| Central Oregon Health Council | Description: | KR A3 - Access to Int. Services | Value Stream ID: | | Site / Location: | | Event Number: | Revision: | |
|---|---|---|---|---|---|---|---|---|---|
| | Sponsor: | COHC | Process Owner/Team Lead: | | Facilitator: | Donna Mills | Sensei: | | |

Current Date: | Event Date: | Team

**1: REASONS FOR ACTION** (Go / No Go)

Problem: Children in Central Oregon have lifelong health and learning challenges due to lack of early identification and access to services.

Aim: Central Oregon children become more resilient

Boundaries: Community services wrap around all families with health and social needs resulting in long-term education achievement for children: early education/health/family stability

**2: INITIAL STATE** (Go / No Go)

- Although regional developmental screening rates by 3 years old across the region have increased from 52% to 59.4% from 2013-2016, there continues to be a significant number of children identified in need of special education services and supports at Kindergarten enrollment.
- Many have not previously been referred to/been supported by services that could effectively serve their needs/improve outcomes or have received a referral that does not result in services.
- Primary care providers anecdotally share that they have limited knowledge of community based services and what happens as a result of referrals made.
- Tracking service referrals received by Early Intervention show that a high number of referrals that they receive do not qualify for services. (need exact percent)
- Parents/Caregivers often do not have information, capacity and/or resources to support follow-up to services.

**3: TARGET STATE:** (Go / No Go)

Improvement Metrics:

% increase in number of children receiving developmental screening by age 3 (as documented)

% increase in referrals from primary care to services that have documented feedback/results

% increase in developmental assessment referrals to primary care providers

Baseline metrics – to be established/collected:

# of primary care referrals to service as a follow-up to development screening (will include referral feedback)

% parent/caregiver satisfaction with communications, tools and resulting service referral

**4: GAP ANALYSIS** (Go / No Go)

- Few established referral pathways from developmental screening to eligible services
- Lack of Primary Care access to information on local service and supports, including eligibility
- Lack of tools to help parents understand results of developmental screening and negotiate referral systems and follow-up
- Developmental screening completed in community based programs are rarely shared with Primary Care providers and/or documented in patient case record
- Lack of systems to track results of referrals from Primary Care to programs and feedback loops to share results

**5: SOLUTION APPROACH** (Go / No Go)

IF WE:

- Support Primary Care workflow to provide information on referral services
- Support service providers to receive and respond to follow-up referrals to development screening
- Arm parents/caregivers with information and warm hand-off to services
- Develop and implement a platform to facilitate referral and follow-up feedback between primary care and services providers

THEN:

- More children will be screened, receive services and enter school ready to learn

RESULTING IN:

- Improved health outcomes
- Improved education outcomes
- Improved system communication and response

**6: RAPID EXPERIMENTS** (Go / No Go)

1. Engage technical assistance from OHSU/OPIP to map and assess current workflow for referrals from developmental screening to services
2. Engage Primary Care partners willing to pilot system improvement
3. Engage Early Intervention, Home Visiting and other service providers to map appropriate referrals for their service, including eligibility criteria
4. Engage Parents/Caregivers to help inform communication and navigation tools to address barriers to access/follow-up service referrals
5. Coordinate with OAHC electronic referral system development to determine system needs to link primary care and service providers to share screening/feedback

**7: COMPLETION PLAN** (Go / No Go)

1. Map and implement pathways from developmental screening to services by community
2. Tools for primary care providers to support service referrals
3. Tools for parents/caregivers to support information on child development and access to services
4. Articulate and implement electronic records sharing between primary care and service providers

**8: CONFIRMED STATE** (Go / No Go)

**9: INSIGHTS** (Go / No Go)

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