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

Columbia Stakeholder Meeting 6/11/18
Agenda

1. Project Overview Refresher

2. Update on Improvement Pilots Within Priority Pathways
   a) **Primary Care- OHSA Scappoose, Family Medicine**
      - QI improvement: Training on medical decision tree, parent supports, and deep dive on specific referrals pathways
      - **Facilitated Discussion:**
        - Review tool created to support parent shared decision making and follow-up, discuss ways to support and engage parents
   b) **Early Intervention**
      - Update on quality improvement activities focused on new referral form, communication feedback loops
      - **Facilitated Discussion:**
        - Discuss strategies to connect families to other resources
   c) **Columbia County Mental Health (CCMH)**
      - **Facilitated Discussion:** Deep dive- GOBHI RFA

3. Next Steps

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Pathways from Developmental Screening to Services for Young Children Identified At-Risk

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

• Two-year project – August 2017-July 2019

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

• The project supports:
  – Phase 1: Across-sector stakeholder engagement and baseline data collection about current processes and where children are lost to follow-up (Complete)
  
  – Phase 2: Implement Pilots to improve the number of children who receive follow-up and coordination of care (Focus for Today)
Aim of the Improvement Pilots is to Increase the Proportion of At-Risk Children that Receive Best-Match Follow-Up

- Funded to pilot **improved processes** with three site. In Columbia county this is:
  1. **One primary care practice**: OHSU Scappoose
  2. **Early Intervention** – Northwest Regional Education Service District
  3. **External Specialty Infant and Early Childhood Mental Health**: Columbia County Mental Health

- Each site receives **improvement and transformation tools**, monthly **implementation support**, and refinements to the tools will be made based on lessons learned and barriers identified

- A key goal is to create a toolkit that is then used to **spread** the learnings and tools to other sites
  - E.g. Other primary care sites
Focus in Columbia County

Pilot Primary Care Site (OHSU Scappoose)
1) Enhanced developmental promotion for all at-risk children
2) Enhanced follow-up to developmental screening supported by:
   a) Development of a follow-up medical decision tree, including secondary follow-up, anchored to: i) ASQ scores, ii) Child and family factors, iii) Resources within the community
   b) Parent education sheet to support shared decision making, care coordination support strategies
   c) CPCCO summary of follow-up services and providers who see children 0-3
   d) Potentially leveraging internal behavioral health & pilot referral to specialty mental health (CCMH)

Early Intervention (NWRESD-Columbia)
1) Enhanced communication and coordination for children referred & not evaluated
2) Communication about evaluation results
   • For Ineligible Children: Communication Back to PCP to Inform Secondary Steps; If Applicable, Referral to Early Learning supports, Pilots of referral to CCMH.
   • For Eligible Children: Communication about EI services being provided to inform secondary steps

Early Learning
Early Learning Provider: CCMH
• Pilot new ways, in collaboration with PCP and early learning providers (for children paneled to OHSU Scappoose), to engage and connect families with mental health.
• Pilot ways EI could refer children for infant and early childhood mental health
Number of Children Assigned to Clinic
By Clinic’s Developmental Screening Rate

Data Source: Provided by CPCCO, October 2017 – FY 16-17 ONLY
Annual Number of Developmental Screens Submitted by 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
Follow-Up Documented in Chart:
1 in 3 At-Risk Children Received Some Level of Follow-Up

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.

