la Paternidad un Placer*)
- This parenting curriculum has been in practice for more than 30 years. It is designed for parents who are highly stressed with children 0 to 8 years old.

Abriendo Puertas (in English *Opening Doors*)
- Nation’s first evidence-based comprehensive training program developed by and for Latino parents with young children between the ages of 0 and 5 years old.

Nurturing Parenting
- Family-centered trauma-informed program designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices.

Collaborative Problem Solving: Parent workshop
- CPS is a strengths-based, neurobiologically-grounded approach that brings new ideas and new hope for helping kids with behavioral challenges.

Mothers and Babies
- This class is designed specifically to provide support and encouragement to mothers who are pregnant or have an infant 36 months or younger. Each mom learns ways to think about and interact with their young baby to create an emotionally and physically healthy reality. Topics include baby development, managing stress and mood changes. Mothers receive individual support from their instructor/coach as well as build support with other new moms.
Successes and Barriers to Referrals to Parenting Classes

**Successes:**
- Providers were excited to learn about parenting classes, as this was not a resource they utilized previously.
- General sentiment is that this would be helpful for many families they care for.

**Barriers:**
- Can be an awkward conversation
  - Value of general efforts to normalize efforts
- Negative stigma of ‘parenting classes’
  - Impacting family engagement and follow through
- Since it is not a traditional referral, practices can’t track referrals and “follow-up” on the “referral”
Looking Forward – Sustaining this Work as Early Learning Hubs
Key Learnings

- Workflow necessary to get into the process
- Champion necessary to keep the work moving forward
- Weave resources into medical visit
- Timely follow-up with parents
- Communication between clinic and early intervention is critical
Moving Forward

- Grant to support expansion into other clinics
- Coaching and technical assistance for providers
- Funding for position at WESD to facilitate conversation
- Training for Early Learning Providers on social emotional skills
- ASQ-3 and ASQ-SE Activities for providers
- Expand outreach to parents
  - Parent Education & Vroom
- YCCO considering inclusion of Early Learning supports in APM applications
Thank You for your Collaboration & Inspiration

• Oregon Health Authority (Funder and Partner)
• Willamette Education Service District (Funder and Partner)
• Parent Advisors
• Partners in Marion, Polk & Yamhill Counties
  – Yamhill CCO
  – Yamhill Early Learning Hub
  – Head Start of Yamhill County
  – Yamhill County Public Health
  – Physician’s Medical Center
  – Newberg School District
  – Discovery Zone Child Development Center
  – Willamette Valley Community Health
  – Marion & Polk Early Learning Hub (Hub, Inc)
  – Childhood Health Associates of Salem
  – Woodburn Pediatric Clinic
  – Marion County Health Department
  – Polk County Health Department
  – Family Link
  – Family CORE
More Information

Colleen Reuland  reulandc@ohsu.edu
Lisa Harnisch  lharnisch@earlylearninghub.org
Jenn Richter  jrichter@yamhillcco.org

www.oregon-pip.org

Section focused on Follow-Up to Developmental Screening:
http://oregon-pip.org/focus/FollowUpDS.html

– Examples of the specific tools available on the website:

  o Asset map to document community pathways from screening to services
  o Follow-up decision tree for primary care providers based on screening result and child and family factors linking to six follow-up resources,
  o Phone follow-up script for referrals made
  o Parent Education Sheet

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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

Hub Governance Meeting 1/16/18
Agenda

1. Setting the Stage - Project Overview

2. Findings from Phase 1:

   *Baseline Data Collection to Understand Existing Pathways and Where Children Fall Out, Opportunities for Improvement Pilots*

   - Stakeholder Engagement and Interviews (Qualitative data)
   - Coordinated Care Organization (Quantitative Data)
   - Pilot Primary Care Practice (Quantitative Data)
   - Early Intervention Data (Quantitative Data)

3. Focus for Phase 2: Focus Areas for Improvement Pilots

   - Pilot Site
   - Proposed pathways
   - Group-level feedback and input
   - Areas identified for improvement, but out of scope or no capacity

4. Next Steps
Opportunity to Focus on Follow-Up to Developmental Screening for YOUNG CHILDREN that is the Best Match for the Child & Family

- Increased focus on developmental screening across the state for children under three
  - Within primary care
  - Within home visiting
  - Within child care
- Goals of screening
  - Identify children at-risk for developmental, social, and/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
- Potential Future Metrics
  - On deck incentive metrics: Follow-up to developmental screening, Kindergarten readiness
  - Early Learning Hub, Early Learning Division measurement dashboard

**Children Identified “At-Risk” on Developmental Screening Tools**
This report is focused on children identified “at-risk” who should receive follow-up services. These are children who 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

Coordinated Care Organization & Primary Care Sites

Early Learning

Early Intervention
Addressing ELH Goals and CCO Goals Related to Young Children

- Both OHA and ODE share a common focus on development screening
  - Developmental screening related metrics exist for CCOs, ELHs, and PCPCHs
- The goal of primary care-based screening is not merely to screen, but to identify at-risk children so that concerns can be addressed early.
  - Recommendations for screening in primary care were made as that is where the most “car seats” for children under three are parked
  - Addressing risks that are identified early increases the likelihood that the child will be ready for kindergarten
  - Timely receipt of services for children identified at-risk for developmental, behavioral, and/or social delays is an important element of this
  - Important focus on the younger children and before preschool
- Kindergarten Readiness a priority for ELH and an “on deck” measure for CCOs
  - What is measured is focused on
  - As the movement for kindergarten readiness as a metric for early childhood health gains steam, the topic of follow up to developmental screening likely to get increased attention
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**: Implement Pilots to improve the number of children who receive follow-up and coordination of care

  Key partners in implementing these pilots within each of those silos:
  1. Primary Care Practices (3 Sites, One in Each Community)
  2. Early Intervention (NWESD – 3 Local Service Area Centers)
  3. Early Learning (Entities Proposed within Each Community)

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

- Dieter F. Uchtdorf -
Phase 1: Stakeholder Engagement & Data Collection to Understand Where You Are Now, Identify Where to Focus Improvement Pilots

**Goal of Phase 1:**
- **Understand the current pathways** from developmental screening to services in each of the three counties
- **Understand community-level assets and resources** that exist
- **Understand where and how children are falling out** of these pathways and not receiving services to address the identified risks
- Understand priority areas to pilot improvements

**Components of Phase 1:**
- Stakeholder engagement
  - Recruitment of parent advisors for the project
  - Individual stakeholder interviews (Qualitative data)
  - Group-level meetings to gather input and guidance (Within each county and today)
- Coordinated Care Organization (Quantitative Data)
- Early Intervention Data (Quantitative Data)
- Primary Care Practice Pilot Site Data (Quantitative Data)
Phase 1: Stakeholder Interviews

