Tools Compendium

The tools presented in this document are models that may be adapted for communities to understand current systems and processes, and use that information to identify best pathways of care for children who are identified at-risk for developmental, behavioral, and social-emotional delays.

Three different sets of tools are included in this PDF. They are bookmarked, and include the following:

1. Tools for Primary Care (PDF page 2)
2. Tools for Referring and Coordinating with Early Intervention (PDF page 13)
3. Tip Sheet on Asset Mapping (PDF page 19)

The page numbers on the pages themselves correspond to the pages within that specific tool- in other words, this PDF is comprised of three separate documents combined, each having their own page number sequence.

**Please note: The tools and resources presented in this appendix are models that were developed for the context of this pilot project within this specific community. These models may be adapted for other communities, however they should not and are not intended to be a replacement of Medical Advice. For questions or clarification about these tools, please contact OPIP staff at: OPIP@ohsu.edu*

Primary Care Tools

The materials in this document are tools and resources that Primary Care Providers can use to enhance their communication and education about services.

The **Follow-Up to Developmental Screening Medical Decision Tree** is a tool that was developed with community stakeholder and developmental pediatrician input to help inform the pathways of follow-up to developmental screening and referral for children identified at-risk using the ASQ questionnaire. This conceptual model was developed in order to determine the best match of community-based services to refer the child/family based on risk factors and family demographics, using the framework of total ASQ score across domains and the ASQ Social-Emotional specific domain. This tool is a conceptual model that may be adapted and used within other communities; however, it should not and is not intended to be used as a replacement of professional Medical advice. Key factors to consider include:

1. ASQ Domain Scores
2. Parent or Provider Concern
3. Child factors that map to specific kinds of delays that can be addressed by community-based programs.
4. Social and Family factors that map to specific kinds of delay that can be addressed by community-based programs.

The **one-page Parent Education Sheet** is a tool that may be used by Primary Care Providers to help explain referrals to parents and to support shared decision making. These sheets include options for referral, an explanation about the services provided, notes about eligibility, and important contact information. Based on the screening results, providers check the box(es) of the appropriate program or service that the child/family is being referred to. Buckets of information may include Early Intervention, Home Visiting Programs, Medical and Therapy Services, and Parenting Supports. This tool can be a helpful resource with information for parents/families to understand next steps, as well as act as a decision support tool for Providers when facilitating conversations during the visit.

List of Tools:

**Please note: The tools and resources presented in this appendix are models that were developed for the context of this pilot project within this specific community. These models may be adapted for other communities, however they should not and are not intended to be a replacement of Medical Advice. For questions or clarification about these tools, please contact OPIP staff at: OPIP@ohsu.edu*

FOLLOW-UP TO DEVELOPMENTAL SCREENINGS CONDUCTED IN OREGON IN FIRST THREE YEARS: MEDICAL DECISION TREE

STEPS TO CONSIDER

CATEGORY 1 3 + domains in the black	CATEGORY 2 2 domains in black	CATEGORY 3 1 domain in black	CATEGORY 4 2 or more in grey

STEP 1: PROMOTE

DEVELOPMENTAL PROMOTION: ASQ Learning Activities for Specific Domains Identified At-Risk

STEP 2: REFER *OR* RESCREEN

REFER TO:
1. **Developmental Behavioral Pediatrician**
   See DB Peds cheat sheet on back; If Under 1 – No Referral, but continue to monitor progress
2. **Early Intervention for an evaluation**
   - *Use **EI Universal Referral Form** and sign **FERPA***
   - *Give Parent Ed Sheet*

Parental Or Provider Concern — YES / NO

REFER TO:
Early Intervention for an evaluation
- *Use **EI Universal Referral Form** and sign **FERPA***
- *Give Parent Ed Sheet*

RESCREEN WITHIN 3 MONTHS:
- *Set up a follow-up if child does not have a visit*

Parental Or Provider Concern — YES / NO

REFER TO:
Early Intervention for an evaluation
- *Use **EI Universal Referral Form** and sign **FERPA***
- *Give Parent Ed Sheet*

RESCREEN WITHIN 3 MONTHS:
- *Set up a follow-up if child does not have a visit*

RESCREEN WITHIN 3 MONTHS:
- *Set up a follow-up if child does not have a visit*
- If rescreened more than once, then proceed with referrals.