*NOTE: N=3 Children received 2 follow-up steps
Follow-Up for At-Risk Children Documented in Chart: By Levels of Risk Identified

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.
Key Areas of Focus to Support Primary Care Pilot to Improve Follow-Up

OPIP Development of Tools to Support Enhanced Follow-Up:

1. Medical Decision Tree
2. Parent Education/Shared Decision Making Tool
3. 36 Hour Phone Follow-Up Script
4. CPCCO Summary of Services

OPIP Implementation Support with OHSU Scappoose QI team:

1. Baseline workflow assessment in site
2. Monthly site visit by OPIP Practice Facilitation
3. Provider-level data reports
4. All site training on the tools
5. Scheduling follow-up meetings with providers who see a lot of providers and were unable to attend training
6. MA Implementation Meeting (coming up)

Examining Referrals to EI and Pathways to Inform QI
Decision Tree Anchored to Services within Primary Care and External Referrals and Supports

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

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

Developmental Promotion Activities

Potential Internal Behavioral Health

Part 2b: Referral to Agency to Address Delays Identified

In Columbia County

EI NW Regional ESD Columbia EI/ECSE

Babies First

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

Outside Columbia County

Developmental Behavioral Pediatrician

1) OHSU-CDRC

2) Providence

OT/PT/ Speech Therapy

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

On Community Action Team (CAT) Contact Us Platform

www.catteam.org/surveys/index.html

NW Parenting

NW Regional Childcare Resources & Referral at 211

Maternity Case Management

Healthy Families

St. Helens High School Child Development and Teen Parent Program

WIC

Head Start

Other Local Agencies that Provide Supports for Specific Families that Referrals and/or Communication About Child’s Development May Be Helpful

Child Welfare, DHS

Options, Inc. (Behavioral Health and family preservation services)

Amani Center (when abuse is a factor)
Determining the “Best Match” Follow Up for the Child and Family

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

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

- Internal Behavioral Health (potentially)
- Mental Health

No Referral - Retest

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

Medical Therapy
Babies First
DB PEDS
EI

Community-Based Supports Addressing Social Determinant of Developmental Promotion

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Follow-Up to Screening Decision Tree

Factors that will drive the *best match follow-up service*

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

- **All children identified at-risk receive developmental promotion**
Follow-Up to Screening Decision Tree
After needs are identified, how do we help families get to needed follow-ups?

- Parent Education/ Shared Decision-Making Tool to Support Conversations with the Family
- Phone follow-up regarding referrals
- Use of communication back from referred entities to inform next steps and family supports
Follow-Up to Screening: How We Can Support Your Child

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

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

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

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

- **Early Intervention**
  - Who is Early Intervention (EI)?
  - EI helps babies and toddlers with their development. In your area, Northwest Regional Education Service District (NWRESD) runs the Columbia Service Center 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.

- **Babies First**
  - Who is Babies First?
  - Babies First are public health nursing programs serving families. Babies First public health nurses work with your family to support your child's health and development. A nurse will meet with you in your home or wherever works best for you and your child.
  - There is no charge (it is free) to families for Babies First services.
  - Contact Information:
    - Healthy Home
    - Phone: 503-197-4051
    - Website: www.phc.dh.org/home-visiting-programs

- **Medical and Therapy Services**
  - Your child's health care provider referred you to the following:
    - Speech Language Pathologist: Specializes in speech, voice, and swallowing disorders
    - Audiologist: Specializes in hearing and balance concerns
    - Developmental-Behavioral Pediatrician: Specializes in the following child development areas: Learning delays, feeding problems, behavior concerns, delayed development in speech, motor, or cognitive skills
    - Autism Specialist: Specializes in providing a diagnosis and treatment plan for children with symptoms of Autism
    - Occupational Therapist: Specializes in performance activities necessary for daily life
    - Physical Therapist: Specializes in range of movement and physical coordination

**Any Questions?**

At OHSU Santéqus, we are here to support you and your child. If you have questions about this process please call us.

Phone Number: 503-918-4622

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

**Shared Decision Making Tool**

Improved engagement with families around decisions related to follow ups and referrals.