- 66 Interviews completed to date across the three counties
- Individuals interviewed across seven sectors
- 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. Opportunities
  3. Barriers
  4. Capacity within the region
  5. Hopes for the improvement pilots
  6. Identify current services to inform the asset map, which may include places where assets are needed but not yet present
<table>
<thead>
<tr>
<th>CPCCO</th>
<th>Primary Care</th>
<th>Interdisciplinary teams that include health care:</th>
<th>EI &amp; Education</th>
<th>NW Early Learning Hub</th>
<th>Mental Health</th>
<th>Home Visiting &amp; Head Start/Early Head Start</th>
<th>Child Care and Parenting Supports</th>
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<tr>
<td><strong>Elicia Miller</strong>&lt;br&gt;(Clinical Integration Manager)</td>
<td>OHSU Scappoose CMH</td>
<td>Interdisciplinary teams that include health care: Community Connections-Tillamook Community Connections-Clatsop</td>
<td>Nancy Ford&lt;br&gt;(Director of Birth to Age 5 Services)</td>
<td>Dorothy Spence&lt;br&gt;(Hub Director)</td>
<td>Mental Health Columbia County Mental Health (1)</td>
<td>Head Start &amp; Healthy Families Home Visiting (4)</td>
<td>CCR&amp;R (2)</td>
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<tr>
<td><strong>Maranda Varsik</strong>&lt;br&gt;(Practice QI)</td>
<td>Providence Seaside*</td>
<td></td>
<td>Tina Meier-Nowell&lt;br&gt;(Special Education Coordinator)</td>
<td>Rob Saxton&lt;br&gt;(Governance Council Chair)</td>
<td>Clatsop Mental Health (2)</td>
<td></td>
<td>Childcare Centers conducting screening&lt;br&gt;(Preschool Promise &amp; SPARK 3 Star &amp; above)</td>
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<tr>
<td><strong>Joell Archibald</strong>&lt;br&gt;(Innovator Agent)</td>
<td>TCCHC Legacy St. Helens*</td>
<td>Vicki Schroeder&lt;br&gt;(EI Data)</td>
<td>Elena Barreto&lt;br&gt;(Community Navigator)</td>
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<td>Tillamook Family Counseling Center (2)</td>
<td>Public Health/ CaCoon/ BabiesFirst (5)</td>
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<td><strong>Nicole Jepeal</strong>&lt;br&gt;(Metrics/QI Analytics Supervisor)</td>
<td>Adventist Yakima VFW*</td>
<td>EL/ECSE Program County Coordinators (3)</td>
<td>Eva Manderson&lt;br&gt;(Early Learning Program Specialist/Preschool Promise Manager)</td>
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<td></td>
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<td>NW Parenting (5)</td>
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<td><strong>Jeanne McCarty &amp; Leslie Ford</strong>&lt;br&gt;(GOBHI)</td>
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<td>EL Referral Intake Coordinators (4)</td>
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<td>Clatsop Kinder Ready</td>
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<td>EL Lead Evaluators (4)</td>
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<td>Preschool Feasibility Study</td>
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<td>DHS (2)</td>
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Key Building Blocks of the **Pathways** for Developmental Screening, Referral and Follow-Up
Stakeholder Interviews Findings:
Developmental Screening – Punchlines

• While CPCCO has met benchmarks and screening rates are relatively high, many children are not getting screened in primary care

• Group 1: Screening in Primary Care Practices (Health Care)
  – Not all children access care, so they can’t get screened
  – Not all practices that children go to are screening or screening to fidelity. Conversely, some practices are screening at every visit, which has implications related to follow-up
  – Children access care in places that are not where they are attributed for primary care
  – Numerous stakeholders reported that there are a number of families that are against government involvement and hesitate to engage with systems, including health care
  – Children age 2-3 less likely to go in for a well-visit, therefore less likely to be screened

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

• Group 3: Childcare (Early Learning): Screening happening in some sites, very limited for 0-3 age group

• Sharing of screening results is not standardized or routinely in place in any group

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Stakeholder Interviews Findings: Follow-Up to Screening

- While some children receive follow-up, there is not standardization in the follow-up provided
- Follow-up anchored to individuals:
  - Knowledge of early learning services in their community
  - Perceptions about capacity of services
  - Perceptions of family’s ability to access those services
  - Perception about the value of those services and what past patients referred have said
  - Perceptions about validity of the ASQ and the ASQ Scores
  - Knowledge about the family and their family context
  - Whether the referred entity communicates back
- People acknowledged making a referral does NOT equal getting a SERVICE
  - Noted barriers to access of referrals
    - Parental engagement or knowledge about why a service is valuable
    - Transportation
    - Stigma, particularly for mental health
    - Family-centered systems and processes
    - Some referrals are for an evaluation, not a service
- Value in communication to “close the loop” on referrals, which often requires a referral form
Stakeholder Interview Findings: Follow-Up for Children Identified At-Risk

Group 1: Primary Care Sites Referral of Children Identified At-Risk on Dev Screening

- In some sites, significant variation by provider (particularly for sites in Tillamook)
- Varied knowledge on developmental promotion supports that could be provided
- Perceptions about EI eligibility and evaluation processes impact whether and who they refer
- Lack of knowledge about the full set of early learning services in the community
- Limited or inconsistent knowledge the infant and early childhood mental health services in the community
- Barriers to referral to developmental pediatricians located in Portland
  - Transportation and time commitment (multiple visits)
  - Wait lists for those referred to developmental pediatrician
- Rarely are secondary follow-up steps considered when a child is ineligible for the first service referred (often EI)
- Community-level variations in primary care practices. Specifically in Tillamook – request to engage Adventist

Opportunities Identified:

- Desire for better two-way communication with resources to which they refer. This would impact likelihood to refer
- Need for better and standardized processes (work flows & tracking) around best match promotion and referrals (who, what, where, how) aligned with community-level assets
- Need for educational materials for parents of children identified at-risk referred
- Need for tools and strategies to engage families in accessing the referrals
Stakeholder Interviews Findings: Follow-Up for Children Identified At-Risk

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

- More knowledgeable about the early learning services. Contact programs directly or meet them through ELH activities
- Have more regular and routine contact with the family to engage them on the follow-up, including promotion activities that they lead
- Use of additional tools to understand the child’s needs (ASQ-SE)
- Also noted barriers to referral to developmental pediatricians located in Portland
- Noted barriers to parent engagement or agreement to go to referral
- Noted a lack of AVAILABLE resources to address risk identified (parenting classes)
- Noted past experiences that made access to mental health difficult

Group 3: Early Learning/Childcare

- Very few are screening children 0-3
- Only one 5 star program interviewed does some referring to EI when appropriate. Work with family to determine best process. Currently no communication to the PCP.
Using Data to Inform Our Discussions and Proposed Priority Areas of Focus for Our Community-Based QI Project
Examining Quantitative Data to Understand The Pathway of Screening to Services for Young

