



Oregon Department of Education  
Salam Noor, Deputy Superintendent

**2016**

**Pathways from  
Developmental  
Screening to  
Early Services**

**Progress Report**

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## **Introduction**

In 2015 the Oregon Legislature directed Oregon Department of Education to identify pathways from developmental screening to appropriate early learning services. The following is the budget note attached to the Early Intervention/Early Childhood Special Education 2017-19 budget.

“The Oregon Department of Education is instructed to use \$500,000 General Fund from the Early Intervention/Early Childhood Special Education (EI/ECSE) budget to support two to four communities in developing pathways from screening to services to make it easier for families to receive services that screening identifies. Use of this funding is aligned with best practices for how EI/ECSE programs should address the needs of children and their families who do not meet the legal requirements for eligibility and connects them to other services and supports. The Early Learning Council shall report on the progress and outcomes of this work to the appropriate legislative committee and include any recommendations for the 2017 session.”

This report provides information on preliminary results of this work. A final report will be provided upon completion of the work in June 2017.

## **A. Background and Context About Importance of this Project, Synergy with State Priorities**

Oregon Department of Education's (ODE) early learning system and the Oregon Health Authority share a common focus on community and population based developmental screening. The 2015 state legislature instructed ODE to use funds from the Early Intervention and Early Childhood Special Education (EI/ECSE) budget to identify community-wide pathways for children that are identified "at-risk" on developmental screening tools to receiving services in two to four communities. Within this community-level work, there is a focus in looking at pathways for children that are found to be ineligible for EI services.

Three communities: Marion, Polk, and Yamhill Counties were chosen for this project. Within this three-county area, there are two Coordinated Care Organizations (CCOs) - *Yamhill Coordinated Care Organization*, and *Willamette Valley Community Health* - and two Early Learning Hubs (ELHs) - *Yamhill Early Learning Hub*, and *Marion and Polk Early Learning Hub*. Across the three counties there is one contractor providing EI/ECSE services, Willamette Education Service District (WESD). Given this project is meant to be synergistic to, and helpful in, informing CCO and ELH efforts, having two different CCOs and two different Hubs was a key design parameter used in selecting the communities of focus. The project is meant to operationalize methods and processes by which enhanced partnerships and collaborations with EI can improve the number of children that go from developmental screening to receiving services that address the risk(s) identified. These communities were also prioritized due to the existence of a centralized EI contractor (WESD) that could be engaged across the three-county efforts and could feasibly provide EI data and implement improvement systems during the relatively short project period. Lastly, given variations in processes that may exist between urban and rural locations, these communities were selected given they contain both environments. The Oregon Pediatric Improvement Partnership (OPIP) has significant experience with developmental screening in these three communities based on previous efforts. This allowed OPIP to build off these efforts and promptly begin the project in May 2016 and complete the expected work by June 2017.

The current CCO and ELH metrics related to developmental screening focus on the number of children screened. The goal of developmental screening is that children identified "at-risk" for developmental, behavioral, and social delays be referred to and receive services addressing those delays. This pathway, from developmental screening to receipt of services, supports early and timely provision of services meant to ensure that children are ready for kindergarten. ELH responsibilities related to family resource management, coordination of services, and ensuring children are kindergarten-ready are aligned with the broader goals around ensuring follow-up services. Children ready for kindergarten and able to thrive in school is also a priority for the ODE.

Early Intervention (EI) is a critical partner in assisting children who are identified "at-risk" based on developmental screening tools. According to national Bright Futures recommendations for primary care providers, EI is a primary service to refer "at-risk" children. Not all children who are identified "at-risk" for delays on developmental screening tools and evaluated by EI will be found eligible for services. Secondary referral and follow-up steps are often needed to address risks identified. Furthermore, for

### **Children Identified "At-Risk" on Developmental Screening Tools**

*This report is focused on children identified "at-risk" that should receive follow-up services. These are children that are identified "at-risk" for developmental, behavioral or social delays on standardized developmental screening tools. In the communities of focus for this work, a majority of providers are using the Ages and Stages Questionnaire (ASQ)<sup>3</sup>. Therefore the children of focus are those identified "at-risk" for delays based on the ASQ domain level findings.*

some EI eligible children, additional and complementary services provided within the health care system and in other community-based programs may robustly address other child needs.

The shared priorities around developmental screening have created a collective action to improve the number of children screened. According to the CCO Developmental Screening Incentive metric, the number of publicly insured children screened increased from N=6,634 in 2013 to N=27,948 in 2015. With this increase in screening, there is a need to: 1. understand how and where children identified “at-risk” through developmental screening tools are being referred, and; 2. whether they are receiving services that meet the child’s and family’s needs. State and local data indicate that a substantial number of children identified “at-risk” are not being referred to services to address those delays. For example, while the number of children receiving developmental screening quadrupled over two years, the number of children served by EI in that same time period increased by 10.5% with N= 3220 children in 2013 and N=3558 in 2015. Primary Care practice-level data collected by OPIP shows that over 60% of children identified “at-risk” for delays by primary care providers using developmental screening were not referred for follow-up services to address those risks.