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Version 3.0: 4/10

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Phone Follow Up within 36 Hours

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

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

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

**Answer questions (frequent questions or concerns highlighted in blue)**

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

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

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

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

We are here to support you, so if you have any questions, feel free to contact (insert name) at (phone number).
Examining Implementation and Why OPIP Focuses on Work Flows and Data Tracking – Example Related to EI Referrals

- OPIP has learned that providing and training on tools is often not enough to support standardized and consistent implementation
- Importance of building processes into workflow and assigning roles and responsibilities
- Importance of examining and tracking data through the project in order to assess implementation, identify gaps, and support improvement.
- Example Related to EI Referrals:
  - At baseline, we showed you population-level data from primary care practice and EI.
  - To inform the QI efforts and identify gaps, we had OHSU Scapoose.send a data file of children the chart indicated they referred to EI or had not referred to EI as they had already been referred to EI.
  - EI then examined the children listed in the database to identify:
    - Was referral received
      - If so, were they able to contact the family
        - If so, were they able to evaluate the family
        - If so, was the child eligible
Screens that Identified a risk N=106

Documentation of Early Intervention Referral N=32
(30% of at-risk children were referred)

Referred at Time of Visit N=17

Of the 17, EI received 11 referrals (35% difference)

EI EVALUATED 4 children (25% of children referred at time of visit)
- 2 children were ELIGIBLE (12% of children referred got services)
- 2 children were INELIGIBLE

EI was NOT ABLE TO EVALUATE 7 children
- Parent declined N=3
- Unable to contact N=3
- Screened Out N=1

Previous Referred N=15

Of the 15, EI received 8 referrals (47% difference)

In process of understanding the outcome of these referrals

Referred, Parent Declined N=3
Communication of Outcome of Referral from EI

- Of the 17, EI has received 11 referrals (59%)
- EI was NOT ABLE TO EVALUATE 7 children
- EI EVALUATED 4 children
  - 2 children were ELIGIBLE (12% of children referred got services)
  - 2 children were INELIGIBLE

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

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

☐ Family contacted on __/__/____. The child was evaluated on __/__/____ and was found to be:
☐ Eligible for services    ☐ Not eligible for services at this time, referred to: __________________________
☐ Parent Declined Evaluation ☐ Parent Does Not Have Concerns
☐ Unable to contact parent  ☐ Attempts__________  ☐ EI/ECSE will close referral on __/__/____.
Communication of Outcome of Referral from EI

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

Service Summary

Child's Name: SAMPLE, Willow

Birthdate: 02/01/00

Your patient Willow was found eligible for Early intervention services on:

Sample was found eligible under the category:

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

IFSP Goal Areas

- Cognitive
- Social / Emotional
- Motor
- Adaptive
- Communication

IFSP Services Provided

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

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

This document represents services determined by the IFSP to provide educational benefit. Any services identified or recommended by medical providers are separate and not represented on this form.

Of the 17, EI has received 11 referrals (69%)

EI was NOT ABLE TO EVALUATE 7 children

EI EVALUATED 4 children

2 children were ELIGIBLE (12% of children referred got services)

2 children were INELIGIBLE
Questions

• What has been the most impactful change since starting this project?
• What are some key successes and lessons learned to date?
• What are you most looking forward to as we continue our work together?
**Shared Decision-Making Tool**

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

**Family Supports**

- What have you learned is key to helping support families to navigate referrals and follow-up?
- What words do you use to describe these services?
- Are there words or ways to describe the services that you have found you need to use for different cultures or educational levels?
Focus in Columbia County

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Early Learning
Early Learning Provider: CCMH
• Pilot new ways, in collaboration with PCP practice and early learning providers (for children paneled to OHSU Scappoose), to engage and connect families with mental health.
• Pilot ways EI could refer children for infant and early childhood mental health
# Areas of Improvement for Columbia Service Center

