

>> Follow-up and Referral Pathways
for Children at Risk For
Developmental, Behavioral and
Social Delays: Yamhill County

Consulting and Technical Assistance from the
Oregon Pediatric Improvement Partnership
Jan. 1–Dec. 30, 2016
Final Project Report

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www.oregon-pip.org

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Executive summary

Background and context



Developmental screening and appropriate referral of young children is critical to identifying children with developmental, behavioral and social delays early and improving their long-term health by providing supportive services and interventions. The Oregon Health Authority contracted with the Oregon Pediatric Improvement Partnership (OPIP) to support community-level efforts to increase appropriate referral for young Medicaid-insured children in Yamhill County identified at risk for a delay. Only half of Yamhill County Medicaid-insured children receive developmental screening. A majority of

the children screened and found to be at risk for delays are not appropriately referred to follow-up services.

OPIP provided consulting and technical assistance to the local coordinated care organization (Yamhill Community Care Organization), Yamhill Early Learning Hub and additional key stakeholders to ensure that young children identified at risk for developmental delays received appropriate follow-up and coordination of services. The project addresses the shared and synergistic goals of the Yamhill CCO and the Yamhill Early Learning Hub related to developmental screening and care coordination.

The project's goals included improving screening and follow-up in Yamhill County and developing tools and materials to allow replication of the project in other regions. Based on their experiences in Yamhill County, OPIP recommends that similar future projects include robust engagement of:

- Local CCOs;
- Primary care providers;
- Early Learning Hubs;
- The local Early Intervention program;
- Local home visiting programs including Early Head Start and Healthy Families Oregon; and
- Child care providers.

Key activities

OPIP led the following four activities during the 12-month project (January–December 2016):

1. Engage and facilitate key stakeholders around the shared goal of ensuring that children identified at risk for developmental, behavioral and social delays receive follow-up services that are the best match for the child and coordinated across systems.
2. Develop a developmental screening triage and referral system map used to identify the best set of services for children identified at risk. This map highlights the resources that exist within the Yamhill region.
3. Develop methods and processes for how to coordinate care, at a child level, across primary care and community-based providers.
4. Summarize key learnings to inform, spread and innovate in the region and to inform state-level efforts.

In collaboration with numerous Yamhill region stakeholders, OPIP developed and piloted new work flows and parental education tools for primary care and child care providers conducting developmental screening. Now children served by the pilot sites whose screenings indicate a possible delay are consistently referred to the local Early Intervention (EI) program and the referral and follow-up process is clearly explained to parents. Children with additional health and family-based risks are also referred for home visiting and other supportive services. The EI program now regularly communicates with the referring provider about whether the child qualifies for EI services and what services they are receiving. OPIP worked with stakeholders to explore many barriers to follow-up and developed processes to address these barriers. The unique features of this project included the use of an existing centralized home visiting referral process (Family CORE) to strengthen communication between providers from multiple sectors and build a stronger partnership with the local Early Intervention program. The project also developed plans to continue improvement in Yamhill County and tools and frameworks to replicate the project in other regions.

Part 1. Project activities

About developmental screening and follow-up

Developmental screening is the use of a brief, standardized questionnaire used to check on a child's general development. Developmental screening identifies children developing on schedule, children who might benefit from support, and children at risk for developmental, behavioral and/or social delays. Developmental screening does not result in a diagnosis or specific course of treatment, but can identify risk for delays in development that should be further evaluated. As a critical element of well-child care, developmental screening in the first three years of life is an incentive metric for Oregon's coordinated care organizations and a success metric for Oregon's Early Learning Hubs.

In Oregon, the most commonly used screening tool in both the health and early learning sectors is the Ages and Stages Questionnaires®, Third Edition (ASQ-3). The ASQ-3 is a parent-completed questionnaire that assesses child development between ages 1 month to 5.5 years in five domains: communication, gross motor, fine motor, problem solving and personal-social. The questionnaire is often completed in a primary care or early learning setting, with the provider assisting in scoring the questionnaire. According to ASQ-3 scoring rubric, a child's score in each domain area can be "above the cutoff" for on-schedule development, close to the cutoff ("in the gray") indicating a need for learning activities and monitoring, or below the cutoff ("in the black") indicating that further assessment with a professional may be needed. Regardless of a child's ASQ-3 scores, best practice is to share the completed questionnaire with the child's primary health care provider, who can review the results with the family and make referrals as needed for follow-up and further evaluation. The American Academy of Pediatrics Bright Futures™ Guidelines and ASQ-3 best practices indicate that any child scoring below the cutoff in one domain or close to the cutoff in two domains should be referred to Early Intervention/Early Childhood Special Education (EI/ECSE) for a comprehensive developmental evaluation.

EI/ECSE provides individually designed services for children and their parents to enhance children's physical, cognitive, communication, social emotional and/or adaptive development. Early Intervention provides services for children birth to age 3, and ECSE serves children from 3 to public school eligibility age. The Oregon Department of Education contracts with local agencies to provide a statewide system of free EI/ECSE services. All children referred to Early Intervention/Early Childhood Special Education and able to be contacted are evaluated for developmental delays; for children birth to age 3, the evaluation must be completed within 45 days of receiving the referral. This evaluation's results determine eligibility for ongoing EI/ECSE services.

Definitions for this project

The project outlined in this report focused on children identified as “at risk” based on ASQ-3 results (one domain below the cutoff or “in the black,” or two domains close to the cutoff or “in the gray”). Due to the project’s focus on the population served by Yamhill Community Care Organization, this work specifically looked at Medicaid-insured children ages 0–3 to align with the CCO incentive metric and Early Learning Hub success metric.

The Oregon Pediatric Improvement Partnership (OPIP) was funded to provide consulting and technical assistance to Yamhill County stakeholders around the shared goal of ensuring that children identified as being at risk for developmental, behavioral and social delays receive appropriate follow-up services coordinated across systems. OPIP led four key activities throughout this project:

1. Engage and facilitate key stakeholders

Community input and engagement was critical to ensuring that the project was tailored to Yamhill County. OPIP conducted stakeholder interviews of people who conduct developmental screening and/or who can provide follow-up services to children identified at risk. These stakeholders engaged in a community asset mapping process to identify available services and resources for young children who screen at risk for delays.

- OPIP conducted more than 30 individual interviews with representatives of numerous community partners from a wide variety of sectors. A list of the stakeholders engaged in this project is on the OPIP website.*
- OPIP hired two parents of young children to serve as project advisors. These parent partners provided insight, shared their experiences, and reviewed all components of the project and new tools developed.

2. Develop a triage and referral system map

A developmental screening triage and referral map (Appendix A) for Yamhill County identifies the best set of services for children identified as being at risk. This map summarizes the community asset mapping from Activity 1 (“Engage and facilitate key stakeholders,” above) related to existing pathways from developmental screening to services.

* <http://www.oregon-pip.org/projects/YamhillCCOandELH.html#Engage>

3. Develop methods and processes to coordinate care

After the stakeholder interviews were completed, OPIP facilitated group-level meetings of these stakeholders to review the findings. OPIP obtained group consensus about the priority pathways and pilot sites for focused improvement efforts and enhanced care coordination processes:

- Physicians Medical Center: A large primary care practice already conducting regular developmental screening
- Discovery Zone Child Development Center: A large child care center already conducting regular developmental screening
- Willamette Education Service District (WESD): The Early Intervention (EI) service provider for Yamhill, Polk and Marion counties.*
- Family CORE: Centralized home visiting referral partnership
 - » Family CORE is an established, centralized home visiting referral process specific to Yamhill County. Yamhill Community Care Organization (YCCO) manages the Family CORE referral submissions and database. Agencies participating on the Family CORE Team meet regularly to review incoming referrals and assign them to the appropriate program(s).

Figure 1 (next page) outlines the detailed work on improvements, tools and methods for communication and follow-up after screening that OPIP facilitated in Yamhill County throughout this project. This work complements and informs the referral and triage map created in Activity 2 above (“Develop a triage and referral system map”) and makes real on-the-ground change in how providers make referrals, communicate with each other and track what happens to children throughout the process.

4. Summarize key learnings to inform, spread and innovate

This report documents OPIP’s findings and lessons learned throughout the project. Parts 4 and 5 of the report help other communities undertake similar projects as well as inform state-level efforts to enhance follow-up to developmental screening.

* During the course of this project, Willamette ESD and OPIP received separate funding focused on pathways from screening to services and secondary referrals for EI-ineligible children across Marion, Polk and Yamhill counties.

Figure 1: Focus of improvement efforts in Yamhill County

Priority pathways for improvement efforts in Yamhill County	Tools and methods to improve follow-up and referral, communication and coordination of care	
OPIP provided on-site facilitation and support to the following processes and developed the tools noted below in the appendices		
<p>1) Within primary care and child care sites conducting developmental screening, improve follow-up for children identified at risk</p>	<p>Focus of Improvements with the primary care pilot site: Physicians Medical Center (PMC)</p> <ol style="list-style-type: none"> 1. Medical decision tree outlining follow-up steps to developmental screening. 2. Training and decision support within the clinic around follow-up. 3. EMR decision support re when and to whom to refer a child. 4. EMR forms and reports to track referrals and whether children receive care. 5. For families of children referred, implementation of enhanced family supports: <ul style="list-style-type: none"> • One-page education sheet for parents whose children are identified at risk and referred to services. See Appendix B. • Phone follow-up script for practice staff to use to follow up with families, within 36 hours, whose children have been referred to EI. See Appendix C. 6. Summary of medical and therapy services covered by Yamhill CCO to inform secondary referral and follow-up. See Appendix D. 	<p>Focus of Improvements within child care site: Discovery Zone Child Development Center</p> <p>For children identified by the child care site as at risk:</p> <ul style="list-style-type: none"> • One-page education sheet for parents explaining the developmental screening process and recommended follow-up steps. See Appendix E.
OPIP provided facilitation and consultation to the following community-based providers on improved communication and coordination methods		
<p>2) For at-risk children referred to community-based providers, improve coordination and communication</p> <p>Priority community-based providers identified for this project:</p> <ol style="list-style-type: none"> a) Early Intervention b) Family CORE (centralized home visiting referral) 	<p>Willamette Education Service District</p> <ol style="list-style-type: none"> 1. Enhanced communication methods to communicate to referring entity when EI is not able to contact or evaluate the child before closing out the child’s case. 2. For EI eligible children: One-page communication form describing the summary of services that are being provided in order to inform secondary follow-up steps. <ul style="list-style-type: none"> • A draft of the currently proposed one-page summary was reviewed by key stakeholders for meaningfulness and value. Through other efforts this draft will be operationalized within EC Web and implemented in 2017. 3. For EI ineligible children — Referral to Family CORE. <ul style="list-style-type: none"> • Use of referral form to Family CORE. • Communication back to PCP about EI ineligibility and referral to Family CORE. <p>*Note: WESD also received funding through another project to focus on these topic areas.</p>	<p>Family CORE</p> <ol style="list-style-type: none"> 1. Improved decision tree clarifying which at-risk children, identified via developmental screening, should be referred to Family CORE. 2. Developed an educational brochure for families that was reviewed by the parent advisors in the project. 3. Improved the intake process. <ul style="list-style-type: none"> • Family CORE now has documentation of their intake decision mapping and processes. 4. Communication feedback loops to referring provider <ul style="list-style-type: none"> • Family CORE developed a letter to referring entity describing general expectations and contact information for specific organization the family was referred to (date, all referrals are placed). 5. Improved tracking and evaluation <ul style="list-style-type: none"> • Family CORE is tracking, of the children referred, how many are contacted, placed and receive services.