STEP 3: MEDICAL SERVICES TO CONSIDER

CONSIDER:
Supplemental Medical & Therapy Services
- *If Communication: Speech therapy & Audiology*
- *If Fine Motor/Gross Motor: OT/PT*

CONSIDER:
1. **Referral to Developmental Behavioral Pediatrician**
   - *If child is at-risk on comm <u>AND</u> problem solving or personal social See DB Peds cheat sheet on back*
   - *If Under 1 – No referral, monitor progress*
2. **Supplemental Medical & Therapy Services**
   - *If Communication: Speech therapy & Audiology*
   - *If Fine Motor/Gross Motor: OT/PT*

CONSIDER:
Supplemental medical & therapy services
- *If Communication: Speech therapy & Audiology*
- *If Fine Motor/Gross Motor: OT/PT*

STEP 4: BEHAVIORAL HEALTH SUPPORTS

If Child is At-Risk (in the black) on Personal Social and/or Problem Solving, (if available) refer to **Internal Behavioral Health** and/or if child presents with additional risk factors, refer for **Specialty Mental Health** (CPP & PCIT)
More Information on Back

STEP 5: COMMUNITY RESOURCES TO CONSIDER

CaCOON
See Info on Back

CONSIDER REFERRALS TO AVAILABLE COMMUNITY RESOURCES
Review potential options for community resources that may be available. See OPIP Issue Brief on "Identifying Assets in the Community"
and examples of resources identified in example decision trees provided.

CaCOON CHEAT SHEET:

Info about program: https://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm

Medical Diagnosis or Medical Risk Factors

+

Social and Family Factors to Consider

- Feels Depressed or Overwhelmed
- Isolation/Lack of Support
- Support with Parenting/Lack of Parenting Skills
- Parent has Disability
- Teen/Young Parent
- First Time Parent
- Newly Pregnant needing assistance
- Tobacco Use
- Domestic Violence (present or history of)
- Alcohol/Drug Use
- Lack of Food/ Clothing/Housing
- Incarceration/Probation
- Low Income
- Migrant/Seasonal Worker
- Unemployed
- Homeless
- Receives TANF/SSI/SNAP
- DHS Involvement

Developmental Pediatrician Referral Cheat Sheet:

Kid in **the BLACK** on the Communication domain

+

Personal-Social domain or Problem Solving Domain

or

If the child is 'In the BLACK' on 2 or more domains and has any of the following presenting concerns:

- Kids who are not progressing in services as expected or recent increase in symptoms
- Kids who have challenging behaviors with inadequate response to behavioral interventions or medication.
- Kids with secondary medical issues that are not responding to usual treatments (including feeding and nutrition)
- Kids who may be experiencing traumatic events

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

ACEs include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Mother treated violently
- Substance misuse within household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

https://www.samhsa.gov

BEHAVIORAL HEALTH SUPPORTS

If child is "in black" on **Personal Social and/ or Problem Solving**

Internal Behavioral Health referral. Example of follow-up steps by IBH staff.

- **Additional screening of child's development (ASQ-SE, Pediatric Symptom Checklist)**
- **Understand Parental Frustration**
- **Understand child risk factors**

If Child has:

Concerns such as oppositional, aggressive, overactive or shy/anxious behaviors, significant sleep, feeding, self-soothing, adjusting to new situations, or irritability concerns

And/ Or

Exposure to Adverse Childhood Events (ACES) in Family Environment

Consider External Referral to Mental Health for Child Parent Psychotherapy (CPP), Parent Child Interaction Therapy, and Other Services

CONSIDER: USE OF EARLY CHILDHOOD MENTAL HEALTH DX CODES

BACK PAGE

FOLLOW-UP TO DEVELOPMENTAL SCREENINGS CONDUCTED IN FIRST THREE YEARS: MEDICAL DECISION TREE

STEPS TO CONSIDER

CATEGORY 1
3 + domains in the black

CATEGORY 2
2 domains in black

CATEGORY 3
1 domain in black

CATEGORY 4
2 or more in grey

STEP 1: PROMOTE

DEVELOPMENTAL PROMOTION: ASQ Learning Activities for Specific Domains Identified At-Risk

STEP 2: REFER *OR* RESCREEN

REFER TO:
1. **Early Intervention for an evaluation**
   - *Use **EI Universal Referral Form** and sign **FERPA***
   - *Give Parent Ed Sheet*
2. **Developmental Behavioral Pediatrician**

See DB Peds cheat sheet
If Under 1 – No Referral, but continue to monitor progress