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

**Available Data That will be Examined**

1. **Census Data** – How many children 0-3
2. **Columbia Pacific Coordinated Care Organization (CPCCO) for Publicly Insured (Funder)**
   - Children covered, continuously enrolled
   - Children who have a visit
   - Children who receive a developmental screening, according to claims submitted
3. **Primary Care Practice Data:** Examples from OHSU Scappoose (a Pilot Site)
   - Children practice identifies as their patient
   - Children who received a developmental screening
   - Children identified at-risk on developmental screen
   - Children identified at-risk who received follow-up
4. **Early Intervention:** According to Bright Futures data, a referral for all children identified at-risk (a Pilot Site)
   - Referrals
   - Referred children able to be evaluated
   - Of those evaluated, eligibility
5. **Early learning providers** (Tracking data will be collected for any specific pilot sites to evaluate pilot)

*Do not reproduce without proper OPiP citation*
## Children 0-3 in Tri-County Region

<table>
<thead>
<tr>
<th>County</th>
<th>Total Children 0-3</th>
<th>Children Covered by CPCCO</th>
<th>Of those: Children Continuously Enrolled for 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clatsop</td>
<td>1,250</td>
<td>828 (66%)</td>
<td>452</td>
</tr>
<tr>
<td>Columbia</td>
<td>1,635</td>
<td>797 (49%)</td>
<td>419</td>
</tr>
<tr>
<td>Tillamook</td>
<td>655</td>
<td>474 (72%)</td>
<td>280</td>
</tr>
<tr>
<td><strong>Total: Tri-County</strong></td>
<td><strong>3,540</strong></td>
<td><strong>2,333 (60%)</strong></td>
<td><strong>1,227</strong></td>
</tr>
</tbody>
</table>
Number of Children 0-3 Publicly Insured in CPCCO (No Continuous Enrollment Requirement)

Data Source: Provided by CPCCO, October 2017

Do not reproduce without proper OPIP citation
Publicly Insured Children Under Three Years Old: Number Continuously Enrolled – Of those: Proportion Who Received a Well Visit, Developmental Screen (96110 Claim)

Data Source: Provided by CPCCO, October 2017

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

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

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

Data Source: Provided by CPCCO, October 2017

Do not reproduce without proper OPIP citation
Developmental Screening Rate for the Tri-County CPCCO Region for NON-Continuously Enrolled Children

Data Source: Provided by CPCCO, October 2017. Developmental Screens according to 96110 Claims.

Do not reproduce without proper OPiP citation
Developmental Screening Rates by Age of Child

Columbia County
Total N=419
63.5% (N=101)
63.0% (N=87)

Clatsop County
Total N=452
77.2% (N=122)
66.3% (N=108)
57.3% (N=75)

Tillamook County
Total N=280
58.0% (N=65)
47.1% (N=41)
53.1% (N=43)

Tri-County
Total N=1227
67.2% (N=313)
61.2% (N=241)
52.7% (N=185)

Continuously Enrolled Publicly Insured Children

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

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

Data Source: Provided by CPCCO, October 2017

Do not reproduce without proper OPIP citation
Developmental Screening Rates in CPCCO Clinics in Columbia, Clatsop & Tillamook Counties

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

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

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

Clinics to Which CPCCO Attributes Children, Number of Non-Continuously Enrolled Children 0-3

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

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

Do not reproduce without proper OPIP citation
Number of Continuously Enrolled vs. Non-Continuously Enrolled Children Attributed to Each Clinic

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

Do not reproduce without proper OPIP citation
Number of Continuously Enrolled Children Attributed to Each Clinic and Well-Visit and Developmental Screens

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

Do not reproduce without proper OPIP citation
Pilot Site Well-Visit and Developmental Screening Rates

Data Source: Provided by CPCCO, October 2017- FY 16-17 ONLY. Continuously Enrolled Children Only

Do not reproduce without proper OPPI citation
The Story of Young Children in the Tri-Counties

- **Children 0-3 in Tri-Counties**: 3540
- **Publicly Insured**: 2333
- **Estimate of Children At-Risk for Delays**: 708
- **EI: Children Receiving Services**: 141

*Do not reproduce without proper OPIC citation*
The Story of PUBLICLY INSURED Young Children in the Tri-Counties

Based on Claims Submitted to CPCCO

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publicly Insured</td>
<td>2333</td>
</tr>
<tr>
<td>Continuously Publicly Insured by Age Cohorts</td>
<td>1227</td>
</tr>
<tr>
<td>Had a Well Visit</td>
<td>922</td>
</tr>
<tr>
<td>Had a Developmental Screen</td>
<td>749</td>
</tr>
<tr>
<td>EI: Publicly Insured Receiving Service</td>
<td>85</td>
</tr>
</tbody>
</table>
Examining Quantitative Data to Understand The Pathway of Screening to Services for Young

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

• **Data Available That will be Examined**
  1. *Census Data* – How many children 0-3
  2. *Columbia Pacific Coordinated Care Organization (CPCCO)* for Publicly Insured (Funder)
     - Children covered, continuously enrolled
     - Children who have a visit
     - Children who receive a developmental screening, according to claims submitted
  3. *Primary Care Practice Data: Example from OHSU Scappoose (Pilot Site)*
     - Children practice identifies as their patient; Of those, number seen
     - Children who received a developmental screening
     - Children identified at-risk on developmental screen
     - Children identified at-risk who received follow-up
  4. *Early Intervention: According to Bright Futures data, a referral for all children identified at-risk (A Pilot Site)*
     - Referrals
     - Referred children able to be evaluated
     - Of those evaluated, eligibility
  5. *Pilot Early Learning Provider (Tracking data will be collected for pilot sites to evaluate pilot)*

*Do not reproduce without proper OPAP citation*
Purpose of the Baseline Data Collection in the Primary Care Pilot Sites

• Baseline Data:
  o Inform **Community-Level Conversations** Meant to Understand Current Population, Referral Patterns, and Opportunities for Improvement → Share at Community-level Stakeholder Meetings
    ✓ General information about number of children see
    ✓ Screening (Claim- 96110, Documentation in EMR)
    ✓ Proportion of screened children identified at-risk (Documentation in EMR)
    ✓ Follow-up steps (Documentation in the EMR)
  o Used to **Compare and Evaluate the Impact** of the Improvement Pilot

• Inform Quality Improvement Efforts
  o Identify potential **improvements in EMR templates**/Smart Phrase aligned with future improved processes and referral pathways for young children
  o Understand current data limitations related to tracking the **quality improvement work** and how it impacts **evaluation measurement**

• Provide **information to CPCCO and other stakeholders related to measurement opportunities and challenges**
  o Follow-up to developmental screening and kindergarten readiness are “on deck” CCO incentive metrics