Data informing the project

OPIP worked with a variety of entities to obtain data about screening, referrals and number of children served to inform the community-level conversations throughout this project. OPIP found this data helped stakeholders see the whole picture and where children were falling out of the referral and follow-up process. The data informed conversations about perceptions and preconceived notions of the effectiveness of current pathways from screening to follow-up.

Key data points informing these conversations included:

- Most children receiving primary care at Physicians Medical Center were being screened for developmental, behavioral and social delays before this project began.
- Approximately 21% of children screened at Physicians Medical Center are identified at risk for delays.
- Referral rates to EI and Family CORE examined during this project indicate that most at-risk children in Yamhill County are not referred for services.
- Of children referred to EI in Yamhill County in 2015:
 - » 108 (64%) were evaluated.
 - » 36% of referrals were not evaluated. The top reasons referrals are not evaluated include parental decision to delay (22%), inability to contact the family (11%), and the family declining the evaluation (2%).
- Of the children evaluated by EI (n=108) in 2015:
 - » 80% (n=86) were eligible for services and 20% (n=22) were ineligible for services.
 - » 96% of Medicaid-eligible children evaluated were eligible for EI services.
 - » 66% of non-Medicaid-eligible children evaluated were eligible for EI services.

Part 2. OPIP observations and learnings regarding shared goals

Intensive stakeholder engagement and new tools and workflows allowed OPIP some unique insights into child-serving systems that can inform future projects and statewide work to support child development and systems alignment goals.

Overarching learnings

- **Parent involvement is critical.** Feedback from parents and parent involvement in the Stakeholder Committee enhanced the focus on methods to support families through the process. Family engagement in system-level improvement is necessary at all levels of the work.
- The support and deep integration among organizations and partners was a key strength in the Yamhill region and key leverage point for this project. In particular, Yamhill CCO's support of the Early Learning Hub and integrated staffing structure serves to benefit both the Early Learning Hub and CCO in their efforts to serve families and meet their metrics. Other communities can consider this kind of support.

CCOs and screening within primary care

The CCO and primary care practices have a limited focus on follow-up to developmental screening.

- **Most children are not screened.** The purpose of this project was to ensure follow-up to developmental screening. That said, at a population level, half of the children in this region are still not being screened and thus cannot be identified to receive early and timely services. If CCOs and Early Learning Hubs are to meet these goals, a majority of children must be screened. This needs to be an ongoing focus.

Opportunities for impact:

- » The CCO incentive metric related to developmental screening could be raised to ensure that most young children are screened. Based on past system- and

practice-level data collection efforts around feasibility, OPIP believes the metric should, over time, be raised to 80% of children screened.

- » OHA could enhance the measure specification and reporting methods to ensure that the screening reported is specific to global developmental screening. The current metric, based on the 96110 claim,* can include children who have only received autism screening.
- **Metrics matter:** The current incentive metric is focused on whether children are screened, not whether they are referred to or receive follow-up services. Therefore, the CCO's focus is to meet the improvement benchmark related to making sure children are screened. The CCO and the practices had not followed up on developmental screening because the metric does not prioritize it.
 - » Metrics development including follow-up to screening for children identified at risk could affect child outcomes. While OPIP philosophically agrees with outcome metrics related to kindergarten readiness, we feel that interim process metrics that assess follow-up should be considered first and developed based on existing data sources.
- **There are several opportunities for CCOs to support follow-up.** This project identified the following specific strategies CCOs can implement to support referral and follow-up:
 - » Develop a summary of medical and therapy services (including children's mental health services) that can address identified risks. Practices can use this benefit summary that describes available services and identifies eligible providers within the community.
 - » Provide or contract with an entity that has relevant skills to train and implement practices on follow-up steps to screening.
 - » Provide support and staffing for centralized referrals among community-based providers, coordination of care and data tracking.
 - » Resource family navigator positions — i.e., parents whose children have been identified at risk and received services and who support other parents through referral and follow-up.
 - » Provide reimbursement for services that address barriers to children receiving follow-up, such as transportation to Early Intervention.
 - » Provide support to the Early Learning Hub for community asset mapping of available services, partner engagement and resources to support developmental promotion activities.

* <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

- **Primary care practices need training and implementation support on follow-up to developmental screening.** Practice-level and Early Intervention data indicated that most children identified at risk for delays in the primary care setting do not receive follow-up.
 - » OPIP has developed a number of novel tools and implementation supports for primary care practices and can help practices and other settings implement them.

Coordination and collaboration across CCOs and Early Learning Hubs that serve proximate geographic regions is essential.

- The tools developed were based on community asset mapping in Yamhill County. However, practices often see children who reside in various counties and not just within the specific regions of one CCO or Early Learning Hub. Therefore, this project did not address workflow for children who reside outside of Yamhill County. Practices that serve children in multiple counties (e.g., clinics in Newberg also serve children from Washington County) may experience confusion about follow-up steps and reduced reliable standardized implementation of follow-up workflows.

Early Learning Hub partnership with providers

- **Partnership and coordination with the local Early Intervention (EI) contractor is essential when focusing on follow-up to developmental screening.** Willamette ESD, the local EI contractor, provides meaningful data and partners to improve referral and care coordination processes. This work can enhance partnerships in many ways. The relationship between EI and the Yamhill Early Learning Hub improved over the course of this project through stakeholder meetings, sharing of EI data, and pilots to improve referrals to EI and EI's communication and coordination.
- **Engagement and partnership with primary care providers is different from engagement with CCOs.** The Yamhill region had the benefit of a primary care provider who was very engaged in the Early Learning Hub. That said, a key part of the stakeholder interviews and engagement was with front-line pediatric providers across the county. As Early Learning Hubs evolve, partnerships and engagement with front-line practices and providers will be critical. While CCO representatives may be aware of high-level partnerships and needs, practice-level providers are often unaware of the resources and opportunities that exist for their patients through the Early Learning Hub.

- **Primary care sites that provide screening identify approximately one in five children as at risk for delays.**
 - » Approximately 21% of children screened in the pilot primary care site were identified at risk and should receive follow-up services.* This number aligns with findings from ABCD III.†
 - » Sharing these data with EI and the Early Learning Hub was helpful in defining the number of children who should be referred for follow-up services. It was also helpful in demonstrating the vast disparity in the number of children identified at risk versus the number of children referred for follow-up services.
- **Workflows and processes being developed are based on needs that reflect the relatively low screening and referral rates in primary care.**
 - » As noted, in the Yamhill region, almost half of the children are still not receiving developmental screening.‡ Of those children screened, a majority are not referred externally.
 - » This pilot focused on uninsured children, but nearly all primary care sites serve both privately and publicly insured children. Many community-based providers have income eligibility requirements for services. This has several implications on centralized referral processes and capacity at EI and other follow-up providers.
 - In Yamhill County, Family CORE agreed to accept all referrals as part of the pilot, regardless of insurance status. Willamette ESD agreed to communicate back about the outcome of all referrals received.
 - » Improving all young children’s screening and referral rates could mean double or triple the current number of children referred into these systems. This would certainly lead to capacity issues.
- **Perceptions about eligibility, availability and robustness of follow-up services affect the number of at-risk children referred to services.** If providers refer to a program that does not have capacity to serve those children, providers will eventually stop referring to the program. Organizations can provide data to each other about numbers of children referred, contacted and served. This sheds light on program capacity and what children and families actually experience throughout the screening and referral process.

* Data provided by the Physicians Medical Center

† <http://oregon-pip.org/projects/abcd.html>

‡ http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf#page=39

- **Most children ineligible for EI were not covered by Medicaid and thus may not be eligible for many Early Learning Hub services.** A key component of this project was secondary referrals and follow-up steps for children who did not go to EI or were ineligible. Willamette ESD examined data showing Medicaid did not insure the majority of EI-ineligible children. This project focused on referring those children to services within Family CORE and Yamhill Early Learning Hub. Most of those services are available only for children from the poorest families, preventing many EI-ineligible children from receiving needed services.
- **It is hard for community-based providers to contact parents.** Many at-risk children do not receive services due to follow-up providers' inability to contact parents or schedule the appointment, even with repeated attempts. This is true for numerous stakeholders engaged in this project including EI and Family CORE. This project prioritized communication back to referring providers when families were unable to be contacted. However, innovative models and approaches to improved family communication should also be explored. Potential models include use of text messaging, email, co-location within the primary care home, and use of parent navigators for outreach.
- Key barriers to communication between primary care and community-based providers must to be addressed. These barriers include:
 - » Lack of specific communication methods, periodicity, expectations and forms;
 - » Lack of stakeholder input on the best form of communication;
 - » HIPAA and FERPA compliance; and
 - » Staffing and resources to conduct the follow-up communication.

This report provides tools and methods to help address these barriers.

Learnings regarding centralized home visiting referral

As noted, Yamhill County's home-visiting programs made a significant effort to create a centralized referral to the various programs, called Family CORE. Stakeholders identified referral to Family CORE as the priority way to improve connection with community-based providers. During the project period, Family CORE moved from the Yamhill County Public Health Department to Yamhill CCO and expanded to include EI.

- **Centralized referral is helpful, but relationships are key.** All of the organizations around the Family CORE table want to develop and continue strong relationships with each other. They are committed to a shared purpose.

Communities looking at this model should understand that creating a centralized referral form and process is not enough. Success requires building lasting relationships between community partners.

- **While referrals can be centralized, each entity has program requirements and norms.** One of the complicated parts of establishing a centralized referral process is understanding and communicating to the referring providers what to expect after the referral occurs. It is important to remember that participating programs have different internal requirements relating to follow-up, communication and coordination. Understanding and communicating this effectively are challenging but critical to ensure referring providers stay engaged.
- **Legal issues regarding consent and HIPPA compliance can be an obstacle.** Implications of participating in a centralized referral process include consent for data sharing across providers and sectors. When Family CORE transitioned to being housed within the CCO, the participating entities had to develop new data sharing agreements.
- **Effective coordination and management take resources.** A centralized referral process that is not appropriately staffed and resourced will likely be unsustainable. Intake, documentation, tracking, family outreach, communication to referring providers, and facilitating coordination between participating entities require major time and effort. Replicating this model helps CCOs and/or Early Learning Hubs provide support for family resource management.
- **Involvement of families in the referral navigation process is ideal.** There is wide agreement that involving parents in advisory and navigator roles facilitates an effective centralized referral to community-based providers.
- **Referrals directly to Early Intervention are still recommended even if EI participates in a centralized home visiting referral process.** It is recommended that all children identified at risk using developmental screening tools receive a referral to EI. Some of these children — depending on community resources and capacity — should also be referred for home visiting services. It is especially important for primary care practices to directly refer to Early Intervention, using the Universal Referral Form to satisfy FERPA requirements. This allows EI to communicate directly back to the primary care provider about the referral. A referral only to the home visiting program could create barriers in communication and potential delays to children receiving an EI evaluation. Furthermore, EI evaluation results regarding a child’s needs give helpful context for home visiting programs.

Part 3. Successes and barriers identified by stakeholders

At the final stakeholder meeting of the project and in individual interviews with key pilot partners, OPIP requested input about Yamhill region stakeholders' perception of the key successes and barriers to the project. Below is a summary of key themes identified.

Key project successes

- **Involvement of parent partners.** Stakeholders emphatically reported that engaging and involving parents in this work from the beginning was critical to making family-centered improvements. The parent partners provide insight and direction to specific elements of this project. They also gave Family CORE feedback on materials and processes. Stakeholders also reported that parent feedback collected as part of this project now informs CCO decisions on staffing and supporting Family CORE sustainability.
- **Use of data to inform priority areas for improvement.** Stakeholders agreed that strategic use of data from stakeholders to set the stage and inform improvement conversations was novel and critical. This allowed stakeholders to both look at the big picture and focus on specific parts of the system to see what may be influencing trends.
- **Seeing implementation in action.** Stakeholders reported that seeing improvements take form has been rewarding, providing additional incentive to continue this important work. Stakeholders mentioned the development of tools and resources as significant successes of the project. They agreed that learning from the pilots as they continue as well as spreading tools and resources developed through the project are two important potential project outcomes.
- **Referral and triage map development.** Stakeholders stated that this map was extremely helpful in seeing processes in detail and prioritizing referral and communication pathways to enhance. Additionally, regular group review of the map triggered important conversations, and stakeholders could see where improvements occurred.

