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

Tillamook Stakeholder Meeting 6/6/18

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1. Project Overview Refresher
2. Update on Improvement Pilots Within Priority Pathways
   a) Primary Care - Tillamook County Community Health Center, Adventist Health
      • Baseline data collection in Adventist
      • Overview of tools created
      • Training on medical decision tree, parent supports, and deep dive on specific referral pathways
   b) Early Intervention
      • New referral form, communication feedback loops, data tracking
3. Facilitated Discussion: Feedback on specific tools, and ways to engage families around referrals to community resources
4. Proposal and Facilitated Discussion: Early Learning Resource Connections
5. Next Steps
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

• Sites piloting the improved processes are:
  
  1. **Primary care practices:**
     • Tillamook County Community Health Center
     • Adventist Health- Women’s and Family Health Clinic
  
  2. **Early Intervention**
     • Northwest Regional Education Service District- Tillamook Service Center

• 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.
### Focus of Improvement Pilots in Tillamook County

#### Pilot Primary Care Sites
(TCCHC and Adventist Women’s and Family)
- **Baseline and evaluation data**
- **General education** on global developmental promotion, EI physician eligibility
- **For children identified at-risk:**
  - Enhanced provision of specific **developmental promotion** that families can do at home
  - Standardized process for enhanced referrals for best match set of services based on assets in the practice and the community:
    - Development of a follow-up medical decision tree, including secondary follow-up, anchored to:
      - ASQ scores
      - Child and family factors
      - Resources within the community
    - Parent education sheet to support shared decision making, care coordination support strategies
    - CPCCO summary of follow-up services and providers who see children 0-3
- **Coordination of care**

#### Early Intervention (NWESD-Tillamook)
- **Data tracking**
- **For Children Referred, Not Able to be Evaluated:** Enhanced communication and coordination for referred children not able to be evaluated, Outreach strategies
- **For Ineligible Children:**
  - Communication Back to PCP to Inform Secondary Steps; If applicable, referral to early learning supports
- **For Eligible Children:**
  - Communication about Services Provided to Inform Applicable Secondary Supports
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

  - 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: 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
Purpose of the Baseline and Evaluation Data Collection in the Pilot Sites

• Collect Baseline Data to Inform the **Community-Level Conversations** to Understand Current Population Need, Current Referral Patterns, and Opportunities for Improvement
  – General information about panel, and panel site
  – Of who they identify at their panel, number who come in
  – Screening (Claims, Documentation in EMR)
  – Proportion of children identified at-risk (Documentation in EMR on domain-level scores)
  – Follow-up steps (Documentation in the EMR)

• Collect Baseline Data Used to **Compare and Evaluate the Impact** of the Improvement Efforts

• Understand current data limitations in order to identify component of the **quality improvement work** that will involve **tracking** and **workflow related to documentation**

• Identify potential **improvements in the EMR templates** that are aligned with future improved processes and referral pathways for young children

• Provide **information to CPCCO and other stakeholders related to measurement opportunities and challenges** given follow-up to developmental screening and kindergarten readiness are “on deck” CCO incentive metrics
Adventist Women and Family’s: Update on Baseline Data Collection

Some background context:

Adventist Women’s and Family
   – Has 3 providers who see children
   – 2 additional providers provide OBGYN services

Electronic Medical Record (EMR)
   – EPIC ....but a different version that used at The Health Center

Developmental Screening Process (Important when designing a metric that is follow-up to developmental screening)
   – Screen at Well-Visits
      • Before 1: 2, 4, 6 and 9 month well-visit
         – For comparability with other pilot sites, our data starts at 6 months
      • Before 2: 12 and 18 month well visit
      • Before 3: 24 months well-visit and 30 month for Medicaid patients
        (Also screen at 36 month well visit - outside scope of data)
Adventist Women and Family’s: Update on Baseline Data Collection

Baseline Data Metrics:
1. Proportion of children who received a developmental screen
2. Proportion of children identified at-risk on developmental screen
   ✓ This is the denominator of the follow-up metric
3. Proportion of children identified at-risk who received follow-up
   ✓ Follow-up includes promotion, retest, referrals within health care, referrals outside of health care