*Do not reproduce without proper OP!P citation*
Barriers to Measurement of Follow-up to Developmental Screening... All Associated with Lack of and Variation in Follow-Up to Screening

- **No claims** related to the denominator or numerator for a measure of follow-up:
  - Screened children, identified at risk (Denominator for a measure of follow-up)
  - Follow-up promotion and referrals (Numerator)
    - Possible to examine claims related to services within health care: Developmental and Behavioral pediatrician evaluation, OT/PT, Speech. Limitations of this approach however.
- Therefore, need to examine the **electronic medical record**
  - 2 sites are on OCHIN EPIC, 3rd site on a different EMR
  - Within OCHIN EPIC, standardized fields related to:
    - Whether ASQ Flowsheet Used (One site can not run a report for this)
    - ASQ Domain level scores as entered by the MA and interpretation of scores
    - Overall Interpretation, Titled “Follow-Up” but searchable fields are “1=Above Cut off, No Further steps Needed, 2= Close to Cut Off, Monitoring Needed, 3- Below cut off, further evaluation needed
  - Not all children screened have a 96110 claim, can’t use the claim to identify population screened
  - Many children received multiple screens given these sites screening at every visits vs. rec. periodicity
  - Therefore, charts for children identified at-risk had to be manually reviewed for each of the possible follow-up
  - That being said, found a number of gaps in documentation related to follow-up. Primary referrals documented.
- **Site capacity related to measurement and reporting**
  - OHSU Scappoose, received centralized reports to run reports and then did manual chart review for all those identified at-risk.
  - TCCHC was not able to run this report, so manually reviewed all the well-visits. Feasible given their relatively low Ns.
  - CMH Astoria’s EMR has no searchable fields related to ASQ, ASQ Scores, or Follow-up. However, they see a much larger number of children. Therefore a standardized sampling procedure will need to be created for their medical chart reviews.
Example from One Site:
OHSU Scappoose & Developmental Screening

- Large teaching practice
  - 21 Faculty Providers, Many of Whom are Part-time in the Clinic
  - Residents that rotate (Currently 7)
- Electronic Medical Record (EMR)
  - OCHIN EPIC
- Developmental Screening Processes
  - Screen at Well-Visits
    - Before 1: 6 and 9 month well-visit
    - Before 2: 12 and 18 month well visit
    - Before 3: 24 months well-visit
      (Also screen at 36 month well visit - outside scope of data)
    - Variation in provider-level use of the 15 month appointment, but if scheduled will administer a developmental screen at that visit
    - Do not OFFER 30 month visit
OHSU Scappoose Baseline Data

- **Baseline Time Period:** 7/1/16 - 6/30/17 (One Year)
- **Children of Focus:** Children Under 3 (1 day-35.99 months)
- **Data Sources:**
  1) **Report** related to panel size, well-visits, use of the developmental screening flowsheet, 96110 claim, searchable fields within the ASQ flowsheet (Domain level scores)
     - Panel, well-visits, screening rates, proportion of screens with a 96110 claim, proportion of screens identifying a child-at-risk
  2) **Chart Review** of ASQ Flowsheets that Identified the Child At-Risk
     (1 or more domains in black and/or 2 or more domains in grey)
     - Used to identify follow-up to developmental screening currently documented in the chart
       - OCHIN Follow-Up Interpretation (Above Cut Off, Close to Cut Off, Below Cut Off)
       - Specific Referrals
         - Referral to Early Intervention
         - Referral to OT/PT
         - Referral to Speech Therapy (ST)
         - Referral to Developmental Behavioral Pediatrician
         - Referral to External Mental Health
     - Follow-Up (FU) Steps **Not Included** in Due to Documentation Limitations, But is Follow-Up
       - Developmental Promotion
       - Rescreen of child (Assumed done at every visit, however a schedule of an earlier visit would be recommended for two year olds)
       - Internal mental health
       - Referrals to other resources: CaCoon/Babies First/Home Visiting, Healthy Families, Head Start, Parent Child Interaction Therapy, and Parenting Classes
- **Data examined by age of child, provider, insurance**
- **Data examined at screen-level AND at a child-level (looking across screens)**

*Do not reproduce without proper OPIP citation*
OHSU Scappoose Baseline Data

- Number of Providers in OHSU Scappoose that Interpreted a Developmental Screen
  - N=26 Providers completed an ASQ flow sheet for a child under 3 (Includes Residents)
- Panel of Children Under 3: N=497
  - Children Who had a Well-Visit in Last Year: N=477
  - Of the Visits with a Developmental Screen: 62% are for children with Medicaid
- Developmental Screens for Children Under 3
  - Number of Screens Completed According Practice’s EMR (ASQ Flowsheet): N=633
    - Of these, Screens Administered at a Well-Visit (616/633)
    - Screens administered at an “urgent visit” – likely a rescreen (17/633)
    - By Age:
      - Under 1: N=285
      - 1-2 yrs: N=266
      - 2-3 yrs: N=82
  - Number of 96110s Billed: N=344
    - 54% of the time a 96110 claim was submitted when a screen done
- Number of Multiple Screens: N=298
- Child-Level Screening
  - Number of Children Screened: N=335
  - Number of Children with Multiple Screens N=183 (54%)
    - Nearly all the children with multiple screens are the younger children due to the periodicity of screening in OHSU
OHSU Scappoose – Number of Developmental Screens Done in One Year for Children Under 3: By Billing Provider

Total Screens Conducted: N=633

Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years.

Do not reproduce without proper OPiP citation
Children Identified At-Risk on the ASQ & Bright Futures Recommendations Related to Follow-Up

• Scoring of “At-Risk” Based on the Ages and Stages Questionnaire
  – At Risk= 1 or more in the Black (2 STD from Normal) AND/OR 2 or more in the Grey (1.5 STD from Normal)

• Bright Futures Recommendation for **Follow-Up for At-Risk**
  – Screen at 9, 18 and 30 month visit (or 24 if not doing the 30)
  – Refer all to Early Intervention and Developmental and Behavioral Pediatrician (DB Peds)

• For the analysis shown:
  – Given OHSU Scappoose is screening multiple times, used the risk level for the **last screen conducted**
    • Under 1: 6 and **9 month** well-visit
    • 1-2: 12 and **18 month** well visit
    • 2-3: 24 months well-visit
  – That said, we ran all analyses by screen as well
OHSU Scappoose – Characteristics of Risk Identified on the ASQ in Children 0-3

Of these:

- Overall At-Risk: 22%
- 3-5 Domains in Black: 2% (Total N=7)
- 2 Domains in Black: 3% (Total N=9)
- 1 Domain in Black: 10% (Total N=35)
- 2+ Domains in Grey ONLY: 7% (Total N=22)

Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented in the EMR. If a child had multiple screens, the most recent screen result was used to determine risk level.