- **Stakeholder engagement and relationship building.** The specificity of the project’s topic allowed this broad stakeholder group to be very detail-oriented about existing processes and how to better coordinate based on a defined group of children and set of risks. This, in turn, strengthened partnerships and improved communication. The project benefited significantly from Yamhill Early Learning Hub’s existing successful engagement of community-based providers and CCO leaders. The established sense of collaboration, connection and partnership within the Yamhill region made this project feasible in the short time period. OPIP was able to build off existing meetings and opportunities to ensure broad stakeholder engagement
- **Willamette ESD Early Intervention as a member of Family CORE.** Stakeholders reported that the project greatly strengthened the relationship among community-based providers participating in the Family CORE centralized home visiting referral process. One success of this project is a new workflow supporting EI to refer children into Family CORE.
- **Positive feedback from community members about improved service provision.** Some stakeholders said they now hear from parents and teachers that resources and services have improved. Stakeholders said they think this is in part due to new attention paid to issues raised through this project or related discussions.
- **Family CORE (centralized home visiting referral) as a key player in this project.** Family CORE already existed when the project began but has evolved significantly over the course of the project. Input from stakeholder interviews, primary care provider interviews and Willamette ESD helped to inform some of the Family CORE improvements.
- **External support from an experienced and skilled facilitator was critical to the success of the project.** Stakeholders emphasized that OPIP played an important and unique role. Stakeholders noted that OPIP had unique experience in leading a community-based cross-sector project, a skill set that often doesn’t exist within individual organizations. They also noted OPIP’s front-line experience with various providers, including primary care and EI, as invaluable to successfully facilitate the project. Lastly, stakeholders noted OPIP’s ability to collect and summarize data in ways that effectively facilitate and inform conversations across varied stakeholders.

Challenges and barriers in the project

- **Staff turnover.** Numerous key players left their organizations during the project period. This created significant barriers such as delayed progress and the need to orient new staff.
- **Importance of standardized systems and processes.** Stakeholders reported that a key element to the project's success was the implementation of standardized systems and processes to create and sustain improvements. While they noted this as a success, stakeholders also pointed out as a challenge that improving or implementing systems can be time- and resource-intensive and may require a skill set not available in a local organization or community.

Stakeholders felt that one-time trainings or meetings between providers from different sectors were not effective in implementing new processes. Investment in professional facilitation of these changes was deemed a much better option to ensure sustainable improvement.

- **EI eligibility findings.** Current data for Yamhill County (see page 12) indicate that only 66% of non-Medicaid eligible children evaluated by EI were eligible for services, compared to 96% of Medicaid-eligible children. The reasons for this difference are unclear and stakeholders agreed that these eligibility rates warrant further investigation.
- **Service availability for non-Medicaid children.** The community remains concerned about service availability for non-Medicaid eligible children identified at risk because most community services and programs have income requirements. Given the large number of EI-ineligible children who are not on Medicaid, the community expressed a need to identify services beyond Family CORE that can serve these children.
- **Organizational capacity among stakeholders.** Stakeholders acknowledged that much of the change resulting from the project required time and availability beyond their normal capacity to attend meetings, prepare for meetings and conduct improvement work in pilot sites.
- **General need for skilled and experienced facilitators.** Stakeholders reported value in having an organization such as OPIP facilitate this project in their community due to stakeholders' lack of time and resources, and their unique skill set. They also appreciated an outside perspective with an understanding of state-level context.

Part 4. Looking forward: Resources for other communities

This section provides tips and resources to other communities in which the CCO and the Early Learning Hub want to focus on ensuring children identified at risk receive follow-up services that are the best match for the child and family.

Tips for project design

- OPIP felt that the structure of **engaging stakeholders**, individually and in group-level meetings, was critical to ensure a community- and population-based approach. When successful, this work cuts across multiple silos within and outside the CCOs and Early Learning Hubs. Multi-stakeholder insight and engagement is integral to making the work successful. This also ensures that the project is anchored to the community's strengths and assets and addresses priority needs for improvement in the identified region.
- **Ideally, use an experienced facilitator with appropriate skills who can facilitate conversations across varied stakeholders and support the pilot improvement efforts identified.** Stakeholders noted the benefits of using an experienced facilitator with experience in:
 - » Working with these various systems;
 - » Using data from various systems to facilitate quality improvement activities; and
 - » Supporting front-line improvement. This includes experience in facilitating small tests of change and subsequent spread. If the facilitator understands state level context and policies, this helps ensure efforts synchronize with broader policy and transformation activities.
- **Start by piloting improved processes in specific settings.** Learning from targeted pilots is a critical first step before spreading improvements across the region. A key component of the pilot is collection of information that will inform discussions about the capacity and ability of various entities to provide follow-up and coordination of services if the efforts spread.
- **Build upon the tools and methods developed in this project** and tailor them to your own setting and set of resources.

Tips for stakeholder engagement

- **Hire parent partners to participate from the beginning.** The parent perspective is extremely important related to project content and in getting stakeholders to engage in family-centered improvement efforts. Parent partners should be involved in project-level discussions and decisions and be able to review any and all parent- and family-facing materials developed throughout the project.
 - » **Recruit multiple parents with varying backgrounds and experiences.** It is important that parent partners represent a variety of perspectives. This will make the final product all the more useful to the community as a whole.
 - » **Parent partners must be compensated.** Parents who participate as partners on a project should be fairly compensated for their time. Beyond being the right thing to do, this sends the message that the parents' place at the table is valued, and they are an equal voice in decision-making. When deciding on a pay rate, consider that the parent may need to obtain child care, which for a child with special health needs can be very expensive.
 - » **Start with an open-ended interview.** The focus for improvement opportunities in this project came largely out of hearing from our parent partners about their experiences (good and bad) and brainstorming solutions to difficult experiences. Having parents help develop solutions is much more effective than having them react to potential solutions developed by someone else.
 - » **Plan meetings far in advance to accommodate schedules.** This allows parents plenty of time to hold the date and arrange for child care if needed. This also gives project staff time to help prepare for the meeting.
 - » **Help prepare parents for meeting participation.** In OPIP's experience, taking the time to meet with parent partners the week before a large public meeting helps them participate in the meeting. Review the agenda, note areas where their feedback and input are important, and be sure they have all the context they need to participate.
 - » **Follow up and debrief after meetings.** It is also very helpful to follow up with parent partners after meetings to answer questions about the project or about context they missed. Professionals often use jargon terms, acronyms and other industry norms that can confuse parents. They may not want to ask at the meeting, and a follow-up call or meeting provides them that context for next time.
- **Conduct stakeholder interviews:** Conduct interviews of people/organizations who have a role with:

- » Developmental screening or
- » Follow-up services that address risks identified by screening.

Structure the interview to gain understanding of current systems and process, opportunities, barriers and hopes for this project. Make sure to ask all interviewees who else in their community should be interviewed.

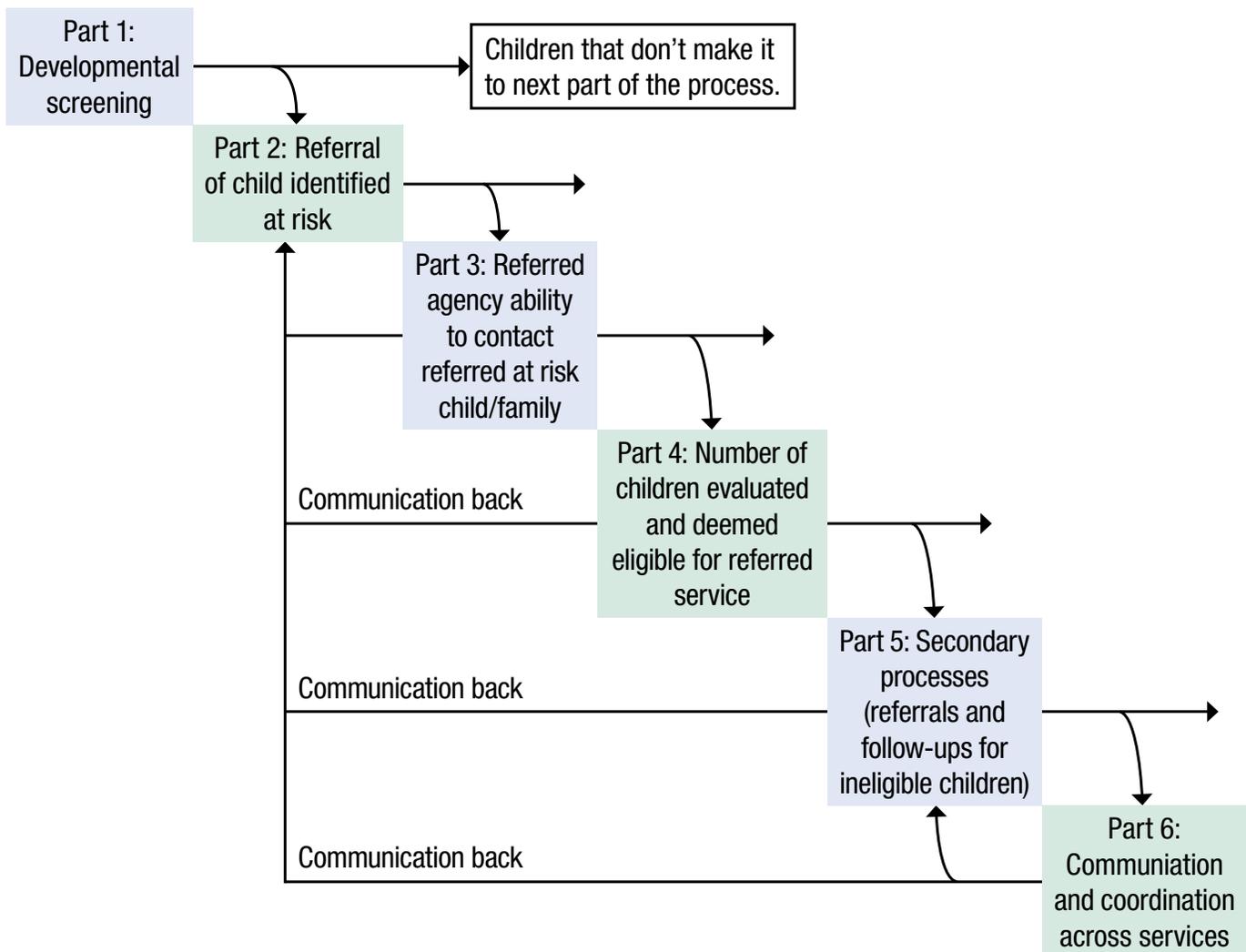
- **Convene stakeholders in a group meeting:** Hold in-person and group-level meetings of these various stakeholders to share learnings and identify priorities and next steps. These in-person meetings are critical to building rapport and understanding across entities and developing a shared commitment. If communities cannot manage the interviews, consider holding stakeholder meetings at the very least.