Parental Or Provider Concern

YES

REFER TO:
Early Intervention for an evaluation
- *Use **EI Universal Referral Form** and sign **FERPA***
- *Give Parent Ed Sheet*

NO

RESCREEN WITHIN 3 MONTHS:
- *Set up a follow-up if child does not have a visit*

Parental Or Provider Concern

YES

REFER TO:
Early Intervention for an evaluation
- *Use **EI Universal Referral Form** and sign **FERPA***
- *Give Parent Ed Sheet*

NO

RESCREEN WITHIN 3 MONTHS:
- *Set up a follow-up if child does not have a visit*

REFER TO:
HELP ME GROW
- *Sign **FERPA***

RESCREEN WITHIN 3 MONTHS:
- *Set up a follow-up if child does not have a visit*

STEP 3: MEDICAL SERVICES TO CONSIDER

CONSIDER:
Supplemental Medical & Therapy Services
- *If Communication: Speech therapy & Audiology*
- *If Fine Motor/Gross Motor: OT/PT*

CONSIDER:
1. **Referral to Developmental Behavioral Pediatrician**
   - *If child is at-risk on comm <u>AND</u> problem solving or personal social See DB Peds cheat sheet*
   - *If Under 1 – No referral, monitor progress*
2. **Supplemental Medical & Therapy Services**
   - *If Communication: Speech therapy & Audiology*
   - *If Fine Motor/Gross Motor: OT/PT*

CONSIDER:
Supplemental medical & therapy services
- *If Communication: Speech therapy & Audiology*
- *If Fine Motor/Gross Motor: OT/PT*

If Child is At-Risk (in the black) on Personal Social and/or Problem Solving –
Refer to **Internal Behavioral Health** and/or with risk factors Refer for **Specialty Mental Health** (CPP & PCIT) or **Relief Nursery**
More Information on Back

STEP 4: COMMUNITY RESOURCES TO CONSIDER

CACOON: HOME VISITING (CAN SERVE CHILDREN BIRTH - 21)
If child has a medical diagnosis *AND* social risk factors
See CaCoon Cheat sheet on back
Refer to **Early Connections**
(*Centralized Home Visiting for All Programs including CaCoon*) *
Sign **FERPA***
https://caowash.org/what_we_do/early-connections/early-connections.html

PARENTING CLASSES:
1)**PARENTING TOGETHER**
Includes parent education, child care resources, family-friendly activities, and web-based resources
https://parentingtogetherwc.org/for-parents/parenting-education/
2) **ABRIENDO PUERTAS** Parenting program in VGMHC

EARLY HEAD START
Promote school readiness of children from birth to age five from low-income families by enhancing their cognitive, social and emotional development

https://caowash.org/what_we_do/head-start/

CaCOON CHEAT SHEET:

Info about program: https://www.ohsu.edu/xd/outreach/occyshn/programs-projects/cacoon.cfm

Medical Diagnosis or Medical Risk Factors

+

Social and Family Factors to Consider

- Feels Depressed or Overwhelmed
- Isolation/Lack of Support
- Support with Parenting/Lack of Parenting Skills
- Parent has Disability
- Teen/Young Parent
- First Time Parent
- Newly Pregnant needing assistance
- Tobacco Use
- Domestic Violence (present or history of)
- Alcohol/Drug Use
- Lack of Food/ Clothing/Housing
- Incarceration/Probation
- Low Income
- Migrant/Seasonal Worker
- Unemployed
- Homeless
- Receives TANF/SSI/SNAP
- DHS Involvement

Referral Form:

https://caowash.org/what_we_do/early-connections/early-connections.html

Developmental Pediatrician Referral Cheat Sheet:

Kid in **the BLACK** on the Communication domain

+

Personal-Social domain or Problem Solving Domain

or

If the child is 'In the BLACK' on 2 or more domains and has any of the following presenting concerns:

- Kids who are not progressing in services as expected or recent increase in symptoms
- Kids who have challenging behaviors with inadequate response to behavioral interventions or medication.
- Kids with secondary medical issues that are not responding to usual treatments (including feeding and nutrition)
- Kids who may be experiencing traumatic events

Potential Referral Sources:

- OHSU – CDRC
- Providence Children's Development Institute

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

ACEs include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Mother treated violently
- Substance misuse within household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

https://www.samhsa.gov

INTERNAL BEHAVIORAL AND MENTAL HEALTH SUPPORT

If child is "in black" on **Personal Social and/ or Problem Solving**

Internal Behavioral Health referral

- **Additional screening of child's development (ASQ-SE, Pediatric Symptom Checklist)**
- **Understand Parental Frustration**
- **Understand child risk factors**

If Child has:

Concerns such as oppositional, aggressive, overactive or shy/anxious behaviors, significant sleep, feeding, self-soothing, adjusting to new situations, or irritability concerns

And/ Or

Exposure to Adverse Childhood Events (ACES) in Family Environment

CONSIDER:

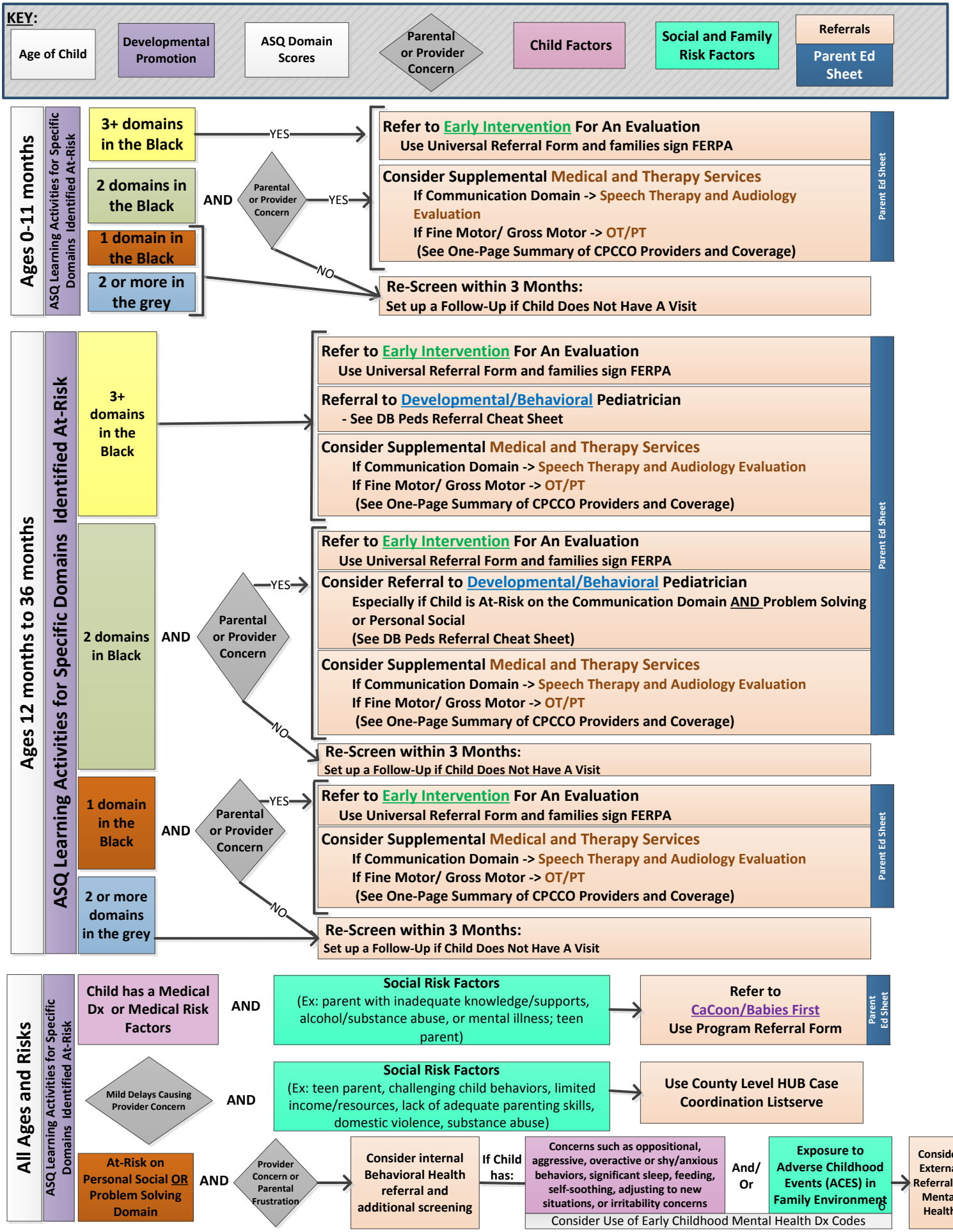
1. USE OF EARLY CHILDHOOD MENTAL HEALTH DX CODES

2. CHILDREN'S RELIEF NURSERY

Teaches parenting skills, strengthening bonds between parents and their babies, providing targeted services, reducing child behavioral problems and improving social-emotional development in very young children.