Do not reproduce without proper OPIP citation
OHSU Scappoose – Proportion of CHILDREN Screened Identified At-Risk on the ASQ: BY Age-Categories

Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented in the EMR. If a child had multiple screens, the most recent screen result was used to determine risk level.

Do not reproduce without proper OPiP citation
Examining Follow-Up to Developmental Screening for Those Identified At-Risk

Aspects of follow-up to developmental screening able to examined in the chart, if documented in the note or referral tracked:

- Specific Referrals
  - Referral to Early Intervention (Bright Futures Recommendation)
  - Referral to OT/PT
  - Referral to Speech Therapy (ST)
  - Referral to Developmental Behavioral Pediatrician (Bright Futures Recommendation)
  - Referral to External Mental Health

Follow-Up Steps **Not Included** in Baseline Data Due Documentation Barriers:

- Developmental Promotion
- Rescreen of child (Assumed done at every visit, however a schedule of an earlier visit would be recommended for two year olds)
- Internal mental health
- Referrals to other resources: CaCoon/Babies First/Home Visiting, Healthy Families, Head Start, Parent Child Interaction Therapy, and Parenting Classes
Follow-Up Documented in Chart (Child-Level): 1 in 3 At-Risk Children Received Some Level of Follow-Up

*NOTE: N=3 Children received 2 follow-up steps

If the chart note indicated a previous referral, we counted that towards a follow-up to that entity.

- **Multiple Referrals, Total Referrals N=3**
  - Child 1: EI & External Mental Health
  - Child 2: ST & DBPeds
  - Child 3: ST & DBPeds

- **DB Peds, Total Referrals N=5 (not child-level)**
- **ST, Total Referrals N=3 (not child-level)**
- **OT/PT, Total Referrals N=3 (not child-level)**
- **Early Intervention, Total Referrals N=15 (not child-level)**

Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented in the EMR. If a child had multiple screens, the most recent screen result was used to determine risk level. Documented follow-up based on chart review.

*Do not reproduce without proper OP/IP citation*
Follow-Up for At-Risk Children Documented in Chart: By Levels of Risk Identified

- Overall At-Risk: 33% (N=24)*
  - 4% (N=3)
  - 1% (N=1)
  - 4% (N=3)
- Specific Levels of Risk Identified on the ASQ
  - 3-5 Domains in Black: 14% (N=1)
  - 2 Domains in Black: 11% (N=2)
  - 1 Domain in Black: 4% (N=3)
  - 2+ Domains in Grey ONLY: 9% (N=3)
  - Total: 43% (N=15)*

Data Source: Provided by OHSU Scappoose & OHSU Data Team, November 2017. Data for screens (According to EMR Flowsheet) between 7/1/16 - 6/30/17 for children under three years and based on domain-level scores documented in the EMR. If a child had multiple screens, the most recent screen result was used to determine risk level. Documented follow-up based on chart review.

Do not reproduce without proper OPIC citation
Using Data to Inform Our Discussions and Proposed Priority Areas to Focus Our Community-Based QI Project:

Data from
Northwest Regional Education Service District (NWRESD) for the Tri-Counties (Clatsop, Columbia, Tillamook)
Value of Data from NWRESD on Early Intervention to Inform This Pilot

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

#2: Data to Inform Processes for At-Risk Children, But EI Ineligible
• A proportion of at-risk children referred to EI, will be found ineligible
  o The goal for this project is to ensure that at-risk children receive follow-up
  o Therefore, a focus of this project is secondary referrals of EI ineligible children
    ▪ Value of descriptive information about these ineligible in order to inform secondary and follow-up services
Data from NWRESD on Early Intervention Referral and Evaluation Outcomes to Be Shared Today

#1: Indication of Follow-Up to Developmental Screening

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

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

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

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

Do not reproduce without proper OPiP citation
Number of Early Intervention Referrals vs
Number of CHILDREN Referred in Tri-Counties

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

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

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

Do not reproduce without proper OP/IP citation
EI Referrals by Referral Source
As Documented in EC Web

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

Do not reproduce without proper OPIP citation
Tri-County EI Referrals by Whether Child Has Medicaid

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

Do not reproduce without proper OPIP citation
Tri-County EI Referrals by Whether Child Has Medicaid

<table>
<thead>
<tr>
<th>County</th>
<th>Total N</th>
<th>Medicaid (%)</th>
<th>Not Medicaid (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clatsop</td>
<td>144</td>
<td>62% (N=89)</td>
<td>38% (N=55)</td>
</tr>
<tr>
<td>Columbia</td>
<td>149</td>
<td>68.5% (N=102)</td>
<td>31.5% (N=47)</td>
</tr>
<tr>
<td>Tillamook</td>
<td>43</td>
<td>72% (N=31)</td>
<td>28% (N=12)</td>
</tr>
</tbody>
</table>

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

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

#1: Indication of Follow-Up to Developmental Screening

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

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

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

<table>
<thead>
<tr>
<th>Percentage of Referrals</th>
<th>SY 15-16 (7/1/15-6/30/16) Total N=281</th>
<th>SY 16-17 (7/1/16-6/30/17) Total N=336</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluated</td>
<td>66% (N=185)</td>
<td>66% (N=221)</td>
</tr>
<tr>
<td>Not Evaluated</td>
<td>34% (N=96)</td>
<td>34% (N=115)</td>
</tr>
</tbody>
</table>

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

Do not reproduce without proper OPIP citation
Percentage of Tri-County EI Referrals Able to Be Evaluated by EI in SY 16-17: By County

- Clatsop
  - Total N=144
  - Evaluated: 77% (N=111)
  - Not Evaluated: 23% (N=33)

- Columbia
  - Total N=149
  - Evaluated: 55% (N=82)
  - Not Evaluated: 45% (N=67)

- Tillamook
  - Total N=43
  - Evaluated: 65% (N=28)
  - Not Evaluated: 35% (N=15)

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

Do not reproduce without proper OPiP citation
Tri-County EI Evaluations BY Medicaid Insurance

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

Do not reproduce without proper OPIP citation
EI Evaluations BY Medicaid Insurance in SY 16-17: By County

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

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

#1: Indication of Follow-Up to Developmental Screening

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

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

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

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

- Due to time constraints today, we don’t have time to review all findings but they have been used to inform our recommendations.
Number of Children Found Eligible in the Tri-Counties

Percent Increase in Tri-Counties from 2016 vs. 2017: **11% (N=15)**

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

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

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

Do not reproduce without proper OPiP citation
Percentage of EI Referrals
Able to Be Evaluated & Eligible for EI in SY 16-17: By County

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

Do not reproduce without proper OPIP citation
EI Referral Outcomes by Medicaid Eligibility