Below is list of key stakeholders that should be identified (note that there will be variation across communities):

Coordinated care organization	<ul style="list-style-type: none"> • Medical director • Person who oversees incentive metrics • Person who oversees engagement with practices on incentive metrics • Mental health director and person who oversees these services • Person who oversees services for children • Person who coordinates or participates in Early Learning Hub partnership • OHA innovator agent assigned to the CCO
Primary care providers	<ul style="list-style-type: none"> • Practices that see a large number of children and already conduct developmental screening as identified by the CCO incentive metric • Within the practices, make sure that interviews are conducted with at least one pediatrician/family medicine physician, a care coordinator (if applicable), a referral coordinator (if applicable), and a practice manager. Each person has a unique perspective and level of input.
Early Learning Hub	<ul style="list-style-type: none"> • Director or executive director • Staff who work on community engagement • Staff involved in efforts related to developmental screening
ODE: Early Intervention, school district representative	<ul style="list-style-type: none"> • Program coordinator of each local EI/ECSE contractors that serves the community • EI referral intake coordinator • School district representative
Programs that provide home visiting and Early Head Start/Head Start	<ul style="list-style-type: none"> • Public health home visiting programs • Healthy Families home visiting • Other community services that provide home visiting • When applicable: entity that manages a centralized home visiting referral program • Early Head Start and Head Start providers
Child care, parenting classes and parenting supports	<ul style="list-style-type: none"> • Childcare Resource and Referral • Child care centers conducting developmental screening • If applicable, the Oregon Parenting Education Collaborative Hub

- Use **Figure 2 below to structure stakeholder interview findings and conversations about community priorities in group-level meetings.** The general framework OPIP used for conversations among stakeholders about the project’s focus outlined pathways from screening to service and building understanding of where children are falling out of this pathway.
- Use **the findings from the stakeholder interviews and the model shown in Figure 2** to describe the pathways from screening to service and where children fall out. Examples of how the interviews were summarized at the March 2016 stakeholder meeting are available on the OPIP webpage.* This model was effective in distilling and summarizing the findings relative to the pathways from screening to services and opportunities for focus.

Figure 2. Parts of the pathway from screening to services



* <http://www.oregon-pip.org/projects/YamhillCCOandELH.html#Engage>

Tips for building a developmental screening triage and referral system map

The purpose of the triage and referral system map is to list out the specific assets in the community as they relate to pathways from screening to services **and** to document how they are currently connected via referral mechanisms and feedback communication loops. The information gathered from the stakeholder interviews and group-level meetings lists the specific community services that can address the identified risk.

Appendix F provides a generic version of the referral and triage map based on the key pathways identified in the Yamhill region. The map's general structure is based on the six parts of the pathway outlined in **Figure 2**. These components are listed on the left-hand side of the map.

Develop a referral and triage map tailored to the community.

- **Step 1:** Within each section, based on the learnings from stakeholder engagement, identify the specific programs that provide the specific services noted on the map.
 - » **Sites conducting developmental screening that need enhancements to follow-up** (Developmental screening conducted in home visiting and Early Head Start/Head Start was not included in this section given follow-up is often already occurring).
 - Primary care: Which practices are screening? Which primary care sites would be pilots for enhanced processes and tools?
 - Child care: Which child care sites are screening?
 - ASQOregon/Oregon Screening Project (free online screening): Is this a resource used robustly in the community? If so, how can those screenings be included for follow-up enhancements?
 - » **Sites that provide follow-up services for the child**
List services identified by the stakeholders. OPIP recommends identifying a minimum of the following services within your community and including them in the Referral and Triage Map. Some communities may have additional high priority resources; the structure and referral mechanism within each community will vary.

Follow-up services:
 - Early Intervention
 - Home visiting programs

- Early Head Start/Head Start
- Parenting classes and supports
- Mental health services
- **Step 2:** Identify the specific connection and feedback loops between the different entities.
 - » **Using the arrows within the legend, create connections among the providers you have listed above and clarify if referral forms, methods and communication feedback loops exist and, if so, where they are located.**
 - How are children referred to the other boxes? Does this happen in a standardized way? Which children are referred?
 - Is there communication back to the referring entity? Is this communication only for children that access the service?

Tips for partnering with primary care providers to ensure follow-up for children at risk

A key component of this project was to develop tools and strategies to support a pilot primary care clinic to provide better follow-up for children identified at risk.

Below are some general tips for other communities hoping to build off this work as well as specific tools for use with primary care sites:

General tips for working with primary care sites

- **Start with pilot sites that screen according to best practices.** The pilot site in this project had been screening for years and had very high screening rates for children receiving well care. However, the practice did not have standardized processes or workflows related to follow-up to developmental screening. In order to focus on follow-up, it is important to engage practices that already screen robustly. Communities should not assume trained clinics that conduct screening also provide screening follow-up.
- **Understand existing levers and priorities.** The state of Oregon's health care reform means that primary care practices are being asked to change many ways they work. Given the impact of drivers such as CCO incentive metrics, a specific focus on follow-up to developmental screening may not be high on the list of a practice's priorities. An approach that is strategic and synergistic with these efforts

is important, with a focus on giving the practice tools, resources and support to follow up and address risks in a way that best meets the family's needs.

- **Engagement of a strong provider champion is critical.** Changes in a primary care practice must be driven from within. It is critical to identify and engage a strong champion at the practice who will help initiate and follow through on tasks related to implementation and serve as a thought leader for practice level changes.
- **Engage a multidisciplinary team at pilot sites.** Practice-level systems and processes related to screening and follow-up typically involve a broad cadre of practice staff ranging from the front desk to the provider. In order to test and implement reliable standardized processes, a multidisciplinary team must be involved.
- **Work to understand perceptions and behaviors.** Take the time to understand the state of screening and follow up to screening in primary care sites. Determine existing referral behaviors and the perceptions that drive those behaviors. For example, we found that perceptions around EI eligibility and robustness of services have affected referral behavior among many primary care providers, to the extent that providers have decided to not refer a majority of children identified at risk.
- **Take a quality improvement approach to implementation, not just academic detailing.** It is important to take a thoughtful approach to implementing changes in busy primary care practices. Start small, implementing small changes with perhaps one provider or one team. Once a change is tested and modified, implement with other providers or teams. It is critical to develop, document and modify standardized workflows. Electronic medical record (EMR) supports, decision trees and workflow diagrams are all helpful tools in implementing sustainable changes.
- **Relationships are important.** The establishment of relationships between providers and the community-based entities they refer patients to is critical. Communication and coordination tend to be far more effective when an in-person introduction occurs and the parties establish norms and expectations with each other.

Specific tools to support practices on follow-up and coordination of services

Through this project, OPIP worked with the pilot primary care site and community-based providers to develop specific tools that enhanced primary care provider knowledge and awareness about referrals, decisions, supports for referrals, and communication and coordination methods to support the family.

- **Clinic workflows to facilitate follow-up.** OPIP supported Physicians Medical

Center (PMC) to design a workflow (Figure 3) for when to refer to EI versus when to refer to Family CORE. This workflow also delineates the various roles of the providers, nursing staff and medical records. OPIP has found that this level of outlining specific steps, processes and roles within the clinic is essential to sustainable and successful implementation of standardized systems.

- **Medical decision tree for primary care practice follow-up to developmental screening**

- » A complementary project funded through Willamette ESD developed a medical decision tree for Physicians Medical Center. This tool continues to be developed and refined. It will be available on OPIP's website when complete.
- » The purpose of this document is to provide guidance and specific pathways, based on the developmental screening scores **and** other child and family factors, leading to the best set of services to meet the child and family's needs. This is a more comprehensive approach to referrals and secondary referrals than practices usually use.

- **Training on the Early Intervention Universal Referral Form**

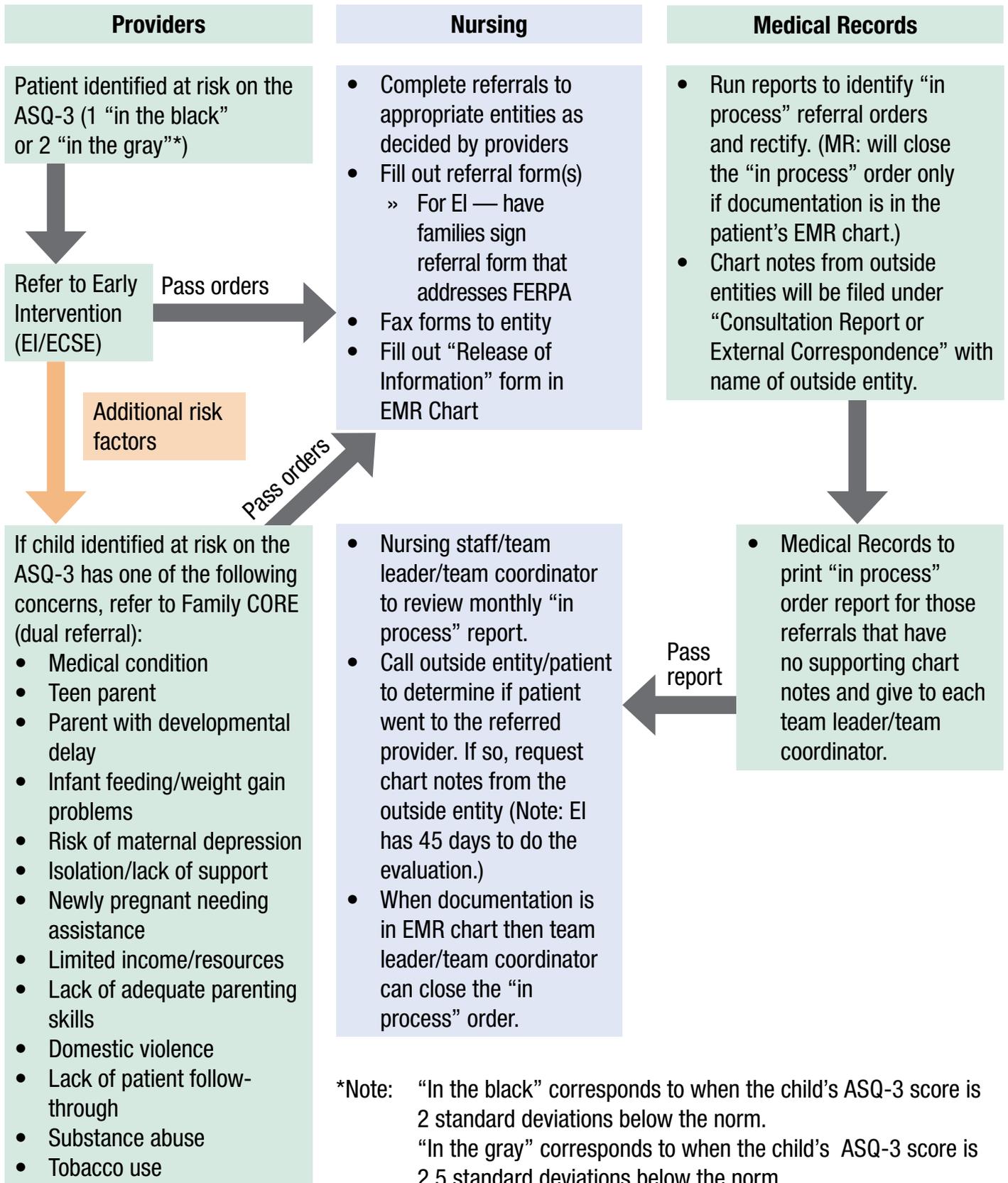
- » See **Appendix G** for the Early Intervention universal referral form
- » This form is accepted across the state by all local Early Intervention contractors. The form ensures all relevant information is included in the primary care provider's referral to Early Intervention. The form also ensures that FERPA requirements are met that allow EI to communicate back to the primary care provider.
- » Providers within Yamhill County were not aware of the specific components of the referral form, the purpose of each form element, and that the form allows for HIPAA/FERPA-compliant communication back to the referring provider.
- » OPIP provided specific training on each component of the form and then provided implementation support to have the form built into the practice's electronic medical record.