## **B. Key Areas of Focus and Questions to Be Answered in This Project**

The work funded by this budget note is specifically focused on: 1) Understanding the current pathways from developmental screening to services; 2) Understanding where and how children are falling out of this pathway and not receiving services to address identified risk(s). This includes an intentional focus on children identified “at-risk” on developmental screening tools and evaluated by EI, but found ineligible; and 3) Identifying and implementing improvement efforts focused on follow-up with the goal of ensuring more “at-risk” children receive services.

### ***Key Questions***

1. Is developmental screening by physicians in primary care and community based providers occurring? What percentage of children is screened? What impact has the CCO incentive metric had on developmental screening rates? What impact has the Early Learning Hub metric had on population-level screening rates?
2. Are children identified “at-risk” for delays referred to Early Intervention for evaluation? If not, why are children not referred to EI? Are there other services or programs “at-risk” children are referred to?
3. What percentage of referred children is evaluated for EI services? If not, what are the reasons referred children are not evaluated?
4. Of the referred children who are contacted by EI, how many are eligible and served?
5. Of the children who are ineligible for EI services, are there clear secondary referral processes in place to ensure the delays(s) identified are addressed?
6. Of the children who are eligible for EI services, are there clear communication processes about EI services to ensure the full set of risks identified are addressed robustly?
7. Are there specific child and family profiles for which there are gaps in available services to address the risks identified?
8. Within the existing pathways for follow-up to developmental screening, what specific improvement opportunities are identified by the community as the most important to pilot and why? Who are the key stakeholders that need to be engaged in these improvement efforts?
9. What are the implications from the identified improvement efforts for health systems, Early Learning Hubs, and Early Intervention?

### **C. Project Design**

The project is structured so that baseline information is collected about existing pathways and number of children lost in the pathways. These data will answer the key questions listed earlier and leverage data already being collected by CCOs, ELHs, and EI. Qualitative data about existing pathways from developmental screening to services and barriers experienced will be collected through stakeholder interviews. New quantitative data about rates of referral for “at-risk” children will be collected from the pilot primary care sites.

Stakeholders within the communities will be engaged to review the baseline data. Informed by shared data, the communities will identify specific priority areas on which to focus improvement efforts. A desired component of the pathway is secondary referral and support strategies for “at-risk” children found ineligible for EI. Community-specific triage and referral processes will be developed that identify follow-up service providers that are the best match for the child and family based on developmental screening risk scores. The sites that will pilot the improved processes are: 1) three primary care practices serving a large number of children who reside in these counties 2) WESD (EI); and 3) community-based providers within the ELH such as home visiting programs. Given that these pilots exist within systems and processes involving CCOs and ELHs, and since they will be paramount to ensuring sustainability, these entities will be engaged to a degree more intensive than other stakeholders. At the end of the project, the improvement tools developed will be made publicly available so that they can be used by other communities across the state.

### **D. Informing Future Improvements**

Efforts in the three communities are designed to inform coordinated priorities within health system transformation (including private payers and CCOs), ELHs and EI services focused on early childhood development and kindergarten readiness. The qualitative and quantitative data gathered will provide information regarding the impact of existing system-level factors, as well as identified refinements and improvements to systems. Secondly, the findings from these pilots will provide information about children who are not served and identify primary barriers that could be addressed by community- and system-level solutions. Lastly, the pilot will inform services that are needed to address risks identified but are not currently available in these communities, and highlight related system-level implications.

#### ***Early Intervention (EI)***

- **EI Procedures Across All EI Contractors:** The development and implementation of state-wide EI procedures related to: 1) Communication regarding referrals when: a) the parent cannot be contacted, b) a parent delays evaluation, c) a parent declines evaluation; 2) Connecting EI ineligible children and their families to community based providers or other resources; and 3) Connecting children eligible for EI services who may need other complementary services.
- **Standardized Data Collection and Reporting Templates in the EC Web Platform Used by EI:** Templates to improve communication and coordination between stakeholders including: 1) One page Communication form back to referring providers that includes: a) evaluation outcomes, b)

#### ***Importance of Engaging Medical, Early Intervention and Community Based Services to Provide Family-Centered Follow-Up to “At-Risk” Children: Findings from the Literature***

- Approximately 24% of all 2-year-old children were ineligible for EI at 2 years of age but still had poor academic or behavioral outcomes at school entry.
- Four variables were associated with both academic and behavioral risk: parental education below bachelor’s degree, little/no shared reading at home, food insecurity, and fair/poor parental health.

Nelson BB, Dudovitz RN, Coker TR, et al. Predictors of Poor School Readiness in Children Without Developmental Delay at Age 2. *Pediatrics*.

current EI service levels for eligible children, c) tracking and monitoring of referrals sent to community based agencies. 2) Methods to track within EC Web monitor and referrals for EI ineligible children to community-based referrals.

- **Partnership with ELH:** Models and methods by which EI can partner with ELHs.
- **Partnership with CCOs:** Models and methods by which EI can partner with CCOs.