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

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Not Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total: 25% (N=29)</td>
<td>Total: 75% (N=166)</td>
</tr>
<tr>
<td>21% (N=24)</td>
<td>41% (N=91)</td>
</tr>
<tr>
<td>4% (N=5)</td>
<td>34% (N=75)</td>
</tr>
<tr>
<td>75% (N=85)</td>
<td>25% (N=56)</td>
</tr>
</tbody>
</table>

94% of those evaluated were eligible
43% of those evaluated were eligible
25% of those evaluated were eligible

Evaluated & Eligible | Evaluated & Did Not Qualify | Not Evaluated
---|---|---

El Referral Outcomes by Medicaid Eligibility in SY 16-17: By County

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

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

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

- Ages 0-1yr Total N=83
  - 55% of those evaluated were eligible (N=24)
  - 29% (N=24) Evaluated & Eligible
  - 24% (N=20) Evaluated & Did Not Qualify
  - 47% (N=39) Not Evaluated

- Ages 1-2yrs Total N=125
  - 62% of those evaluated were eligible (N=49)
  - 39% (N=49) Evaluated & Eligible
  - 24% (N=30) Evaluated & Did Not Qualify
  - 37% (N=46) Not Evaluated

- Ages 2-3yrs Total N=128
  - 69% of those evaluated were eligible (N=68)
  - 54% (N=68) Evaluated & Eligible
  - 23% (N=30) Evaluated & Did Not Qualify
  - 23% (N=30) Not Evaluated

Total:
- 46% (N=60) Evaluated & Eligible
- 61% (N=76) Evaluated & Did Not Qualify
- 23% (N=30) Not Evaluated

Do not reproduce without proper OPIP citation
EI Referral Outcomes by Age of Child in SY 16-17: By County

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

Do not reproduce without proper OPiP citation
SY 16-17 Outcomes of Evaluation for Tri-Counties
By Top Referral Sources

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

Do not reproduce without proper OPiP citation
SY 16-17 Outcomes of Evaluation for Tri-Counties
By Physician/Clinic Referrals – By County

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

Do not reproduce without proper OPiP citation
Part 2: Based on these Learnings, What do We Focus On

DATA

\[ \downarrow \]

INSIGHTS

\[ \downarrow \]

Actions
Community-Level Assets Identified Through Phase 1

- Each interview asked people to identify resources in the community that can provide follow-up specific for children identified at-risk.
  - People interviewed across seven sectors
- Cataloged resources by whether they were:
  - A primary referral that provides a service directly related to risk identified
  - A secondary support for the family
    - Some resources address delays or promote developmental promotion, but eligibility and inclusion don’t map to screening periodicity (e.g. Healthy Families)
    - Some resources don’t serve children 0-3 (Head Start)
    - Some resources exist, but haven’t been used for young children yet (PCP internal behavioral health)
- Tracked resources people noted that they wished existed, but didn’t
  - Robust parenting classes and support, parenting supports for specific issues
  - Family nurse partnerships, more expansive home visiting
  - Mental health
  - PCIT (In one of the three counties)
  - Relief Nursery
  - Early Head Start
  - Quality medical translation services *(For screening and to support follow-up)*
PATHWAYS FOR DEVELOPMENTAL SCREENING OF CHILDREN 0-3 & REFERRAL FOR CHILDREN IDENTIFIED AT-RISK IN CLATSOP, COLUMBIA & TILLAMOOK COUNTIES

KEY STEPS

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

Primary Practices Conducting Screening at Recommended Periodicity (Based on CPCCO Claims):
1) CMH Pediatrics (CL - Pilot)
2) OHSU Scappoose (CO - Pilot)
3) Legacy St. Helens (CO)
4) Tillamook County CHC (TI - Pilot)

Primary Practices Who Appear Not to be Screening to Recommendation (Based on CPCCO Claims):
1) Coastal Family Health Center (CL)
2) Providence Seaside (CL)
3) Peacehealth Longview (CO)
4) CHC of Clatskanie (CO)
5) Adventist Health (TI, based on claims - perhaps not across all providers)
6) Rinehart Clinic (TI)

Community-Based Providers:
1) Home Visiting Programs [all]
2) Some WIC Nurses Use the ASQ [all]

Screening Fairs
Children 2-6 [all]

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

Developmental Promotion Activities [all]

Internal Behavioral Health [all]

Part 2b: Referral to Agency to Address Delays Identified

Devel. Behavioral Pediatrician*
1) OHSU-CDRC
2) Providence [all]

OT/PT/Speech
1) CMH Rehab Clinic (CL)
2) CO*
3) Adventist (TI)

EI/ESD/ECSE [all]

CaCoon/Babies First

Maternity Case Management [all]

Head Start CAT Inc. [all]

Healthy Families
1) CAT Inc. (CL, CO)
2) CARE Inc. (TI)

Child/Parent Psychotherapy
1) Clatsop Behav. Health (public only)
2) Columbia Cty Mental Health (public/private)
3) Tillamook Family Counseling Center (public)
4) Shasta Counseling (TI, out of pocket only)

PCIT Columbia County Mental Health

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

NW Parenting [all]

Options, Inc. (CL, CO)

Clatsop Community Action (CL)

Library Story Hours & Parent Groups (TI)

NW Regional Childcare Resources & Referral [all]

Community Connections Network (CL, TI)

Amani Center - when abuse is a factor (CO)

Lower Columbia Hispanic Council Classes (TI)

Child Welfare, DHS [all]

The Harbor Women’s Center (CL)

St. Helens HS Child Dev. & Teen Parent Prog (CO)

NOTE: Childcare sites not included in map as ages served puts them out of scope of the project. Numerous childcare sites are screening in this community.

LEGEND
COLOR CODING BY SERVICE TYPE

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

Early Intervention: Referral is for an Evaluation
CaCoon/Babies First

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

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

*Located outside the community

CL = Clatsop, CO = Columbia, TI = Tillamook

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### Part 2b – Expanded View: Referral to Agency to Address Delays Identified

<table>
<thead>
<tr>
<th></th>
<th>Devel. Behavioral Pediatrician</th>
<th>OT/PT/Speech</th>
<th>EI</th>
<th>CaCoon/Babies First/ Maternity Case Management</th>
<th>Head Start</th>
<th>Healthy Families</th>
<th>Child/Parent Psychotherapy</th>
<th>Parent &amp; Child Interaction Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clatsop</td>
<td>✗</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, public only</td>
<td>✗</td>
</tr>
<tr>
<td>Columbia</td>
<td>✗</td>
<td>✗</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tillamook</td>
<td>✗</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, public and out of pocket only</td>
<td>✗</td>
</tr>
<tr>
<td>Outside Community</td>
<td>OHSU CDRC Providence</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Note about the Future & Potential Role of NWELH

Community Level Need:
• Throughout all the interviews, the value of having a master document of resources in the community that serve these young children was noted as valuable.
• That said, resources change and their contact information change.
• It is also valuable to understand the capacity of those resources.
• It also would be valuable to add in WHO to refer (eligibility criterion) and HOW to refer to those resources and whether there are models of two-way communication.

