Ensuring Young Children Identified on Developmental Screening Receive Follow-Up:

*Lessons From A Community-Based Approach Engaging Primary Care, Early Intervention, and Early Learning System Providers*

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Momentum Around Developmental Screening in Oregon

*Within Health Care:*
- Coordinated Care Organization Incentive Metric – Developmental Screening
- Oregon Patient Centered Primary Care Homes (PCPCH) Standards - Includes Developmental Screening as “Must Pass” Standard

*Within Early Learning:*
- Early Learning Hub Metrics – 1st wave Included CCO Developmental Screening Incentive Metric
- High quality child care – part of highest level designation
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 Early Intervention (EI) have increased, but not proportional to screening rates
  - Number of children **served** by EI also did not increase 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).
Key Components of Community-Based Improvement Efforts to Increase the Number of Children Receiving Follow-Up

1. Community-level Stakeholder **Engagement** Across Six Sectors, Including 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:*

A. Primary Care Providers  
B. Early Intervention  
C. Early Learning
Current Pathways and Community Asset Map: Example from Marion and Polk County
Community-Based Improvement Opportunity: Pilot Sites Implementing Efforts to Improve Follow-Up

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 HUB (e.g. VROOM, ACT Early, ASQ Learning Activities)
2) NEW referrals from PCP/EI being to:
   • Centralized home visiting referral
   • Evidence based parenting classes

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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

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
- Mental Health
- No Referral - Rest

- 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

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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
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 Risk Factors Present or Exposure to Adverse Childhood Events & would benefit from Home Visiting and/or Head Start

Publicly Insured

- 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?

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

- Marion & Polk Early Learning Hub
  www.earlylearninghub.org
  Email: parentinghub@earlylearninghub.org
A new Individual Family Service Plan (IFSP) was developed for your patient $Fname on $ifsp. These services will be reviewed again no later than $nextifsp.

IFSP Services:

Early Intervention Goal Areas: Cognitive [ ] Social Emotional [ ] Motor [ ] Adaptive [ ] Communication [ ]

Services Provided by:

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

Please contact $service coordinator 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 by this process.
Family Supports in Navigating Referrals

Informed by parent advisors, developed tools and 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 topics to be assessed as your child's development. The one you completed will help identify if 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

For children referred, better parent support:
More Information

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2. 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