- **Information sheet for parents**

- » **Appendix B** provides an example information sheet developed in this project for primary care providers to give to families of children referred to follow-up services.

Figure 3. Physicians Medical Center screening and follow-up to screening processes

Workflow for patients identified at risk via ASQ-3 at the 9-, 18-, 24- and 36-month well visit



- » The parent partners for this project indicated that a one-page educational sheet would be helpful to parents to facilitate the conversation with the provider and as something they could take with them and refer to as needed. The parent partners identified important information to include:
 - What screening is and why they needed to fill out the screening tool
 - Where they are being referred and why
 - Information about the places they are being referred
 - How to get more information about where they are being referred
 - Who to contact with questions
 - What to expect next
- » Other communities will need to tailor the education sheet to the resources in their community and to the referral processes used within their community.
- » Both parents and project stakeholders reviewed the one-pager several times. Formal reading level assessments, translations into other languages beyond Spanish and assessment for understandability in other cultures was beyond the scope of this project. This is an opportunity for future exploration.
- **Phone follow-up script for primary care practices referring to EI**
 - » See **Appendix C** for the phone follow-up script. The primary care practice now uses this script to call patients who received a referral to Early Intervention.
 - » Given the high rates of referred families who decline services or never connect with EI (39% in Yamhill County), the purpose of the follow-up phone call is to support the family and address questions and concerns they might have about the referral.
 - » This follow-up call can be made by office staff such as the referral coordinator, care coordinator or support staff to the provider.

Tips for partnering with child care providers conducting developmental screening

Child care sites, especially large and accredited ones, are beginning to administer developmental screening tools that the parent or child care staff complete. Oregon’s standardized trainings on implementing developmental screening all include training on referral and follow-up. However, stakeholder interviews in the Yamhill region indicated that not all child care providers had received this training and further engagement is needed.

During this project, OPIP worked with one child care site that was conducting developmental screening to develop a one-page information sheet for families, outlining next steps after screening.

- **Appendix E** provides the information sheet developed for the child care provider to use with families of children identified at risk for delays.
 - » This sheet is adapted from the version developed for the primary care providers, but altered significantly.
 - » EI is included because this specific child care site facilitates direct referrals to EI, which is not currently widely practiced among child care providers. This document will need modification for future use with other sites, but the structure and format are generalizable.

Tips for partnering with Early Intervention (EI)

Early Intervention is a critical partner to CCOs and Early Learning Hubs in addressing risks identified by developmental screening tools. Over the course of this project, OPIP received additional funding from Willamette Education Service District to broaden the focus of this work to Marion and Polk counties, and to support data collection and implementation efforts in Yamhill, Marion and Polk counties. Therefore, the summary below highlights activities within Yamhill County supported through multiple funding sources.

General tips for partnering with EI

- **Partner with EI to train on the Universal Referral Form.** EI can help train practices and community-based providers on the elements of the Universal Referral Form and why they are important and valuable. It is important that EI explain the possible difference between a practice's EI referral criteria and the EI eligibility criteria. There is confusion among providers about the fact that the ASQ-3 is not used to identify children who are eligible for EI. Therefore, it is possible that children can be identified as at risk on the ASQ-3, evaluated by EI and found ineligible for EI services.
- **Use and share EI data to inform discussions about the effectiveness of existing referral practices.** Stakeholders repeatedly expressed the value of seeing and discussing EI data, which helped illuminate aspects of the system that are not clearly visible or well understood by community partners. Data elements that are helpful to share and discuss include:
 - » Number of referrals to EI
 - » Referrals by referral source

- » Number of referrals able to be contacted by EI
- » Outcome of the referral (evaluated, parent chose to delay, no parental concerns, etc.)
- » Outcomes by referral source
- » Eligibility (and by referral source)

It is also extremely helpful to stratify the variables above by age, race and Medicaid eligibility.

- » Example slideshows that include data from Willamette ESD are available on the OPIP website.* OPIP and Willamette ESD created these slides to share the EI findings with the stakeholder group. They may be helpful models to present EI data in an understandable way to a multi-stakeholder audience.
- » It is important to note this kind of data reporting and presentation to stakeholders is not necessarily a resourced activity within EI. While the previous discussions about EI data have been paramount to this project, other funding sources supported using data for this purpose and facilitating these conversations.
- **Facilitate dialogue between EI and primary care providers.** Education and health care systems are very different, despite their shared goals of improved child outcomes. A key role of OPIP in this project was to facilitate conversations, navigate culture and language differences between the sectors, and build shared understanding between primary care and EI.

Specific tools for enhancing referral, coordination and communication with EI

- **Early Intervention Universal Referral Form[†]**
 - » See **Appendix G** for the Early Intervention universal referral form.
 - » This form, which existed before this project began, is accepted across the state by Early Intervention contractors. The purpose of the form is to be sure that all relevant information is included in the referral to Early Intervention so that contact with the family and communication with the primary care provider can occur without delay.

* <http://www.oregon-pip.org/projects/YamhillCCOandELH.html#Engage>

† <http://www.oregon.gov/ode/students-and-family/SpecialEducation/earlyintervention/Pages/default.aspx>

- **Work with each EI contractor in the community to map out and understand the referral intake process, number of attempts to contact a family and communication feedback loops.**
 - » A key part of the primary care providers’ training, as well as providing information to parents, is a description of what happens when a child is referred and what all participants in the process can expect.
 - » Meet with EI staff to understand the process from receiving a referral to how they contact the family and what they do when they can’t, to completion of feedback communication to the referring provider.
- **Develop stronger Early Intervention communication back to the referring provider when EI cannot evaluate the child.** A significant number of children referred to EI cannot be evaluated because the family cannot be contacted or the parent declines the evaluation. This project focused on models for EI to communicate with other providers in a timely manner when children are not evaluated.

EI began a process of using the bottom of the Early Intervention Universal Referral Form to send information back to the referring provider at the same time as EI sent a letter to the family about not being able to contact them.

Figure 4 shows an example of communication provided when a child was unable to be evaluated. This allowed the referring provider to reach out to the family and support them to receive the follow-up service and address potential barriers the family was experiencing.

Figure 4: Example use of the EI Universal Referral Form to communicate to the referring provider about attempts to contact the family

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

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

Family contacted on 07 / / The child was evaluated on / / and was found to be:

Eligible for services Not eligible for services at this time, referred to: _____

EIVCSE County Contact/Phone: _____ Notes: contact attempts: 8/12/16, 8/20/16, 9/1/16

Attachments as requested above: _____ closure letter mailed 9/1/16

Unable to contact parent Unable to complete evaluation EIVCSE will close referral on 9.1.16 due to NO CONTACT

Form Rev. 10/23/2013

RECEIVED
OCT 11 2016
BY: AM

8/12 vum 8/20 vum
9/1 letter W 13

Tips for partnering with centralized home visiting referral programs

Home visiting and Early Head Start/Head Start programs are critical community-based providers. Some children identified at risk for delays should be referred to these programs. In the Yamhill region, a centralized home visiting referral form is used across the various programs that provide home visiting services. Therefore, the tips below are specific to communities that have this kind of centralized resource.

- **Understand the specific eligibility criteria and capacity within each program in order to identify which children identified at risk for delays should be referred.** This includes questions about key child and family risk factors that help identify appropriate children to refer for home visiting. Program eligibility requirements may require questions to determine families' income status or poverty level.
- **Clarify the referral and communication process.** Understand the specific referral process, including how families are contacted after a referral is made, in order to inform provider training and an accurate parent information sheet. Clarify the communication feedback loops so all partners are on the same page.
- **Address any legal issues regarding informed consent and HIPPA compliance.**

Further information regarding Family CORE is available online, including the Family CORE Referral Form.* The intent of this form is to provide the necessary information needed for the Family CORE group to collectively determine the best services for that child at their weekly meeting. Referrals to Family CORE come from a variety of entities in the community, so a simple and user-friendly form is ideal.

- **Appendix H** provides an example of the Family CORE feedback letter sent to the referring provider. The purpose of this letter is to inform the referring provider the result of the referral to Family CORE. This includes identification of the specific entity that received the referral, what to expect regarding communication from that entity, and how to contact that entity with questions.

* http://media.wix.com/ugd/27215c_d917fc1c8df7469aad6610680d130084.pdf

Part 5: Next steps and future opportunities

While the proposed activities were completed and stakeholders in Yamhill County made key accomplishments, a number of next steps are needed to realize the ultimate outcome of children receiving needed follow-up.

Next steps for spread, dissemination and sustainability within Yamhill County

- Standardized implementation at pilot sites of the tools developed in this project;
- Evaluation of the impact of implementation in order to identify refinements and improvement before disseminating across the county.
 - » OPIP has received funding from Willamette Education Service District to support implementation in the pilot primary care site and Willamette ESD. More information about this is available on the OPIP website.*

Opportunities for spread to other primary care practices in Yamhill County

- Dissemination, training and implementation support to other primary care practices conducting developmental screening in Yamhill County;
 - » OPIP was only able to work with one primary care site for this project. It is important to train practices conducting screening to implement follow-up tools and refine and tailor the tools to their practice settings.
- Dissemination, training and implementation support to primary care practices in Yamhill County not yet conducting developmental screening.
 - » Future efforts should support practices not yet screening a majority of their patients to conduct developmental screening to fidelity and to provide appropriate follow-up.

* <http://www.oregon-pip.org/projects/PathwaysWESD.html>

Opportunities for Yamhill CCO

- The following were identified as opportunities Yamhill CCO could support:
 - » Finalize the draft summary of medical and therapy services developed through this project and include mental health services (See Appendix D);
 - » Provide or contract with an entity to conduct training and implementation support for follow-up steps to screening;
 - » Continue to support Family CORE;
 - » Provide support for peer navigators to support parents whose children have screened at risk and enhance their connection to services; and
 - » Reimburse for services reducing barriers to children receiving follow-up, such as transportation to Early Intervention.

Opportunities for Yamhill Early Learning Hub and Family CORE

- The following were identified as future opportunities for Yamhill Early Learning Hub:
 - » Continue to support Family CORE;
 - » Maintain partnership and collaboration with Early Intervention;
 - » Consider developing community asset mapping and resource management for the areas identified in this project as important, but not identified as a priority for this project. This includes examination of EI eligibility rates by insurance status, and follow-up steps specific to children identified with social-emotional delays.
- Within Family CORE the following opportunities were identified:
 - » Dissemination and refinement of educational materials and a website about Family CORE;
 - » Consideration of enhanced methods to connect with families that were noted on page 17;
 - » Consideration of the use of family navigators and more family involvement in decisions about services that could be provided; and
 - » Training of providers in the community on how and when to refer to Family CORE.

Spread and dissemination across the state

This project developed a process for how CCOs and Early Learning Hubs can engage their community around the shared goal of ensuring children identified at risk receive coordinated follow-up services that are the best match for the child. The project also developed novel tools and strategies for use by other communities.

OPIP is aware of the unique strengths and characteristics of Yamhill County. Therefore, it may be valuable to spread this effort to two or three communities to inform more generalizable tools and strategies for spread across the state.

It is crucial to provide training and implementation support on follow-up steps to primary care practices across the state. With facilitated support, there is tremendous opportunity for primary care providers to increase screening rates while ensuring that children are referred to and connected with the follow-up services they need.

Related topics needing further exploration

Given the timeline and resources within this project, the priority focus was limited to specific follow-up pathways prioritized by the Yamhill region. That said, opportunities to refine and operationalize pathways from developmental screening to services were identified for the following providers and could be addressed by future efforts:

- Referrals to mental health services and strategies to identify appropriate referral and diagnostic codes
- Behavioral health services provided within primary care to support children and families
- Further clarification of the specific medical and therapy services available and understanding of current capacity and barriers to capacity
- Secondary referral pathways for EI-ineligible children with private insurance
- Standardized and family-centered methods by which information about child and family risk factors can be identified so referrals are made that meet the needs of the child and family
- The parent education sheets should be reviewed for reading level and health literacy as well as translated into other languages.