Opportunity:
• This may be a good role for the ELH to play as part of family resource management to periodically update this document and set of resources and identify best dissemination methods.
• That said, it is integral that resources within health care (beyond just within CCO) be included in this map.
Phase 2: Improvement Pilots

- Baseline information and community-level input and priorities would guide areas of focus in each of the three counties.
- In proposal, sites that **pilot the improved processes (as defined in the project)**:
  1. **Primary care practice in each county** serving a large number of publicly insured children that, based on claims data, was conducting developmental screening: **OHSU Scappoose, CMH Astoria, Tillamook CHC**
  2. **Early Intervention** – Northwest Regional Education Service District local Service Centers
  3. Priority **Early Learning Provider** identified as a priority pathway in the community for this specific population (0-3 identified at-risk on screening tool)
- Sites will receive **improvement and transformation tools**, monthly **implementation support**, and refinements to the improvement tools will be made based on lessons learned and barriers identified
  - OPIP → Primary Care & Referrals from Primary Care
  - NWELH → EI and Early Learning
- At the end toolkits will be developed to spread to other stakeholders (**e.g. other primary care practices in the region, early learning providers**)

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Phase 2: Improvement Pilot Focus Areas

- Meetings held in Clatsop and Columbia Counties; Tillamook happens on 2/7 to review and confirm priorities
- Need for county-level variation
  - Primary care level of follow-up and knowledge of engagement with early learning providers varied
  - Resource availability different in each of the counties
  - Partners interested and invested in piloting new methods vary
- Areas Similar Across the Counties
  1. **Primary Care**: Enhance follow-up given majority of at-risk children do NOT receive follow-up
     - Decision tree for who, how and when to refer, including “dot connection” to early learning
     - Developmental promotion supports provided to the family that day
     - Parent education and shared decision making supports
     - Track the referrals made for at-risk youth
     - Care coordination and supports
     - Secondary referrals and supports depending on eligibility
  2. **Early Intervention**
     - Inform decision tree on best referrals to EI given EI eligibility standards
     - Children Referred, **Not Evaluated**: Communication and coordination to enhance rate
     - Children Evaluated, **Not Eligible**: Communication, Where applicable secondary referral to mental health
     - Children Evaluated, Eligible: Communication about services provided to inform secondary referral steps
Phase 2: Improvement Pilot Areas in Early Learning

- Early Learning Provider Pathway – Breadth Strategy
  - Asset map to share with stakeholders about WHAT exists in the community
  - In all three counties, the decision tree created for primary care will identify specific children who should be referred to specific community-level early providers

- Early Learning Pathway – Mental Health: In Clatsop (CBH) and Columbia (CCMH) Counties: Pilot of Specific Strategies to Engage Families with Young Children Identified with Social Emotional Delays and/or Delays and Exposure to ACES
  - Services exist within these communities
  - The mental health agency staff in these community want to pilot better connections between primary care and mental health for young children
  - Many people noted negative experiences with referrals for children, opportunity to address past experiences and create a “new narrative”
  - Stakeholders noted a number of barriers that the pilot could try and address ways to improve access of this pathway
    - Knowledge in primary care about the services
    - Talking points for PCPs in talking to families about the services
    - Ways to refer to mental health, ways to leverage internal primary care behavioral health services
    - Way to engage the family in the referral, including referral forms, “warm handoffs”
    - Two-way communication and feedback loops
  - Value in a small pilot that within just the pilot primary care sites and for applicable EI Ineligible children given concerns about what it will take and concerns about capacity of the system
Phase 2: Improvement Pilot Areas

In Tillamook County:

- EI referral rates are an issue, appears to be underuse of early learning resources
- Provider-level variation – two providers seem to be driving the follow-up that is occurring
- Within CPCCO, Adventist attributed slightly more young children than TCCHC to provide primary care
  - However, according to claims data, Adventist did not appear to be screening to periodicity or across their providers, early learning providers report majority of providers not screening
  - Therefore, TCCHC was chosen to be pilot site given they had the largest number of children **screened**
  - Community-partners repeatedly noted wanting Adventist to be engaged
  - Referral rates from Adventist to EI and Early Learning relatively low and largely driven by one provider highly respected in the community and by early learning providers
  - Adventist sponsors the Screening Fairs
  - In interview, Adventist noted they wanted to be engaged in this effort and that Child Health is a priority, noted that they are screening, but variation in provider-level knowledge of claims and follow-up
  - The provider who saw the most children in TCCHC (Pilot site) left in mid-January to join Adventist

- Therefore, if Adventist providers agree on 1/17, then we are proposing on February 7th:
  - OPIP provide Adventist follow-up to screening tools and support in exchange for Adventist agreement to address spread to the other providers in their system
  - Expands the breadth of this strategy to be engaging the two primary care sites to which 90% of CPCCO children are attributed to for primary care
  - Focus on how primary care – at large – can enhance best match referrals to the early learning providers in the community

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Community-Level Desire for Focus of Improvement Pilots Out of Scope of the Project, But Important to Note

- **General Understanding and Support for Developmental Promotion and Addressing Delays in Young Children:**
  - **General messaging**- synergistic approaches to addressing existing misperceptions in the community around the importance of screening and developmental promotion in general. Value of activities to promote children ready for kindergarten
  - **Address Stigmas**- Community wide approaches to address existing stigmas impacting families from following through on recommendations around development

- **Upstream Approaches to Engage Families and Provide Developmental Support to Prevent Delays:**
  - More universal home visiting services for all parents.
  - Parenting classes and parenting supports for all families.
  - Focus on access of mental health for children 3-5.

- **Work with practices not screening or not screening to fidelity to get them screening and then to do follow-up, work with all practices in the community**

- **Address children who lose continuous insurance coverage and potential access to care**

- **access of well-child care for children 2-3 years old**

- **Address attribution methods and understand better the differences between practice-level and system-level report of the number of children not coming in, to inform population management**

- **Develop capacity of existing systems, build capacity and existence of services**
Next Steps

• Follow-up to questions or needs for additional information raised today
• 2/7 Tillamook Meeting
• Baseline PCP data collection in 3rd site, CMH Astoria (ahead of timeline of project)
• Focus on the priority pathways discussed today, incorporating refinements noted in our discuss
  – Primary Care pilot site improvement efforts
  – EI pilot improvement efforts
  – Mental health pilot improvement efforts
  – Asset mapping with community-based providers
• Next Board Meeting the Findings will be Shared: June 2018
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
Slides Providing An Overview of Examples of Supports That will be Provided: We Will Prioritize Group Discussion Over Reviewing these Details
Support to Primary Care Pilot

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

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

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

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

- Early Intervention
- DB PEDS
- No Referral - Rest
- Mental Health
- CaCoon/Babies First
  - Centralized Home Visiting
  - Parenting Classes