Consider External Referral to Mental Health for Child Parent Psychotherapy (CPP), Parent Child Interaction Therapy, and Other Services

Medical Decision Tree for Follow-Up to Developmental Screening Conducted in the first Three Years of Life and Referral Opportunities Addressing Risk in Clatsop County



Developmental Pediatrician Referral Consideration

Risk Factor Considerations – inclusive of specific county level criteria

Developmental Pediatrician Referral Cheat Sheet:

Refer to a Developmental Pediatrician if:

- Kid 'In the BLACK' the Communication domain AND either the Personal-Social domain or Problem Solving Domain

Or if the child is 'In the BLACK' on 2 or more domains and has any of the following presenting concerns:

- Kids who are not progressing in services as expected or recent increase in symptoms
- Kids who have challenging behaviors with inadequate response to behavioral interventions or medication.
- Kids with secondary medical issues that are not responding to usual treatments (including feeding and nutrition)
- Kids who may be experiencing traumatic events

Child Factors to Consider

- Lack of Prenatal Care
- Support with Breastfeeding
- Support with Infant Care
- Drug Exposed Infant/ Pregnancy
- Support with Attachment/ Bonding
- Has Disability
- Born Premature
- Home Environment Concerns
- Development Concerns
- Social/Emotional Concerns
- Behavior Concerns
- Feeding Concerns
- Health Concerns
- Weight Concerns

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

ACEs include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Mother treated violently
- Substance misuse within household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

https://www.samhsa.gov

Social and Family Factors to Consider

- Feels Depressed or Overwhelmed
- Isolation/Lack of Support
- Support with Parenting/Lack of Parenting Skills
- Parent has Disability
- Teen/Young Parent
- First Time Parent
- Newly Pregnant needing assistance
- Tobacco Use
- Domestic Violence (present or history of)
- Alcohol/Drug Use
- Lack of Food/ Clothing/Housing
- Incarceration/Probation
- Low Income
- Migrant/Seasonal Worker
- Unemployed
- Homeless
- Receives TANF/SSI/SNAP
- DHS Involvement

Pilot Medical Decision Tree for Follow-Up to Developmental Screening Conducted in First Three Years of Life & Referral Opportunities Addressing Risks in Marion, Polk and Yamhill County

KEY: ASQ Domain Scores* | Developmental Promotion Provided At Visit | Referral | Parent Ed Sheet | Child Factors | Family Factors | Family Income | County | Referral | Parent Ed Sheet

Follow-Up Based on Total Score Across Domains:

GROUP A — 3 or More in the Black
- Developmental Promotion:
  - ASQ Learning Activities for Specific Domains Identified At-Risk
- Refer to Early Intervention For An Evaluation
  - Use Universal Referral Form and families sign FERPA
- Consider Referral to Developmental/Behavioral Pediatrician
  - See DB Peds Referral Cheat Sheet
- Consider Supplementing Medical and Therapy Services
  - See One-Page Summary of WVCH Providers and Coverage

Give Parent Education Sheet

GROUP B — 2 in the Black AND Parental Concern
- Developmental Promotion:
  - ASQ Learning Activities for Specific Domains Identified At-Risk
- Refer to Early Intervention For An Evaluation
  - Use Universal Referral Form and families sign FERPA
- Consider Supplementing Medical and Therapy Services
  - See One-Page Summary of WVCH Providers and Coverage

Give Parent Education Sheet

GROUP C — 2 or more Grey or 1 in Black AND Parental Concern
- Developmental Promotion:
  - ASQ Learning Activities for Specific Domains Identified At-Risk
- Re-Screen in 3-6 Months, Set up a Follow-Up if Child Does Not Have A Visit

Three Community Resources To Consider for Groups A-D

Resource #1

Child has a Medical Dx or Medical Risk Factors (ex: FTT, elevated lead, seizure disorder) **AND** Social Risk Factors (Ex: parent with inadequate knowledge/supports, alcohol/ substance abuse, or mental illness; teen parent) — YES → **Refer to CaCoon/ Babies First Use CaCoon Program Referral Form**