<table>
<thead>
<tr>
<th>Component of the EI Referral, Evaluation, and Service Process</th>
<th>Columbia Baseline</th>
<th>QI Focus Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QI Focus #1: Connection with Children/Families Referred, Timely Communication Back to Referring Entity To Inform Their Outreach to the Parent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach to Referred Child/Family</td>
<td>2-3 Phone Calls</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Text</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Letter (Sent when outreach will stop)</td>
<td>X</td>
</tr>
<tr>
<td>Communication to Referral Source When Not Able to Evaluate.</td>
<td>Fax URF When Letter Sent (Before Case Closed)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Fax At 45/60 Day (When Case Closed)</td>
<td>X</td>
</tr>
<tr>
<td>Standardized Data Entry in ECWeb of Non-Required Fields</td>
<td>Practice and Provider Name</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Feedback Sent for Unable to Contact</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Feedback Sent on Non-Evaluated Children</td>
<td>X</td>
</tr>
<tr>
<td><strong>QI Focus #2: Referred Children Evaluated, Communication about Results of Evaluation</strong></td>
<td>Mon at 1 Thurs/Friday at 9 or 1 Th</td>
<td>As of July 1: T/W/Th offered 2 timeslots each day</td>
</tr>
<tr>
<td>Days/Time of Evaluation for EI Services</td>
<td>Ineligible Children: Fax Back Bottom of URF When Not Eligible</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Eligible Children: Communication Requested Sent Back (Eval Summary, IFSP etc.)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Summary of Services (New Form), if New URF Used</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Data Entry in ECWeb of Non-Required PCP Feedback Field</td>
<td>X</td>
</tr>
<tr>
<td><strong>QI Focus #3: New Outreach and Education Supports and Referral of EI Ineligible</strong></td>
<td>Standardized Call Back Process to Reassess Child</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Provision of CDC Act Early Materials</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Standardized Referral Process of Applicable Children to Mental Health</td>
<td>X</td>
</tr>
</tbody>
</table>
Standardized Documentation in **ECWeb**:  
Clinic and Provider Level Documentation  
Communications sent to referring providers

**Improved Communication**  
Piloting additional approaches of outreach including email and text  
Communication when not able to contact families  
When child is evaluated and found **INELIGIBLE**  
When child is evaluated and found **ELIGIBLE**

As of July 1, additional evaluation spots will be available
Updates were made to the **Universal Referral Form** based on collective feedback from a previous pilot facilitated in partnership between OPIP and Willamette Education Service District (WESD).

In March, ODE made it the “standard” the items that were key components of the pilot
Columbia Service Center sends this to referring providers noting that the ESD Coordinator was unable to contact the referred family.
Columbia Service Center sends the Service Summary to referring providers for children when:

- Referred children are found **ELIGIBLE**
- Whenever changes are made to the services being provided (annually)
High level Improvement Workflows

1. Data Collection and Sharing Improvements
2. Communication to Referring Provider Improvements
3. Improved Family Engagement QI

Key:
- Purple: Primary Care Process
- Diamond: EI Service Center Process
- Box: NEW Process to Pilot

URF – Universal Referral Form
SS – Service Summary

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Amani Center (when abuse is a factor)
Early Learning Provider Pathway Pilot in Columbia County

Enhance Pathways to Infant and Early Childhood Mental Health at CCMH

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

Initial Plans for the Pilot included:

- Patient-Centered Methods for Engagement and Referral to CCMH from Pilot Primary Care Practice (Includes secondary referrals for OHSU Scappoose Patients referred to EI):
  - Referral processes- Primary Care (OHSU Scappoose) to CCMH
  - Secondary Referral processes- EI to CCMH for both eligible and ineligible children
  - Communication/coordination with referring entity- Two way communication to support coordination of care
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 (Potentially)
- Assessment of family
- Engagement of family on mental health services, models for safe connection

Child/Parent Psychotherapy/ Parent/Child Interaction Therapy
Columbia Community Mental Health (CCMH)

If Applicable, Referral to CCMH Or PCP and Internal Behavioral Support

KEY STEPS

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

EI Ineligibility Report

New Referral/ Communication Form to CCMH For Young Children

EI: NW Regional ESD Columbia EI/ECSE

EI Evaluation

EI: Eligible EI Ineligible

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**Pathway Pilot To Specialty Infant and Early Childhood Mental Health**

