Promoting Optimal Health for Young Children: Strategies and Learnings from Oregon in Supporting System-, Community- & Practice-Level Improvement

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Agenda

• Background on involvement with the Assuring Better Child Development (ABCD) national effort
• Highlight of strategies we have used in Oregon (OR)
• Building off these successes (much like in Colorado), current and future areas of focus
Some Background: Experience With ABCD Nationally

National Assuring Better Child Development Initiative (http://www.nashp.org/abcd-state)

- Engaged 27 states, Four phases
  - Phase 1: Developmental screening at a community-level
  - Phase 2: Developmental screening primary care practices
  - Phase 3: Developmental Screening: State policies & practice-level QI
  - Phase 4: Follow-Up to Developmental Screening, Specific focus on referrals to Early Intervention (EI)

- Able to participate in all four phases
  - Supported state Medicaid agencies and practices on measurement strategies to gauge the impact of their efforts
    - Parent-reported metric of developmental screening include in the National Survey of Children’s Health
    - Developmental Screening in the First Three Years of life metric include in the CHIPRA Core Measure Set(based on claims data and/or medical chart reviews)
  - Participated in OR ABCD efforts over the years

Given My Experience with ABCD, Why I Was Thrilled To Be Here Today to Recognize CO ABCD’s Impact

- Colorado seen as a leader within the ABCD efforts, Kindred Spirit
- CO ABCD committed to child and family-centered approaches, integral importance of parent partners
- CO ABCD understands the importance of supporting front-line QI
  - Beyond academic detailing (which has mixed results)
  - Align the carrots and provide Part IV Maintenance of Certification
  - Beyond primary care clinic, consideration of the community-context
- CO ABCD understands the importance and system-level focus
  - Systems are perfectly designed to get the outcome we see on the front-line
  - Importance of levers at the state and health system-level
- CO ABCD has outcomes that demonstrate their impact
  - Colorado one of the top three states, according to the National Survey of Children’s Health, for developmental screening
Promoting Optional Child Development in Oregon: Past and Current Efforts to Improve Quality

Previous Efforts in Oregon

- ABCD Screening Academy – OR’s Focus
  - Focused on developing the standard of care related to screening & follow-up aligned with Bright Futures recommendations
    - Implemented across ten offices in Kaiser Permanente Northwest
    - Included front-line support related to implementation
    - Development of tools within the Electronic Medical Record
  - Universal Referral to Early Intervention
    - Referral form addressed FERPA requirements, Feedback forms
  - Payment Policies
    - Assurance that 96110 was “above the line” for OHP coverage
    - Clarification of which tools counted
    - Incentives for increases

- ABCD III- Focus on Follow-Up to Developmental Screening
  - Helped to establish the Oregon Pediatric Improvement Partnership
    - External Quality Review-Like Organization, Based at OHSU
    - Eligible for federal match for QI activities aligned with Medicaid goals
  - Performance Improvement Project (required of states with Managed Care)
    - Focus on systems, policies, and trainings to support FOLLOW-UP to developmental screening and CARE COORDINATION
    - Eight Managed Care Organizations (MCOs)
    - Partnership with state-level Early Intervention (EI) and local EI contractors
    - Community cafes of parents of young children on their experiences
Transformative Changes in Key Systems that Serve Young Children

1. Oregon Health Reform
   - Coordinated Care Organizations
2. Oregon Early Childhood Reform
   - Early Learning Hubs

Coordinated Care Organizations
(or what some call OR’s Version of ACOs)

– Creation of Coordinated Care Organizations (2012-2017 Waiver, Proposal to Continue in Waiver Extension in Final Stages of Review)

  o Network of all types of health care providers (physical health care, addictions and mental health care and dental care providers)
  o Global budget; Expectation to hold in growth of health care costs
  o Flexibility in budgets to provide services meant to achieve goal of meeting the Triple Aim of better health, better care and lower costs
  o 16 CCOs operating in communities around Oregon
  o CCO model also implemented by the Public Employees’ Benefit Board for state employees.

– Accountability components. Examples:
  o Metrics
    » CCO-level incentive metric
    » State-level metrics accountable to federal CMS
  o Required performance improvement project
### 2016 Incentive Metrics

1. Adolescent well-care visits
2. Alcohol or other substance abuse
3. Ambulatory care: Emergency department utilization
4. CAHPS Composite: Access to care
5. CAHPS Composite: Satisfaction with care
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 Enrollment
17. Prenatal and postpartum care: Timeliness of prenatal care

### Early Learning System & Early Learning Hubs

- Senate Bill 909 (2011) established the Oregon Education Investment Board (OEIB) and Early Learning Council (ELC)

**Goals:**

1. Children arrive at kindergarten ready to succeed
2. Families are healthy, stable and attached
3. Early Learning System is coordinated, aligned and family-centered
Oregon’s Early Learning Hubs