Update on Status of Working with Adventist to Collect Baseline Data:
- Understanding what is searchable in the EMR (and a report can be created) and what is not searchable.
- Searchable Fields: 1) Screen, 2) Proportion At-Risk
  o A report request has been submitted and will be available in mid-June
- Not Fully Searchable: All fields within follow-up
  o Will require a medical chart review
  o Will generate the sample for the medical chart review based on the report
Key Areas of Focus to Support Improved Follow Up

Pilot Primary Care Sites

• **General education** on global developmental promotion, EI physician eligibility
• **For children identified at-risk:**
  - Enhanced provision of specific developmental promotion that families can do at home
  - Standardized process for enhanced referrals for best match set of services based on assets in the practice and the community:
    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
• **Coordination of care**

**OPIP Development of Tools to Support Enhanced Follow-Up Aligned with Resources in the Community:**

• Medical Decision Tree
• Parent Education/Shared Decision Making Tool
• Phone Follow-Up Script
• CPCCO Summary of Services

**OPIP Implementation Support – Use of tools with TCCHC and Adventist QI teams**

• Baseline workflow assessment on site
• Monthly site visits by OPIP Practice Facilitator
• Training on tools developed
• Planning for training with community-based providers

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# Assets Identified Within Primary Care Sites, Referral Entities and Community-Level Supports

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

### Key Steps

**Part 1:** Children 0-3 Identified At-Risk on a Developmental Screening

- **Primary Practices Conducting Screening at Recommended Periodicity:**
  1. TCCHC

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

- **Developmental Promotion Activities**

**Part 2b:** Referral to Agency to Address Delays Identified In Tillamook County

- **OT/PT/ Speech Therapy at Adventist**
  - NW Regional ESD Tillamook EI/ECSE
- **CaCoon/ Babies First**
- **Child/Parent Psychotherapy (CPP)**
  - Tillamook Family Counseling Center (TFCC)
- **CPP Shasta Counseling (no insurance)**

Outside County

- **Developmental Behavioral Pediatrician**
  1. OHSU-CDRC
  2. Providence

**Additional Family Supports that Address Child Development and Promotion**

- **NW Parenting**
- **NW Regional Childcare Resources & Referral**
- **Self Sufficiency, DHS**
- **Child Welfare, DHS**
- **WIC**
- **Community Connections Network**
- **Head Start CAT Inc**
- **Healthy Families CARE Inc**
- **Maternity Case Mgmt**
- **Lower Columbia Hispanic Council Classes**
- **Library Story Hours and Parent Groups**

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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

Numerous Factors Determine the Best Match Follow Up

ASQ Screen- Child Identified At-Risk

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

Community-Based Supports Addressing Social Determinant of Developmental Promotion

No Referral - Retest

Medical Therapy

CaCoon/Babies First

EI

DB PEDS
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 Developmental Screening: Priority Referrals that Address Specific Delays

Based on asset map for Tillamook County, priority follow-up referrals include:

1. Early Intervention (EI)
2. Developmental Behavioral Pediatrics (DBP)
3. Medical and Therapy Services
4. CaCoon/Babies First

<table>
<thead>
<tr>
<th>Part 2b: Referral to Agency to Address Delays Identified</th>
<th>In Tillamook County</th>
<th>Outside County</th>
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<td>2) Providence</td>
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Figure 3.6: Medical Decision Tree for Follow-Up to Developmental Screening Conducted in the first Three Years of Life and Referral Opportunities Addressing Risk in Tillamook County

Follow-Up to Screening Decision Tree

- Ages 0-11 months
  - ASQ: 10 domains identified in black
  - Parental/Provider Concern
  - Refer to Early Intervention For An Evaluation
    - Use Universal Referral Form and families sign FERPA
    - Consider Supplemental Medical and Therapy Services
      - If Communication Domain > Speech Therapy and Audiology Evaluation
      - If Fine Motor/ Gross Motor > OT/PT
      - (See One-Page Summary of CPCCCO Providers and Coverage)
  - Re-Screen within 3 Months:
    - Set up a Follow-Up if Child Does Not Have A Visit