Relevance to state-level policies and systems

This project was intentionally designed for synergy with CCO and Early Learning Hub goals and priorities. The findings from the project can inform improvements and refinements to the following policies within each system:

OHA and CCOs

- **Metrics committees:** (Metrics and Scoring, Health Plan Quality Metrics Committees): Refinements to the current developmental screening metric, and consideration of metrics focused on follow-up to developmental screening.
- **Coverage:** Clarification of medical and therapy services for children identified at risk covered by health providers in the community and available services covered by CCOs. This includes a summary of mental health services and applicable early childhood mental health diagnoses.
- **Primary care transformation:** During Patient Centered Primary Care Home (PCPCH) site visits, ensure that global developmental screening is occurring to fidelity at each of the recommended well visits and that these children receive referral tracking and care coordination.
- **CCO collaboration within community:** Emphasize the importance of collaborations with the Early Learning Hub and EI to ensure at-risk children receive services. CCO use of EI data can inform capacity assessments, partnerships and care coordination models with home visiting programs.

Early Learning Council and Early Learning Hubs

- **Coordination within communities:** Early Learning Hub service providers, CCOs and EI need to further collaborate to ensure strong pathways from screening to services. Continued development of strong relationships among these organizations is critical.
- **Family resource management:** It is important to clarify opportunities related to follow-up to developmental screening and pathways focused on ensuring kindergarten readiness. Also of value is the provision of models for community asset mapping based on types of risks identified via developmental screening and program eligibility.
- **Early Learning Hub metrics:** Refinements to existing metrics and consideration of a metric on follow-up to developmental screening within the Early Learning Hub are warranted.

- **Collaboration between the Early Learning Hub and EI:** Models for use of EI data at Early Learning Hub meetings and as part of community-needs assessments are valuable to inform pathways to services.

Appendices

Appendix A. Developmental screening triage and referral system map for Yamhill County

Appendix B. Parent education sheet (primary care): For parents whose children are identified at risk and referred to services by the pilot primary care provider (Physicians Medical Center)

Appendix C. 36-hour phone follow-up script: For medical practice staff to use to follow up with families who have been referred to EI

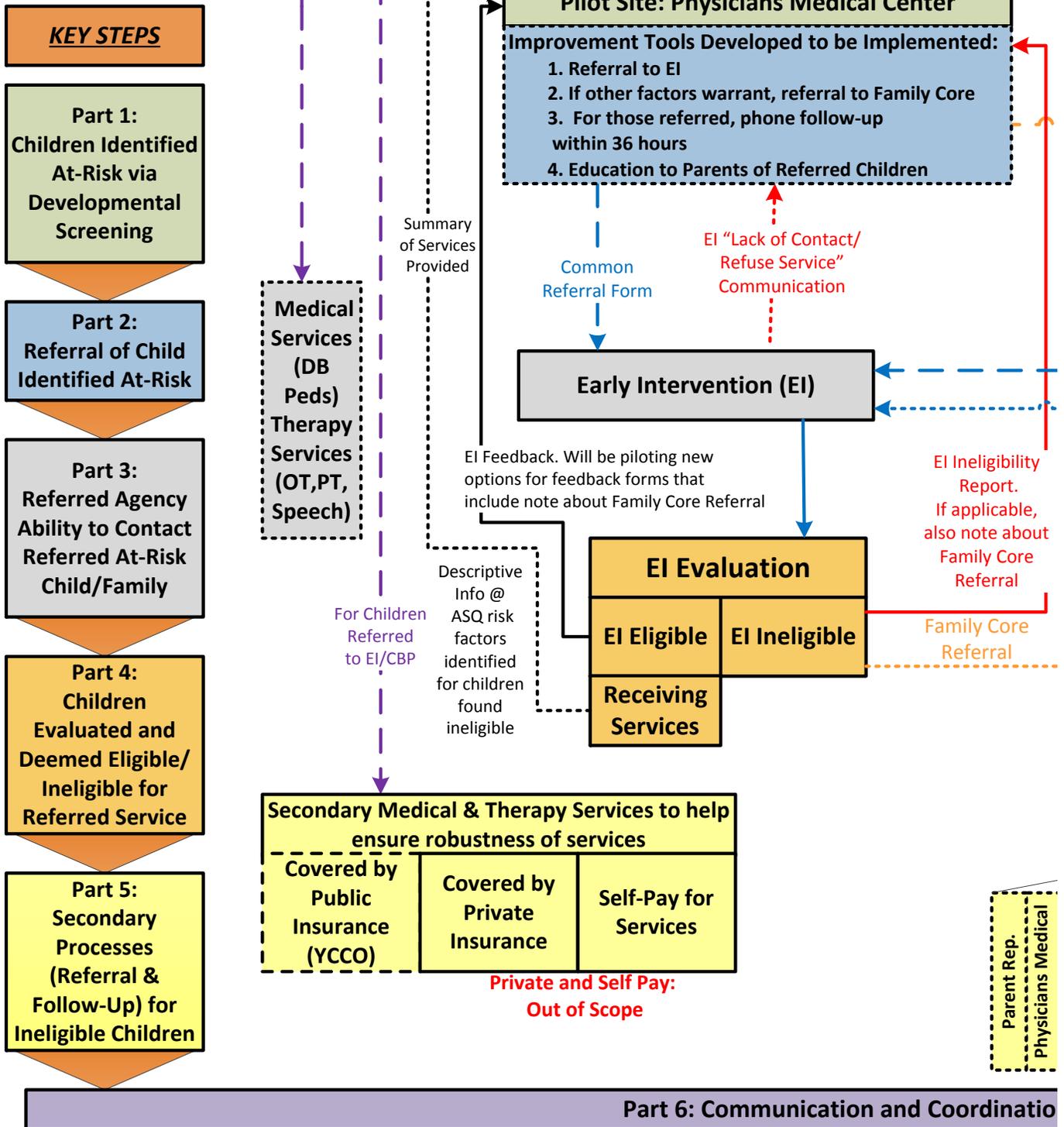
Appendix D. Summary of medical and therapy services covered by YCCO

Appendix E. Parent education sheet (child care): For parents whose children are identified at risk, explaining the developmental screening process and recommended follow-steps used by the pilot child care site (Discovery Zone).

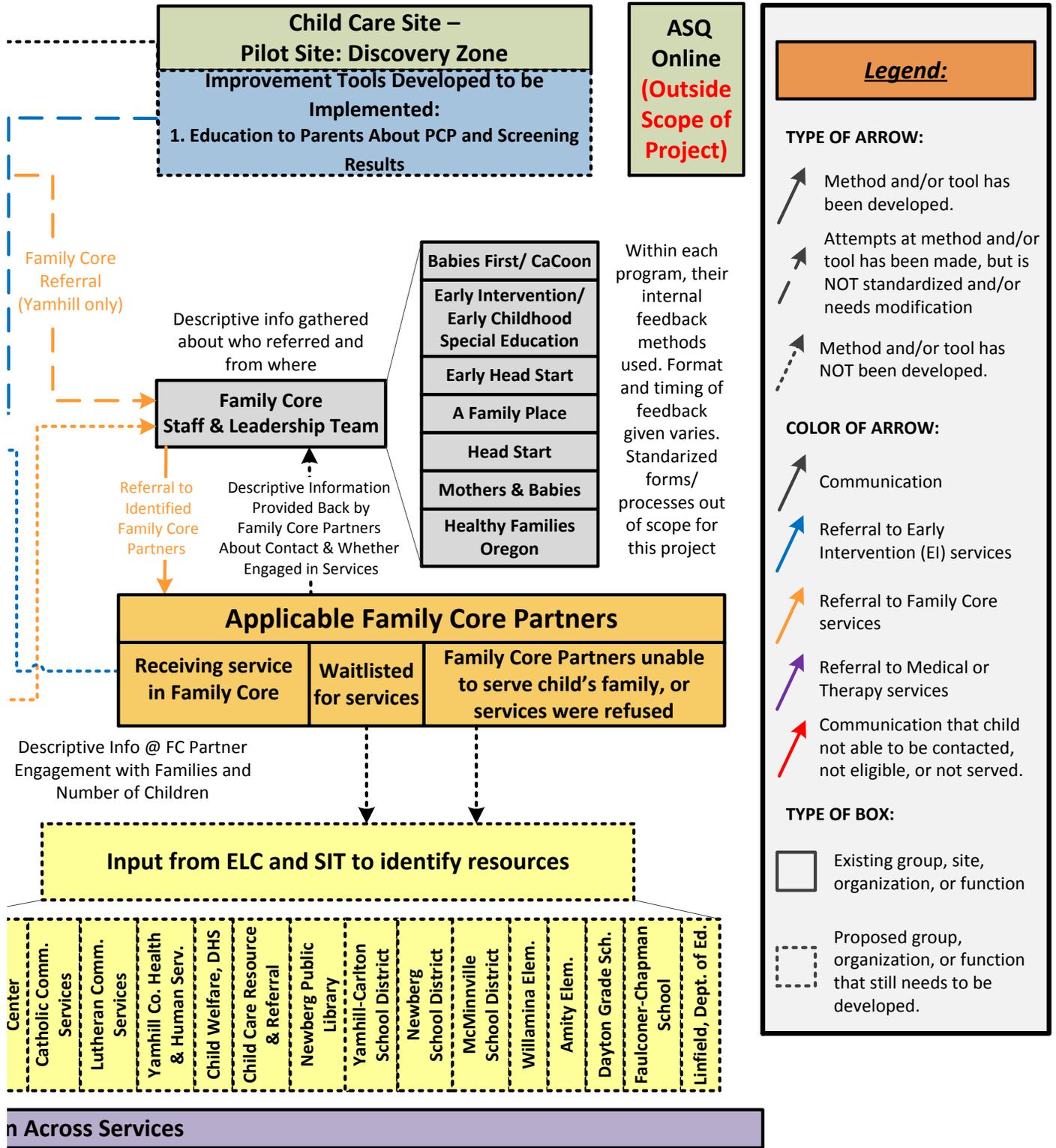
Appendix F. Generic version of the developmental screening triage and referral system map

Appendix G. Universal referral form to Early Intervention/Early Childhood Special Education

Appendix H. Family CORE follow-up letter to referring provider



Pathways from Developmental Screening to Services



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 (EI)

Who is Early Intervention?

EI helps babies and toddlers with their development. In your area, Willamette Education Service District (WESD) runs the 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.

What can you expect if your child was referred to EI:

- WESD will call you to set up an appointment for their team to assess your child.
- If you miss their call, you should call back to schedule a time for the evaluation. They have a limited time to set up the appointment. Their phone number is 503-435-5918.
- The results from their assessment will be used to determine whether or not EI can provide services for your child.

Contact Information:
WESD Intake Coordinator
503-435-5918 | www.wesd.org

Family CORE

Who is Family CORE?

Family CORE is a group of community organizations. This group meets each week to identify the best program and services to meet the needs of the child and family. Family CORE services have eligibility requirements.

There is no charge (it is free) to families for Family CORE services.

What can you expect if your child was referred to Family CORE:

One of the community organizations will reach out to your family to schedule an appointment.

Contact Information:

Jennifer Jackson
Member Engagement Supervisor
503-376-7426

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 concern, 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: Specialize in performance activities necessary for daily life
- Physical Therapist: Specializes in range of movement and physical coordination

Why did you sign a consent form?

As your child's primary care provider, we want to be informed about the care your child receives so that we can provide the best care possible. The consent you signed allows the programs to share information back to us.