**Work to date**
- Engaging relevant teams from OHSU and CCMH, Meeting held with each team
- Requests for existing tools, strategies, and methods related to:
  - Within Primary Care: Internal pathways to behavioral health and understanding of infant and early childhood mental health
  - With CCMH: Referral forms, assessment, communication feedback loops
- Literature review, interviews of experts around the country, and overall search for helpful information, tools, and models that exist
  - Workflows and models
  - Talking points and information sheets
  - Assessments
  - Referral Forms
  - Communication Forms
  - Information about billing and coding in both primary care and mental health
OPIP Proposal to GOHBI to Support Needs Identified in This Project

• In preliminary discussions with the sites and gathering current processes, we identified that a number of the tools, strategies and pathways are not developed or in place.
• This development work goes beyond the scope of the current CPCCO funding
• GOHBI asked OPIP to submit a grant request to support the tools and strategy need AND to support implementation strategies.
  – Collaborative effort with OPIP, OHSU Scappoose and CCMH
  – This will be funded, GOHBI determining level of support they can provide
• Will be exploring funding to address the broader need and area of focus for pregnant moms and young children overall.

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Training, Curriculum and Implementation Support Needed to Ensure a True Pathway Addressing Mental Health for Young Children

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

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

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

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

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New Opportunity- OPIP Proposal to GOHBI

_Hearing from you:_

- Questions or comments regarding this new and “deeper” work related to support infant and early childhood mental health?
- Any feedback or input regarding the approaches we described?
- Are there any other considerations we missed? Any challenges or barriers that exist?
Resources and Connection to the Family: What are ways to operationalize best match supports?

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

**PATHWAY FOR DEVELOPMENTAL SCREENING & REFERRAL FOR CHILDREN 0-3 IDENTIFIED AT-RISK IN COLUMBIA COUNTY**

<table>
<thead>
<tr>
<th>Part 2a: Developmental Supports to Address Delays Identified By Entity Who SCREENED</th>
<th>Developmental Promotion Activities</th>
<th>Potential Internal Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In Columbia County</strong></td>
<td><strong>EI</strong></td>
<td><strong>Child/Parent Psychotherapy/PCIT</strong></td>
</tr>
<tr>
<td>NW Regional ESD</td>
<td>Columbia EI/ECSE</td>
<td>Columbia County Mental Health (CCMH)</td>
</tr>
<tr>
<td>Babies First</td>
<td><strong>OT/PT/ Speech Therapy</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outside Columbia County</strong></td>
<td><strong>Developmental Behavioral Pediatrician</strong></td>
<td></td>
</tr>
<tr>
<td>1) OHSU-CDRC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Providence</td>
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<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>On Community Action Team (CAT) Contact Us Platform</th>
<th>NW Parenting</th>
<th>NW Regional Childcare Resources &amp; Referral at 211</th>
<th>Maternity Case Management</th>
<th>Healthy Families</th>
<th>St. Helens High School Child Development and Teen Parent Program</th>
<th>WIC</th>
<th>Head Start</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.catteam.org/surveys/index.html">www.catteam.org/surveys/index.html</a></td>
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</tr>
</tbody>
</table>

**Other Local Agencies that Provide Supports for Specific Families that Referrals and/or Communication About Child’s Development May be Helpful**

| Child Welfare, DHS | Options, Inc. (Behavioral Health and family preservation services) | Amani Center (when abuse is a factor) | |
|---|---|---|
Next Steps

• Follow-up to questions or needs for additional information raised today

• Focus on the **priority pathways** discussed today, incorporating refinements
  – Primary Care Pilot site improvement efforts
    • **Including pilot of Resource Connection**
    – EI improvement efforts
    – CCMH Pilot

• Presentation on this work at Innovation Café for CCOs in June

• **Next Stakeholder Meeting- Monday, December 10th**
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)