#### ***Health Care Transformation and CCO***

- **Metrics committees:** (Metrics and Scoring, Health Plan Quality Metrics Committees): Impact of current Developmental Screening in the First Three Years of Life metric, potential refinements and improvements.
- **Coverage:** Summary of medical and therapy services for children identified “at-risk” covered by health providers in the community and services covered by CCO for which there are available providers.
- **Primary care transformation:** Patient centered primary care home processes related to follow-up to developmental screening and care coordination for children identified “at risk” and their families, including levers within that program.
- **Family support:** Centralized patient navigation services for families of children identified “at-risk” that could be supported by CCOs.
- **CCO collaboration within community:** Opportunities for collaboration with the ELH and EI to ensure “at-risk” children receive services. Use of EI data to inform capacity assessments, partnerships, and care coordination models with home visiting programs.

#### ***Early Learning Council and Early Learning Hubs***

- **Coordination within communities:** Collaboration is needed between ELH providers, CCOs, and EI to ensure pathways from screening to services in a way that would impact kindergarten readiness.
- **Family resource management:** Opportunities specifically related to follow-up to developmental screening, and pathways focused on ensuring kindergarten readiness. Models for community asset mapping relative to risks identified via developmental screening and program eligibility.
- **ELH metrics:** Opportunities regarding the impact of current metrics, refinements to existing metrics and proposal for future metrics to consider.
- **Collaboration between ELH and EI:** Models for use of EI data at ELH meetings and as part of community-needs assessments.

#### **E. Preliminary Results from the Community-Based Efforts – November 2016**

The project began in May 2016 and baseline data has been collected, stakeholders have been engaged, and the opportunities and priorities for improvement efforts have begun. On the following page is a brief summary of selected findings to-date.

#### ***Half of Children Are Not Screened, Disparities Exist in Screening by Practice***

- While both CCOs (WVCH and YCCO) in these communities met the improvement benchmark for developmental screening, only half of children are screened.
- A small proportion of pediatric practices (that serve a large number of children in these communities) are drivers of the CCO-level population rates. A majority of practices (serving smaller numbers of children) are still not doing developmental screening in alignment with recommendations. For example, among the 50 practices WVCH contracts, 86% are not doing developmental screening to fidelity.
- Since both CCOs met the improvement benchmark, developmental screening and/or follow-up to developmental screening have not been identified as a priority given competing demands.

### ***While Developmental Screening by Primary Care Has Increased, Follow-up to Screening Has Not***

- Primary care practice-level data and stakeholder interviews indicate that while developmental screening has increased, consistent follow-up and referral for children identified “at-risk” is not yet occurring. For example, in the pilot primary care sites approximately 60% of “at-risk” children were not referred for follow-up services.
- EI is a primary referral for “at-risk” children. While there are increases in referrals, the increases are not correlated with the magnitude of increases in developmental screening.
- Based on the ASQ specifications and practice-level data collected for this project, 20% of children are identified as “at-risk” on the developmental screening tools. In these three counties, based on screening rates, this would mean that approximately 1,980 children are identified “at-risk” and should receive follow-up services. That said, WESD only received 915 referrals across the three counties. This means that an estimated **57% of children identified were never referred**.
  - The number of children who received a developmental screen in the WVCH CCO **increased by 2440 children (79%)** between 2013 and 2015. The increase in the number of children found eligible for EI services in this community was **26 children (10%)** for the same time period.

### ***For Those Children Identified “At-Risk” and Referred to Services, Improvement Opportunities Exist***

- Of children identified as “at-risk” that were referred to WESD EI (915), **562 (61%) were able to be evaluated**. There are a number of reasons for the 39% of referrals not being evaluated, including **parental delay (18.6%), an inability to contact the family (16.8%), and the family declining the evaluation (2.4%)**.
- Of the children able to be evaluated (562), **347 (62%) were found to be eligible for services**, meaning 38% were ineligible for services.
- **Ninety-five percent of Medicaid eligible children evaluated were found to be eligible** for EI services. Conversely, **41% of Non-Medicaid eligible children were found to be eligible for EI services**- meaning these children would likely be found ineligible (due to family income) for home visiting services within the ELH.

### ***Priority Areas Identified by Yamhill, Marion and Polk Stakeholders to Focus Improvement Efforts***

Established via baseline data and input from stakeholders, the following areas of focus for the community-based efforts have been identified:

- **Primary Care:** Processes to support increased follow-up for “at-risk” children identified, including a referral decision tree based on ASQ results and family risk factors to guide follow-up referrals as well as parent education and supports.
- **EI-WESD:** Processes to enhance communication and coordination to increase the number of children referred that are able to be evaluated. Enhanced communication about evaluation results and EI services provided to eligible children to ensure follow-up for the risk identified.
- **Community based providers and resources:** Processes to ensure follow-up for “at-risk” children to providers within the ELH including home visiting, mental health, and parenting classes.

The project will end July 2017 and final report will be provided upon completion. Given the relevancy of the findings, the project team is available to meet with leaders within CCOs, ELC, and ELHs.