- Ages 12 months to 36 months
  - ASQ: 10 domains identified at Risk
  - Parental/Provider Concern
  - YES:
    - Refer to Early Intervention For An Evaluation
      - Use Universal Referral Form and families sign FERPA
      - Consider Referral to Developmental/Behavioral Pediatrician
        - See DB Peds Referral Cheat Sheet
      - Consider Supplemental Medical and Therapy Services
        - If Communication Domain > Speech Therapy and Audiology Evaluation
        - If Fine Motor/ Gross Motor > OT/PT
        - (See One-Page Summary of CPCCCO Providers and Coverage)
    - Re-Screen within 3 Months:
      - Set up a Follow-Up if Child Does Not Have A Visit

- All ages and other domains identified at Risk
  - Social Risk Factors
    - Malnutrition
    - Income/insurance
    - Domestic violence
    - Child abuse
  - Parental/Provider Concern
    - Refer to CaCaOo/Babies First
      - Use Program Referral Form
      - Use County Level HUB Case Coordination Platform

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Trainings Completed in Pilot Sites

Tillamook County Community Health

April 11th – Trained all staff on medical decision tree, with a deep dive on specific referrals to:

1. Early Intervention (EI)
2. Developmental Behavioral Pediatrics (DBP)
3. Medical and Therapy Services
4. CaCoon/Babies First

Adventist Women’s and Family Health

• Training of two providers who see the most children (Ann, Erin) and MA staff on:
  – Medical decision tree
  – Early Intervention
In Development for Primary Care Pilots

Speech, Physical, and Occupational therapy ICD-10 diagnosis codes

Speech:
F80.0 Specific developmental disorders of speech and language
  F80.0.0 Phonological disorder/Dyslalia/Functional speech articulation disorder
F80.1 Expressive language disorder
F80.2 Mixed receptive-expressive speech delay
F80.4 Speech and language developmental delay due to hearing loss
F80.8 Other developmental disorders of speech and language
  F80.8.1 Childhood onset fluency disorder/stuttering
  F80.8.2 Social pragmatic communication disorder
  F80.8.9 Other developmental disorders of speech and language
F80.9 Developmental disorder of speech and language, unspecified/communication disorder/language disorder
F84 Pervasive developmental disorder
  F84.0 Autistic disorder
  F84.9 Pervasive developmental disorder, unspecified
F98.2 Other feeding disorders of infancy and childhood
  F98.2.1 Rumination disorder of infancy
  F98.2.9 Other feeding disorders of infancy and early childhood
G35.3 Disorder of central nervous system, unspecified
G98.8 Other disorders of nervous system
H90.25 Central auditory processing disorder
R23.1 Dysphagia

In partnership with Sonya at Adventist Rehabilitation Center

• Working to develop a list of diagnosis codes to improve a child’s eligibility for services
• We are engaging frontline providers and coders in the development of this tool
After needs and follow ups are identified, how do we help families get to needed follow-ups?

Tools and Strategies Developed by OPIP:

1. **Parent Education/ Shared Decision-Making Tool to Support Conversations with the Family**

2. **Phone follow-up regarding referrals**

3. **Practice-level work flow on 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?
  - If your child receives services through Early Intervention, we will ensure that their services are coordinated.
  - There are no changes related to families for EI services.

- CaCoOn/BabiesFirst
  - Who is CaCoOn and BabiesFirst?
  - CaCoOn and BabiesFirst are public health programs serving families in public health nurseries. We will work with your family to support your child’s health and development.

- Medical and Therapy Services
  - Speech Language Pathologist: Specializes in speech, voice, and swallowing disorders.
  - Audiology: Specializes in hearing and balance disorders.
  - Developmental Behavioral Pediatrics: Specializes in the following child development areas: Learning delays, feeding problems, behavior disorders, delayed development in spacial, social, or cognitive skills.
  - Autism Specialist: Specializes in providing a diagnostic and treatment plan for children with symptoms of Autism.
  - Occupational Therapist: Specializes in skills necessary for daily life.
  - Physical Therapist: Specializes in range of movement and physical coordination.
  - Behavioral Health: Along with medical care, the Health Center can offer Behavioral Health counseling to help promote healthy development.