ASQ Screen- Child Identified At-Risk
Targeted Developmental Promotion Materials for Areas of Development Identified: ASQ Learning Activities

Numerous Factors Determine the Best Match Follow Up

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Example of Medical Decision Tree from Past Projects

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

**Figure 1.0: Decision Tree - Pilot to Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks**

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

**GROUP A**
- **2 or More in the Black**
- **N= 111**
  - 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 Pediatrics](#) (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 in Black OR 2 or More in Grey**
  - And could benefit from EI
  - **N = 190**
  - 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**
- **“Waitlist Waiting”**
  - Borderline: 2 or More Grey OR 1 in Black But Not Ready to Refer to EI
  - Re-Screen in 3-6 Months, Set up a Follow-Up if Child Does Not Have A Visit

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

**Resource #1**
- **Child has a Medical Dx or Medical Risk Factors**
  - Ex: FTT, elevated lead, seizure disorder
  - AND
  - Social Risk Factors:
    - Ex: parent with inadequate knowledge/supports, alcohol/substance abuse, or mental illness, teen parent
  - Refer to CaCoon/Babies First
  - Use CaCoon Program Referral Form

**Resource #2**
- **Family Link**
  - Include Info on EI Referral
  - Child Lives in Marion/Polk County
  - Child Lives in Yamhill County

**Resource #3**
- **Mid-Valley Parenting**
  - www.midvalleyparenting.org
  - Parent Resources@co.polk.or.us
  - www.earlylearninghub.org

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

**GROUP D**
- In Black on Social Emotional Domain
  - Refer to internal behavioral health staff for further assessment and support
  - Behavior/Impulsivity with significant functional impact (e.g., eslapsed from child care)
  - Consider Use of Early Childhood Mental Health Dx Codes

- Options Counseling North Valley Mental Health, Salem Psychiatry
- Child Lives in Marion County
- Child Lives in Polk County

**Developed and Distributed by the Oregon Pediatric Improvement Partnership for Childhood Health**

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Family Supports in Navigating Referrals

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

- **Education sheet** for parent and to support shared decision making
- **Phone follow-up** for children referred
- **Communication back from Early Intervention** when child can’t be contacted, Care Coordination support from practice to reach out to the family
Follow-Up to Screening: How We Can Support Your Child

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

Our goal is to help young brains and bodies develop and grow to their fullest potential. These support services can help prepare your child for kindergarten and beyond.

National recommendations call for specific tools to be used to assess a child’s development, such as the one you completed. This tool helps identify kids who may be at-risk for delays. It is important to identify these delays early, as there are services that can address them.

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

<table>
<thead>
<tr>
<th>Early Intervention (EI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

1. **What to expect if your child was referred to EI:***
   - **WESD** will call you to set up an appointment for their team to assess your child.
   - **If you miss their call, you should call back to schedule a time for the evaluation.** They have a limited time to set up the appointment. Their phone number is (503) 335-3714.
   - **The results from their assessment will be used to determine whether or not EI can provide services for your child.**

*Contact Information:*
- **Tonya Color:** EI Program Coordinator
  - Phone: (503) 335-4366
  - Email: ode.state.or.us

<table>
<thead>
<tr>
<th>Medical/Therapy Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your child’s health care provider referred you to the following:</td>
</tr>
</tbody>
</table>
  - Speech Language Pathologists: Specializes in speech, voice, and swallowing disorders
  - Audiologists: Specializes in hearing and balance disorders
  - Occupational Therapists: Specializes in performance activities necessary for daily life
  - Physical Therapists: Specializes in range of motion and physical coordination
  - Developmental Behavioral Pediatricians: 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 assessment, individual/family group counseling, skills training, and crisis intervention
  - Autism Specialists: Specializes in providing a diagnosis and treatment plan for children with symptoms of Autism

<table>
<thead>
<tr>
<th>Parenting Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classes located in Marion County</td>
</tr>
<tr>
<td>Classes located in Polk County</td>
</tr>
</tbody>
</table>

**For children referred, better parent support and shared decision making**

1. **Sheet for parents to explain referrals to support shared decision making between primary care provider and parent**
2. **Phone follow-up within two days**
Phone Follow Up within 36 Hours

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

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

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

Answer questions (frequent questions or concerns highlighted in blue)

- When completing the referral, you were asked to sign the consent form. This gives Early Intervention permission to share information about the evaluation back to us. This helps us to provide the best care for (insert child name)
- Why go to EI/ What does EI do: At the appointment Willamette Education Service District will be doing a more detailed evaluation of (insert child’s name) development. Then, based on their assessment they will help us understand what we can do to support (insert child’s name) and whether your child may benefit from services.

Can you think of any barriers that might come up for you and your family in getting (insert child)’s name to these services?

- Barrier is transportation – discuss TripLink and how to set up a ride as needed

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

If no further questions: Great. You should be getting a call from the Early Intervention Coordinator, their names are Sandra or Gemma, to schedule an appointment.

We are here to support you, so if you have any questions, feel free to contact (insert name) at (phone number).
Early Intervention Support from NWELH and OPIP

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

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

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

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

Proposal is to Enhance Pathways to Infant and Early Childhood Mental Health
• Addresses an important high-risk population that would be identified on developmental screening and not address fully in current pathways
• Have capacity and expertise for the 0-3 population specifically
  – Child and Parent Psychotherapy
  – PCIT (Columbia Only)

Pilot would include
• Patient-Centered Methods for Engagement and Referral to MH from Pilot Primary Care Practices
  o Referral processes- pilot an improved referral process between Primary Care and MH, including workflow utilizing internal behavioral health resources at PCP (when available), and implementing new processes to expedite MH assessment processes, and improved collaboration between the two entities
  o Referral processes- pilot an improved referral process between EI and MH
  o Communication/coordination with PCP- about whether children get into referral, and follow up steps depending on the result. Improved workflows and processes

• Implementation Support
  – Meetings with PCP, MH and EI to confirm scope and opportunities for pilot
  – Development of engagement, referral and work flow processes, parent input and insight
  – Data collection to assess impact of the pilot

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Enhanced Pathways for Children Referred by Primary Care to Early Intervention and Engagement in Mental Health

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

OHSU Scappoose (Primary Care Pilot Site)

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

New Referral/Communication Form to CCMH

Child/Parent Psychotherapy and/or PCIT
Columbia County Mental Health (CCMH)

New Feedback Communication

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

Part 2: Referral to Agency to Address Delays Identified

EI Feedback Form Based Evaluation

Universal Referral Form

Ineligibility Report

EI: NW Regional ESD Columbia EI/ECSE

EI Evaluation

EI Eligible EI Ineligible

If Applicable, Referral to CCMH or OHSU PCP and In-Clinic Behavioral Support

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