Give Parent Education Sheet

Resource #2

Family Risk Factors Present or Exposure to Adverse Childhood Events & would benefit from Home Visiting and/or Head Start → **Publicly Insured*** — YES
- Child Lives in Marion/ Polk County → **Refer to Family Link Include Info on EI Referral**
- Child Lives in Yamhill County → **Refer to FamilyCORE Include Info on EI Referral**

Give Parent Education Sheet

Resource #3

Support developmental promotion by addressing issues such as literacy/ reading, parenting skills, food insecurity → Could benefit from **parenting classes?**
- Classes in Yamhill & Polk Counties → **Mid-Valley Parenting** www.midvalleyparenting.org Email: parentresources@co.polk.or.us
- Classes in Marion Counties → **Marion & Polk Early Learning Hub** www.earlylearninghub.org Email: parentinghub@earlylearninghub.org

And, If Applicable, Follow-Up for a Specific Domain:

GROUP D — In Black on Social Emotional Domain
- #1 → Provide: ASQ Learning Activities for SE Domain
- #2 → Possible refer to internal Behavioral Health Staff for further assessment and support
- #3 → Behavior/Impulsivity with significant functional impact(e.g. expulsed from child care) **And/ Or** Exposure to Adverse Childhood Events (ACES) in Family Environment

Consider Use of Early Childhood Mental Health Dx Codes

If YES:
- Privately Insured
  - Child Lives in Marion County → #1 Refer to Marion County Child. Behv. Health for PCIT; #2 Options Counseling North, Valley Mental Health, Salem Psychiatry
  - Child Lives in Polk County → Options Counseling North, Valley Mental Health, Salem Psychiatry
- Publicly Insured
  - Child Lives in Marion/Polk County → Options Counseling North-Child, Marion County Children's Behavioral Health, Mid Valley BCN, Valley Mental Health, Inter-Cultural Ctr for Psychology, Polk Mental Health -Child, Legacy Silverton Health

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

Who is Early Intervention (EI)?

EI helps babies and toddlers with their development. In your area, Northwest Regional Education Service District (NWRESD) 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 to expect if your child was referred to EI:

- NWRESD 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 503-338-3368.

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

Contact Information:
NWRESD Intake Coordinator
503-338-3368 | www.nwresd.org

☐ CaCoon

Who is CaCoon?

CaCoon is a public health nursing program serving families. CaCoon public health nurses work with your family to support your child's health and development. A CaCoon nurse will meet with you in your home, or wherever works best for you and your child.

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

Contact Information:
Mandy Mattison
Phone: 503-325-8500
http://www.co.clatsop.or.us/publichealth/page/maternal-child-health-programs

Supports within CMH

At our practice we are lucky enough to have a Family Transitional Planner who could help your family with things like:

- Additional developmental promotion resources
- Social and emotional supports
- Navigating community resources

Contact Information:
Misty Bottorff
Family Transitional Planner
Phone:503-338-7598

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.

Any Questions?

At Columbia Memorial Hospital - Pediatrics, we are here to support you and your child. If you have questions about this process please call us!

Phone Number: 503-325-7337

Version 1.0: 4/4/18

OPIP Designed and distributed by Oregon Pediatric Improvement Partnership.

Seguimiento al Chequeo Médico: ¿Cómo podemos ayudar a su hijo?

¿Por qué le pedimos que llene un cuestionario sobre el desarrollo de su hijo?

Nuestra meta es ayudar a desarrollar al cuerpo y el cerebro de los niñospara que puedan alacanzar todo su potencial. Estos servicios de ayuda y apoyo pueden ayudarle a preparar a su hijo para el kinder y los años siguientes.

Las recomendaciones nacionales de la Academia Americana de Padiatría indican que ciertas técnicas sean usadas para asesorar el desarollo de los niños, así como el cuestionario que usted ha completado. Ésta técnica ayuda a identificar a niños que pudieran estar en riesgo de retraso. Es importante poder identificar temprano estos retrasos, ya que hay servicios disponibles que pueden ayudarle.

Basado en estos resultados, estamos recomendandole a su hijo/a los siguientes servicios que están indicados abajo.

☐ Early Intervention (E.I.)
(Intervención Temprana)

E.I. ayuda a los bebés y niños pequeños en su desarollo. En su área, Servicios de Educación del Distrito del Noroeste (NWRESD) ejecuta el programa de E.I.