- Tillamook Library
  - Storytime
    - The library offers storytimes for kids of all ages. Reading aloud to your child is a great way to promote language development.

Any Questions?

At the Health Center, we are here to support you and your child. If you have questions about this process, please call the Health Center at [phone number].

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Shared Decision Making Tool

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

We would also like your feedback for future iterations of this tool.
Pilot: Phone Follow-Up Script for Referred Children

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 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 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).
Hearing from Pilot Sites

• The Health Center
• Adventist Women’s and Family

• 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?
Gail’s perspective on accessing services for her granddaughter
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 of Improvement Pilots in Tillamook County

Pilot Primary Care Sites (TCCHC and Adventist Women’s and Family)
- **Baseline and evaluation data**
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    - **CPCCO summary of follow-up services and providers** who see children 0-3
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Early Intervention (NWESD-Tillamook)
- **Data tracking**
- **For Children Referred, Not Able to be Evaluated**: Enhanced communication and coordination for referred children not able to be evaluated, Outreach strategies
- **For Ineligible Children**: Communication Back to PCP to Inform Secondary Steps; If applicable, referral to early learning supports
- **For Eligible Children**: Communication about Services Provided to Inform Applicable Secondary Supports
NWRESD- Tillamook Improvement Efforts since January

Standardized Documentation in ECWeb:
- Clinic and Provider Level Documentation
- Communications sent to referring providers
  Currently this is only for Physician/Clinics – working on spread to all referring entities

Improved Communication
- Communication when not able to contact families
- When child is evaluated and found INELIGIBLE
- When child is evaluated and found ELIGIBLE
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,
**Early Intervention**
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
   • For Eligible Children: Communication about EI services being provided to inform secondary steps

**Pilot Primary Care Sites**
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

**QI Work Impacted by the New URF**

**Training on the new URF, standardized use and completion, training & implementation supports**

**Use of the information EI provides back is part of the PCP QI process for:**
1) Children not able to be evaluated
2) Children ineligible
3) Children eligible

**Children eligible and a summary PCPs will use - New Summary of Service**
EI/ECSE Unable to Contact

Tillamook Service Center sends this to referring providers noting that the ESD Coordinator was unable to contact the referred family.
Tillamook 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)
### Areas of Improvement for Tillamook Service Center

<table>
<thead>
<tr>
<th>Component of the EI Referral, Evaluation, and Service Process</th>
<th>Tillamook Baseline</th>
<th>QI Focus Area</th>
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<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>
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<td><strong>Outreach to Referred Child/Family</strong></td>
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<td>Text X</td>
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<td>Email X</td>
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<td>Letter (Sent when outreach will stop) X</td>
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Hearing from NWRESD- Tillamook Service Center

– 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?
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*

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Early Learning Resource Guide

Focused on resources and support available for children ages 0-5

• Brief description of program
• Location (area served)
• Ages served
• Eligibility criteria
• Contact information
• How to refer (link to referral form- fax, call, etc.)
• Any cost associated
• Other things that would be important to include
• Logo
Early Learning Resource Connection Proposal

Listserv
Connect partners directly to each other to share resources, ideas, and connections
- Pose questions for one another
- What resources/programs are appropriate for families
- Share family factors without PHI

DHS Self-Sufficiency Child Welfare

WIC

Community Connections Network

Head Start

Healthy Families

Maternity Case Management

Lower Columbia Hispanic Council

NW Regional CCR&R

NW Parenting

Library Story Hours

Parent Groups
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
  - EI improvement efforts

- Presentation on this work at the Innovation Café for CCOs in June

- **Next Stakeholder Meeting- December 5th, 2018**
Questions? Want to Provide Input?
You Are Key to the Success of This Work

- Door is always open!
- NWELH Lead
  - Dorothy Spence:
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    - 503-614-1682 (office)
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