Different programs have different consent requirements. You will likely be asked to sign more of these to give permission for different providers to communicate about your child's care.

Version 1.0: 12/15

OPIP Designed and distributed by Oregon Pediatric Improvement Partnership.

Any Questions?

At Physicians Medical Center we are here to support you and your child and help you get the best care possible. If you have questions about this process please call us!

Phone Number: 503-472-6161

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 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?

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).

DRAFT (11/15/16) — YCCO Coverage of Medical and Therapy Services for Children with Developmental, Behavioral or Social Delays

Type of Medical or Therapy Service Addressing Developmental Delays	Covered (Y/N)	Benefit Coverage, Any Requirements for Service to be Approved	Providers in YCCO Contract That are Able to Provide Services	Do they Serve Children 1 month-through three years old
Occupational Therapy	Y	No Authorization Required for evaluations for ATL diagnosis which pairs with CPT code. Authorization required for therapy visits. With Authorization, an evaluation and five (combined OT, PT, ST) visits are covered for BTL diagnoses.	Chehalem Physical Therapy	Case by case determination
			Neurotherapeutic Pediatric Therapies- McMinnville	Yes
			Sanders Hand Therapy Inc. Woodburn	Yes
			Hand Center of Oregon	Not known
			Providence Occupational Health Bridgeport	Yes
Physical Therapy	Y	No Authorization Required for evaluations for ATL diagnosis which pairs with CPT code. Authorization required for therapy visits. With Authorization, an evaluation and five (combined OT, PT, ST) visits are covered for BTL diagnoses.	Chehalem Physical Therapy	Case by case determination
			Marquis Physical Therapy	No
			Ability Physical Therapy and Fitness	Yes
			TAI- Newberg	Case by case determination
			TAI- Sherwood Physical Therapy	Case by case determination
			Therapeutic Associates Physical Therapy- West Salem	Yes
			West Hills Physical Therapy	Case by case determination - not typically

Type of Medical or Therapy Service Addressing Developmental Delays	Covered (Y/N)	Benefit Coverage, Any Requirements for Service to be Approved	Providers in YCCO Contract That are Able to Provide Services	Do they Serve Children 1 month-through three years old
Speech Therapy	Y	No Authorization Required for evaluations for ATL diagnosis which pairs with CPT code. Authorization required for therapy visits. With Authorization, an evaluation and five	Heart to Heart Speech Therapy LLC	Yes
			Speech with Sarah	Yes
Behavioral Psychology				
Mental Health Services				
Social Skills Groups				
Applied Behavior Analysis				
Medical Services				
Developmental/ Behavioral Pediatrician		For Specialists: 1) No authorization if member has not been seen for 3 years, regardless of diagnosis 2) No authorization required for visits for Above the line diagnoses	OHSU Salem Developmental Clinic	
			OHSU Neurodevelopmental Clinic	
			OHSU Child Development Clinic	
			Providence Neurodevelopmental Center for Children	Yes
			Providence Children's Development Institute (is this same as above?)	
Autism Evaluation OHSU Autism Clinic		For Specialists: 1) No authorization if member has not been seen for 3 years, regardless of diagnosis 2) No authorization required for visits for Above the line diagnoses	OHSU Autism Team	
			OHSU Child Development and Rehabilitative Center (is this the same as above?)	

Type of Medical or Therapy Service Addressing Developmental Delays	Covered (Y/N)	Benefit Coverage, Any Requirements for Service to be Approved	Providers in YCCO Contract That are Able to Provide Services	Do they Serve Children 1 month-through three years old
Other Potential Services – Assume Not in YCCO Contract				
Social Work Services				

Follow-Up to Screening of Development: How We Can Support Your Child

Why did you complete a survey about your child's development?

Our goal is to help young brains develop and grow to their fullest potential. National recommendations call for specific tools to be used to assess a child's development. The screening tool your child care team completed is one of those recommended tools. This screening tool helps identify kids who may be at risk for developmental delays.

It is important to identify these delays early because available services can help young bodies and brains develop and grow to their full potential. These support services can help prepare your child for kindergarten and beyond.



Completing the developmental screening questionnaire is a great first step!
Based on the results, we recommend that your child go to the following:

Early Intervention (EI)

In partnership with you, we recommend that Early Intervention evaluate your child to see if they can help support your child's development.

Who is Early Intervention?

Early intervention (EI) is a program that provides services that helps babies and toddlers with their development. EI focuses on helping babies and toddlers learn skills that typically develop during the first three years of life. EI services enhance language, social and physical development through play-based interventions and parent coaching.

In Oregon, the EI program is based in the Oregon Department of Education. In your area, Willamette Education Service District (WESD) runs the Early Intervention program.

There is no cost to the parent for EI services.

How does EI set up an evaluation?

Within the next three weeks you can expect a call from Willamette Education Service District to set up an appointment with their team. WESD will call you twice to setup the appointment. If they don't reach you, after the second phone call, they will send you a letter saying they're unable to contact you. If you miss their call, you should try and call back to schedule a time for the evaluation as they have a limited time to set up the appointment. Their phone number is 503-435-5918.

The results from the assessment will be used to determine whether or not EI can provide services for your child.

Questions? Contact:
Cynthia Barthuly, EI Yamhill County Coordinator
503-435-5941

Your Child's Primary Care Doctor or Other Health Provider

Your child's doctor or other health provider is a key partner to you in supporting your child.

Discovery Zone is providing the results from the developmental screening tool to you. This is important information about your child that should be shared with your child's doctor or other health provider.

When you call your child's doctor's office you may say something like:

"My child attends childcare at Discovery Zone Child Development Center and they completed a developmental screening tool called the Ages and Stages Questionnaire.

They suggested that I reach out to you to discuss the screening results and follow-up steps my child's doctor or other health provider would recommend "

Your child's doctor or other health provider may want to schedule an appointment to review the results.

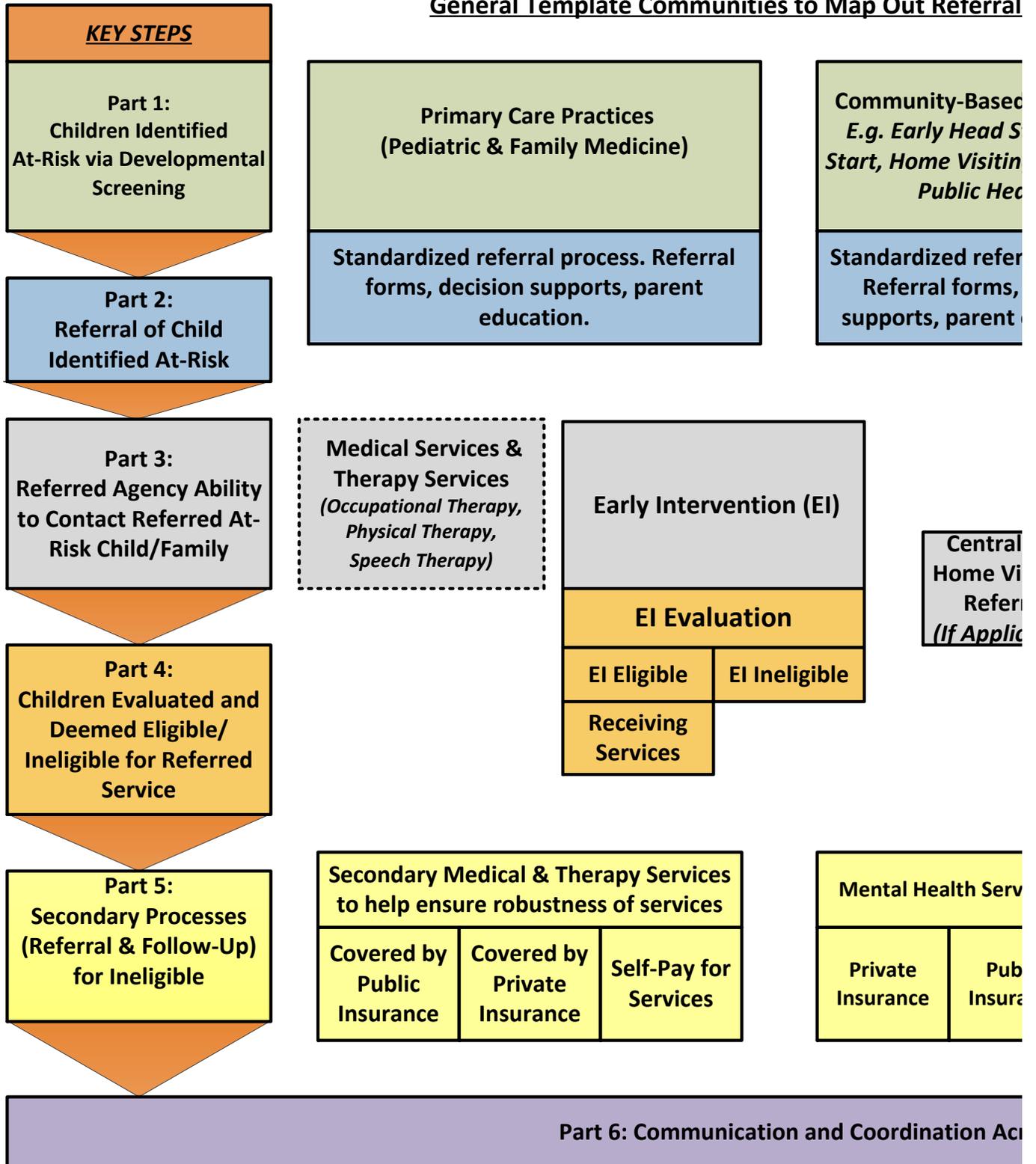
Any Questions?

At Discovery Zone, we are here to support you and your child. If you have questions about this process please call us!
Phone Number: 503-435-1414

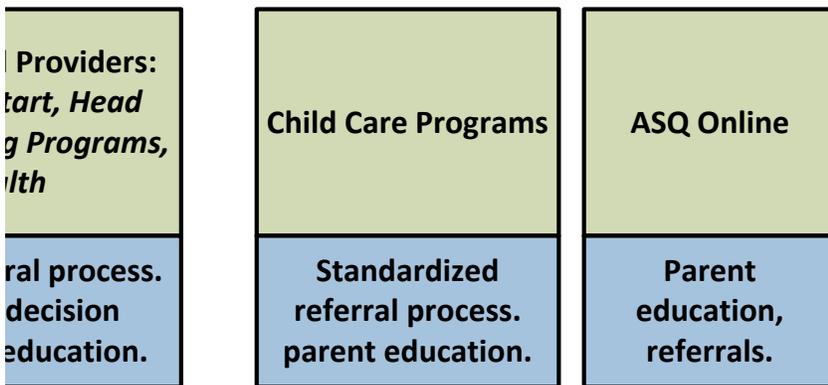
 OPIIP Designed and distributed by Oregon Pediatric Improvement Partnership.

General Template Communities to Map Out Referral

Generic version of the developmental screening triage and referral system map



& Triage Pathways for Children Identified At-Risk



Legend:

TYPE OF ARROW:

- Method and/or tool has been developed.
- Exists, but is NOT standardized or improvements in process could be made

COLOR OF ARROW:

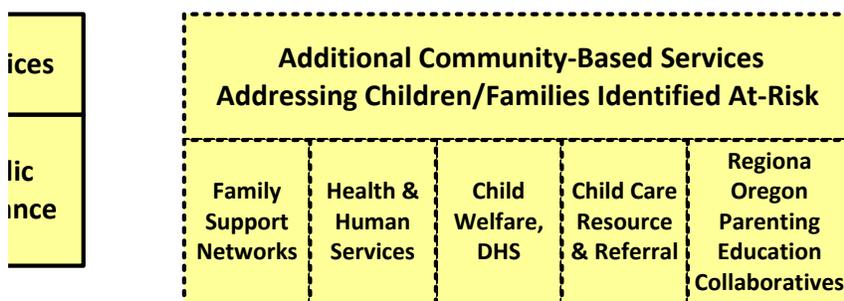
- Communication
- Referral to Early Intervention (EI) services
- Referral Form to Home Visting
- Referral to Other Community-Based Agencies
- Referral to Medical or Therapy services
- Communication that child not able to be contacted, not eligible, or not served.