E.I. se enfoca en ayudar a niños pequeños a aprender hablilidades. Los servicios de E.I. mejoran el desarollo del lenguaje, social y físico por medio de interveciones basadas en juegos y entrenamiento de los padres.

No hay cobros, los servicios de E.I. son gratuitos para las familias.

¿Qué es lo que pudiera esperar si su hijo/a fuese recomendado/a para E.I.?

- NWRESD le llamaría para hacer una cita con su equipo para evaluar a su hijo.
- Si tiene una llamada perdida, debería de devolver la llamada para hacer una cita para la evaluación.
- Su número de teléfono es 503-338-3368

Los resultado de la evaluación se utilizarán para determinar si el E.I. puede ofrecerle servicios a su hijo.

Información de contacto:
Coordinador de Admisión de NWRESD
503-338-3368 | www.nwresd.org

☐ CaCoon

CaCoon es un programa de enfermeros de salud pública que ayudan a las familias. Los enfermeros de salud pública trabajan con su familia para ayudar con la salud y desarollo de su hijo. Un enfermero de CaCoon le visitará a su casa o donde usted o su hijo prefieran reunirse. No hay cargos, los servicios de CaCoon son gratuitos para las familias.

Información de contacto:
Mandy Mattison
Phone: 503-325-8500
http://www.co.clatsop.or.us/publichealth/page/

Soportes disponibles en CMH

Tenemos la suerte de tener una planificadora de Transición Familiar que puede ayudar a su familia con:

- Recursos adicionales de promoción del desarrollo
- Apoyo social y emocional
- Navegando recursos de la comunidad

Información de contacto:
Misty Bottorff
Planificadora de Transición Familiar
Teléfono: 503-338-7598

Servicios Médicos y Terapéuticos

El proveedor de salud de su hijo le recomienda los siguientes servicios:

- ☐ Patólogo del lenguaje y el habla (Speech Language Pathologist): Especialistas en trastornos del habla, del lenguaje y de la deglución.
- ☐ Audiólogo (Audiologist): Especialistas en problemas auditivos y del equilibrio.
- ☐ Terapista Ocupacional (Occupational Therapist): Especialista en el rendimiento de actividades necesarias para la vida diaria.
- ☐ Terapista Físico (Physical Therapist): Especialista en rango de movimiento y coordinación física.
- ☐ Los pediatras de desarrollo conductual (Developmental-Behavioral Pediatrician): Especialistas en las siguientes àreas del desarrollo del niño: retrasos de aprendizaje, problemas de alimentación, problemas de conducta, retraso en el desarrollo del habla, destrezas motoras o cognitivas.
- ☐ Servicios de Salud de Comportamiento: (Child Behavioral Health Services) Especializados en valoraciones de salud mental, consejería individual/familiar/en grupo, entrenamiento de habilidades e intervención de crisis.
- ☐ Especialista en autismo (Autism Specialist): Especialista en proveer una diagnosis y plan de tratamiento para niños/as con síntomas de autismo.

¿Por qué firmó un formulario de consentimiento?

Cómo proveedor médico de atención primaria de su hijo, queremos estar informados sobre el cuidado que recibe su hijo/a para poder ofrecerle el mejor cuidado posible. El formulario de consentimiento que usted firmó permite que los programas nos compartan la información.

Diferentes programas tienen diferentes requisitos de consentimiento. Para que los diferentes proveedores puedan comunicarse sobre el cuidado de su hijo, probablemente le pedirán que firme más de un permiso.

¿Tiene alguna pregunta?

En CMH - Pediatrics, estamos aquí para ayudar a usted y a su hijo. Si tiene preguntas sobre éste proceso, ¡por favor llámenos! Número de teléfono: 503-325-7337

OPIP Diseñado y distribuido por Oregon Pediatric Improvement Partnership. Version 1.0 4/4/18

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 recommend referring your child to the services checked below:

☐ Early Intervention (EI)

EI helps babies and toddlers with their development. In our area, Northwest Regional Education Service District (NWRESD) runs the regional program. Washington County Service Center administers the evalutions and services.

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 to expect if your child was referred to EI:

- NWRESD 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 503-614-1446.
- The results from their assessment will be used to determine whether or not EI can provide services for your child.