• Early Learning 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.
  Example of community-based providers part of the ELH:
  – Home visiting programs
  – Early Head Start/Head Start
  – Child care
  – Parenting classes (Oregon Parenting Education Collaborative)
  – Public health services (including mental health)

• Currently there are N=16 HUBS across the state

Opportunity to Connect the Fantastic Individual Silos to Better Meet Needs of Young Children
Community-Based Improvement Opportunity:
Align Silo’d System-Level Goals to Develop and Implement Standards of Care Across Systems for Follow-Up to Developmental Screening

Coordinated Care Organizations
Goals Related to:
1) Developmental Screening
2) Well-Child Care
3) Coordination of Services

Early Intervention
Provide services to young children to achieve educational attainment goals

Early Learning Hubs
Goals Related to:
1) Family Resource Management
2) Coordination of services
3) Ensuring children are kindergarten ready

School Readiness

A look at the data, where is the need for improvement even AFTER Oregon’s decade of work on developmental screening?

Population-Level Data Across Silos to Inform Quality Improvement Focus

An example from work we are doing in a tri-county area of Oregon with both rural and urban settings, two different CCOs, two different Early Learning Hubs and one local EI contractor.
Data from a High-Performing & High Functioning Primary Care Site
Most At-Risk Children NOT Referred for Services

Number of ALL Children in Clinic (Publicly and Privately Insured) WHO RECEIVED A DEVELOPMENTAL SCREEN IN ONE YEAR:
N=2125

Of these children, if past data used, number who were identified at-risk and SHOULD HAVE BEEN REFERRED TO EI:
N=425

NUMBER REFERRED TO EI: 65% NOT REFERRED
N=150

2015 EI Referral Outcomes:
2 in 5 Referrals Do Not Result in an Evaluation

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

Total N=915
Of Children Able to be Evaluated - 2015 Outcomes of EI Evaluation;
Nearly 2 in 5 Evaluated Are NOT Eligible for Services

Marion, Polk & Yamhill Counties
Total N=562

Eligible

Ineligible

Within Coordination Care Organization:
- Asset mapping of physical health AND mental health resources that address specific risks
- Data about the NEED from practice sites and EI to inform discussion about service needs (e.g. mental health)
- Supports for Electronic Medical Record decision support related to screening AND follow-up
- Coverage of services outside normal scope – e.g. Transportation to EI, Patient navigators to support families

Primary Care Pilot Sites: Focus of QI Efforts
- Develop referral and follow-up pathway diagram anchored to:
  1) ASQ scores
  2) Resources within Community
- Improve referral processes used to be more parent centered
  - Parent education materials and supports
  - Phone follow-up for referred children within 36 hours to answer questions and address barriers

Early Learning Hub:
- Asset mapping of community-based resources that address specific risks
  - Home visiting programs
  - Early Head Start/Head Start
  - Childcare settings
  - Parenting classes

Community-Based Provider Sites
- Ways primary care can refer to centralized home visiting referral
- Ways primary care can refer to parenting classes for the EI eligible
- Methods for childcare settings who are doing developmental screening to give education to parents and encourage connection with the PCP

Early Intervention - WESD
- Provide data to inform needs assessments
- Enhancing communication to referring provider when not able to contact the child OR the family declines services
- Enhancing feedback forms about service being provided so that secondary referral resources can be identified.
- Enhanced processes around directing EI ineligible children to other community-based providers (e.g. centralized home visiting referral form)
Factors to Consider in Identifying Best Follow-Up to Meet Child and Family Needs

- Based on these factors referral pathways to the following:
  - Early Intervention
  - Home Visiting Programs
  - Parenting Classes
  - Mental Health
  - Medical and Therapy Services
- Included in the decision tree is secondary follow-up steps depending on whether child is eligible or not
  - For example: Right now, pathway stops when a kid is Ineligible
  - Secondary referral and pathways for the EI ineligible children

Pilot Education Sheet for Parents To Explain Referrals
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) 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 TriMet 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).

Pilot EI Communication Form to Inform Secondary Referral

A new Individual Family Service Plan (IFSP) was developed for your patient $name on sfp. These services will be reviewed again no later than $nextISP.

IFSP Services:

- Early Intervention
- Cognitive
- Social Emotional
- Motor
- Adaptive
- Communication

Services Provided by:

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

Frequency

Current Provider

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.
Centralized Referral to Home Visiting Programs within the Community

Similarities Between Oregon & Colorado and Implications for Future Focus

- Standards of Care Developed – At the elbow support now needed to support implementation
  - You have trained and very able staff in ABCD CO
  - Need to tailor training to the provider type and value of the carrot of MOC within ABCD CO
  - Varied community-based settings and resources to address the risks identified through screenings
    - Need to tailor implementation support to the community settings and engage home visiting services and parent supports
    - ABCD CO has great experience that can built off for this
  - Opportunity support coordinated care across “physical” and “mental” health with an applied focus on school readiness given new Accountable Care Collaborative