TYPE OF BOX:

- Existing group, site, organization, or function
- Groups of different services

Home Visiting and/or Early Head START/Head START Programs

ized siting ral (able)	CaCoon/ BabiesFirst	Healthy Families	Head Start Programs	Early Head Start Programs
	Receiving Service	Waitlisted for services	Unable to serve child's family, or services were refused	



Cross Services

Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers* Birth to Age 5

CHILD/PARENT CONTACT INFORMATION

Child's Name: _____ Date of Birth: ____/____/____
 Parent/Guardian Name: _____ Relationship to the Child: _____
 Address: _____ City: _____ State: _____ Zip: _____
 County: _____ Primary Phone: _____ Secondary Phone: _____ E-mail: _____
 Primary Language: _____ Interpreter Needed: Yes No
 Type of Insurance:
 Private OHP/Medicaid TRICARE/Other Military Ins. Other (Specify) _____ No insurance
 Child's Doctor's Name, Location And Phone (if known): _____

PARENT CONSENT FOR RELEASE OF INFORMATION (more about this consent on page 4)

Consent for release of medical and educational information

I, _____ (print name of parent or guardian), give permission for my child's health provider _____ (print provider's name), to share any and all pertinent information regarding my child, _____ (print child's name), with Early Intervention/Early Childhood Special Education (EI/ECSE) services. I also give permission for EI/ECSE to share developmental and educational information regarding my child with the child health provider who referred my child to ensure they are informed of the results of the evaluation.

Parent/Guardian Signature: _____ **Date:** ____/____/____

Your consent is effective for a period of one year from the date of your signature on this release.

OFFICE USE ONLY BELOW:

Please fax or scan and send this Referral Form (front and back, if needed) to the EI/ECSE Services in the child's county of residence

REASON FOR REFERRAL TO EI/ECSE SERVICES

Provider: Complete all that applies. Please attach completed screening tool.

Concerning screen: ASQ ASQ:SE PEDS PEDS:DM M-CHAT Other: _____

Concerns for possible delays in the following areas (please check all areas of concern and provide scores, where applicable):

- | | | |
|---|---|---|
| <input type="checkbox"/> Speech/Language _____ | <input type="checkbox"/> Gross Motor _____ | <input type="checkbox"/> Fine Motor _____ |
| <input type="checkbox"/> Adaptive/Self-Help _____ | <input type="checkbox"/> Hearing _____ | <input type="checkbox"/> Vision _____ |
| <input type="checkbox"/> Cognitive/Problem-Solving _____ | <input type="checkbox"/> Social-Emotional or Behavior _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clinician concerns but not screened: _____ | | |

Family is aware of reason for referral.

Provider Signature: _____ **Date:** ____/____/____

If child has an identified condition or diagnosis known to have a high probability of resulting in significant delays in development, please complete the attached Physician Statement for Early Intervention Eligibility (on reverse) in addition to this referral form. Only a physician licensed by a State Board of Medical Examiners may sign the Physician Statement.

PROVIDER INFORMATION AND REQUEST FOR REFERRAL RESULTS

Name and title of provider making referral: _____ Office Phone: _____ Office Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Are you the child's Primary Care Physician (PCP)? Y ___ N ___ If not, please enter name of PCP if known: _____

I request the following information to include in the child's health records:

- | | | |
|--|--|--|
| <input type="checkbox"/> Evaluation Report | <input type="checkbox"/> Eligibility Statement | <input type="checkbox"/> Individual Family Service Plan (IFSP) |
| <input type="checkbox"/> Early Intervention/Early Childhood Special Education Brochure | <input type="checkbox"/> Evaluation Results | |

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: _____
- EI/ECSE County Contact/Phone: _____ Notes: _____
- Attachments as requested above: : _____
- Unable to contact parent Unable to complete evaluation EI/ECSE will close referral on ____/____/____.

* The EI/ECSE Referral Form may be duplicated and downloaded at this Oregon Department of Education [web page](#).
 Form Rev. 1/30/17

Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers* Birth to Age 5

**STATEMENT OF ELIGIBILITY - EARLY INTERVENTION
PHYSICAL OR MENTAL CONDITION LIKELY TO RESULT IN
DEVELOPMENTAL DELAY**

Child's Name: _____ Birthdate: _____

Program: _____ Resident District: _____

The team has obtained the following requirement:

A medical condition statement documenting that the child has a diagnosed physical or mental condition that is likely to result in a developmental delay (form 581-5150D-X):

Physician/Physician Assistant./Nurse Practitioner

Date

The team has determined that the child meets the following criteria:

1. The child has a physical or mental condition that is likely to result in developmental delay as described below:

The team agrees that this child _____ does _____ does not qualify for early intervention services.

Signatures of Team Members	Title/Agency	Agree	Disagree
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

The physician has indicated that this child has a:

- Vision Impairment
- Hearing Impairment
- Orthopedic Impairment
- A copy of the evaluation report and the eligibility statement is given to the parent(s).

OREGON EI/ECSE CONTACTS

Baker County Phone: 800.927.5847 Fax: 541.276.4252	Douglas County Phone: 541.440.4794 Fax: 541.440.4799	Lake County Phone: 541.947.3371 Fax: 541.947.3373	Sherman County Phone: 541.238.6988 Fax: 541.384.2752
Benton County Phone: 541.753.1202 x106 877.589.9751 Fax: 541.753.1139	Gilliam County Phone: 541.238.6988 Fax: 541.384.2752	Lane County Phone: 541.346.2578 800.925.8694 Fax: 541.346.6189	Tillamook County Phone: 503.842.8423 Fax: 503.842.6272
Clackamas County Phone: 503.675.4097 Fax: 503.675.4205	Grant County Phone: 800.927.5847 Fax: 541.276.4252	Lincoln County Phone: 541.574.2240 x101 Fax: 541.265.6490	Umatilla County Phone: 800.927.5847 Fax: 541.276.4252
Clatsop County Phone: 503.338.3368 Fax: 503.325.1297	Harney County Phone: 541.573.6461 Fax: 541.573.1914	Linn County Phone: 541.753.1202 x106 877.589.9751 Fax: 541.753.1139	Union County Phone: 800.927.5847 Fax: 541.276.4252
Columbia County Phone: 503.366.4141 Fax: 503.397.0796	Hood River County Phone: 541.386.4919 Fax: 541.387.5041	Malheur County Phone: 541.372.2214 Fax: 541.473.3915	Wallowa County Phone: 541.927.5847 Fax: 541.276.4252
Coos County Phone: 541.269.4524 Fax: 541.269.4548	Jackson County Phone: 541.494.7800 Fax: 541.494.7829	Marion County Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959	Warm Springs Phone: 541.553.3241 Fax: 541.553.3379
Crook County Phone: 541.693.5630 Fax: 541.693.5661	Jefferson County Phone: 541.693.5740 Fax: 541.475.5337	Morrow County Phone: 800.927.5847 Fax: 541.276.4252	Wasco County Phone: 541.296.1478 Fax: 541.296.3451
Curry County Phone: 541.269.4524 Fax: 541.269.4548	Josephine County Phone: 541.956.2059 Fax: 541.956.1704	Multnomah County Phone: 503.261.5535 Fax: 503.894.8229	Washington County English: 503.614.1446 Spanish: 503.614.1299 Fax: 503.614.1290
Deschutes County Phone: 541.312.1195 Fax: 541.693.5661	Klamath County Phone: 541.883.4748 Fax: 541.850.2770	Polk County Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959	Wheeler County Phone: 541.238.6988 Fax: 541.384.2752
			Yamhill County Phone: 503.385.4714 888-560-4666 x4714 Fax: 503.540.2959

EI/ECSE contact information also available at this Oregon Department of Education [web page](#).

or please call 1-800-SafeNet

SOUTHWEST WASHINGTON EI/ECSE CONTACTS

(NOTE: EI/ECSE Program Requirements differ in each state; please contact these offices for Washington Requirements)

Clark County Phone: 360.896.9912 ext.170 Fax: 360.892.3209	Cowlitz County Phone: 360.425.9810 Fax: 360.425.1053	Klickitat County Phone: 360.921.2309 Fax: 509.493.2204	Skamania County Phone: 509.427.3865 Fax: 509.427.4430
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Early Intervention/Early Childhood Special Education (EI/ECSE) Referral Form for Providers* Birth to Age 5

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN HEALTHCARE PROVIDERS and EARLY INTERVENTION

Information for Parents

This consent for release of information authorizes the disclosure and/or use of your child's health information from your child's health care provider to the Early Intervention/Early Childhood Special Education (EI/ECSE) program. This consent form also authorizes the disclosure of developmental and educational information from the Early Intervention/Early Childhood Special Education program to your child's health care provider.

Why is this consent form important?

Your child's health care provider sees your child at well-child screening visits and for medical treatment. Sometimes your child's health care provider may see the need for more information, like evaluation or follow up by other specialists, to identify your child's special health care needs. The Early Intervention/Early Childhood Special Education (EI/ECSE) program can be a resource to help identify your child's needs. The primary goal of this consent form is to allow communication between your child's health care provider and EI/ECSE programs so these providers can work together to help your child.

Why am I asked to sign a consent on this form?

The consent allows your child's health care provider to share information about your child with EI/ECSE, and allows EI/ECSE to share information about your child with your health care provider. Your consent for the release of information allows your child's health care provider and EI/ECSE communicate with one another to ensure your child gets the care your child needs. However, as your child's parent or legal guardian you may refuse to give consent to this release of information.

How will this consent be used?

This consent form will follow your child as he/she is screened and/or evaluated at EI/ECSE. The information generated by this release will become a part of your child's medical and educational records. Information will be shared with only individuals working at or with EI/ECSE or the office of your child's health care provider for the purpose of providing safe, appropriate and least restrictive educational settings and services and for coordinating appropriate health care.

How long is the consent good for?

This consent is effective for a period of one year from the date of your signature on the release.

What are my rights?

You have the following rights with respect to this consent:

- You may revoke this consent at anytime.
- You have the right to receive a copy of the Authorization.

Family CORE

Coordinated 0-5 years Referral Exchange

Thank you so much for your referral

Date:

To:

Child/Family name:

Your referral was received by the Family CORE team, composed of representatives from Yamhill County's home visiting programs. We have given this referral to the program that we feel will best meet their needs:

Head Start of Yamhill County: (503) 472-2000

Lutheran Community Services: (503) 472-4020 x206
You should hear the outcome of this referral in 2-3 weeks.

Provoking Hope: (503) 895-0934
You should hear the outcome of this referral in 1-3 weeks.

Public Health: (503) 434-7525
You should hear the outcome of this referral in 1-3 weeks.

Willamette Education Service District: (503) 435-5918
You should hear the outcome of this referral in 3-4 weeks.

Family and Youth Programs

The information provided was not sufficient to make a referral.
Please:

Each Agency will make several attempts to contact families. If there is anything else we can do to help please let us know.

Thank-you,

The Family CORE team



PUBLIC HEALTH DIVISION
Maternal and Child Health
Phone: 503-891-9335

You can get this document in other languages, large print, braille or a format you prefer. Contact Maternal and Child Health at 503-891-9335 or email elizabeth.m.stuart@state.or.us. We accept all relay calls or you can dial 711.