Contact Information:
NWRESD Intake Coordinator
503-614-1446 | www.nwresd.k12.or.us/

☐ Early Head Start/ Head Start

Programs providing free learning and developmental services to eligible children ages birth to 5 from low-income families. Early Head Start and Head Start welcome children with disabilities.

www.ohsa.net or www.ocdc.net/apply

https://caowash.org/programs/early-childhood-development

☐ CaCoon

CaCoon is a public health nursing program serving families. A public health nurse will work with your family to support your child's health and development. A nurse will meet with you in your home, or wherever works best for you and your child.

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

Contact Information:
503-846-4872
https://www.co.washington.or.us/hhs/publichealth/mchft/index.cfm

☐ Early Connections

Single point of entry for Washington County early childhood and community services. For free!

Early Connections can help you:
- Get Insurace through the Oregon Health Plan
- Access Prenatal Care
- In-Home Parenting Support
- Parenting Resources : Childcare, preschool, and parenting classes

Contact Information:
9340 SW Barnes Road, Suite 100
Portland, OR 97225
(503) 726-0879
https://caowash.org/programs/early-childhood-

☐ Help Me Grow

Help Me Grow is an integrated network that connects families with young children to resources in the community to enhance their child's development. For free!

Contact Information:
Help Me Grow Oregon
Swindells Resource Center
at Providence Child Center
833-868-4769 | helpmegrow@providence.org

Services within Virginia Garcia

☐ Behavioral Health Specialist who can help your family with:
- Health and family coaching
- Child development support
- Social and emotional support

Contact: Irma Rosales (English & Spanish): 503-726-0879,
Amy Mild (English): 503 352-8569

☐ Community Health Outreach Worker: Specialist who can help your family navigating community resources Contact Jessica Zamudio: 503-352-8569

☐ Parenting with Initiative: Facilitating communication with children 503-359-8513, Vgarcia2@vgmhc.org

Services Outside Virginia Garcia

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

☐ Occupational Therapist: Specialize in performance activities necessary for daily life

☐ Physical Therapist: Specializes in range of movement and physical coordination

☐ Developmental-Behavioral Pediatrician: Specializes in child development areas including learning delays, feeding problems, behavior concerns, delayed development in speech, motor, or cognitive skills

Any Questions?

At Virginia Garcia Memorial Health Center, we are here to support you and your child. If you have any questions about the process or have not heard from your referral in two weeks, please call your child's medical team. We are here to support you.

Why do 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 sign allows the programs to share information back to us. You will likely be asked to sign more of these to give permission for different providers to communicate about your child's care.

OPIP Designed and distributed by the Oregon Pediatric Improvement Partnership. Version 1.0 - 9/24/18

Early Intervention Tools

The tools presented in this document are resources that providers can use to enhance their communication and coordination with Early Intervention (EI)/Early Childhood Special Education (ECSE).

In 2017, updates were made to the Universal Referral Form based on collective feedback from a pilot project facilitated in partnership between OPIP and Willamette Education Service District (WESD).

The goals of the updates were to:

1. Help facilitate improved communication between EI/ECSE and the referred family
2. Streamline communication between referring providers and EI/ECSE
3. Support enhanced timely communication so that PCPs can assist with outreach and engagement of families
4. Inform follow-up steps for EI ineligible and EI eligible

Completing the referral form to fidelity will enhance communication and coordination between Early Intervention and the referring entity.

Version of Universal Referral Form can be found on the Oregon Department of Education website here: https://www.oregon.gov/ode/studentsandfamily/SpecialEducation/earlyintervention/Pages/default.aspx

List of Examples Provided:

**Please note: The tools and resources presented in this appendix are models that were developed for the context of this pilot project within this specific community. These models may be adapted for other communities, however they should not and are not intended to be a replacement of Medical Advice. For questions or clarification about these tools, please contact OPIP staff at: OPIP@ohsu.edu*

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: _____

Text Acceptable: ☐Yes ☐ No Best Time to Contact: _____

Primary Language: _____ Interpreter Needed: ☐Yes ☐ No

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 ☐M-CHAT ☐Other:_____

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

☐Communication _____ ☐ Fine Motor _____ ☐Personal Social _____

☐ Gross Motor _____ ☐Problem Solving_____ ☐Other: _____

☐ Clinician concerns (including vision and hearing) 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

Referring Provider Name: _____ Referral Contact Person: _____

Office Phone: _____ Office Fax: _____ Address: _____

_____City: _____ State: _____ Zip: _____

Primary Care Provider: _____

If the child is eligible, medical provider will receive a copy of the Service Summary.

EI/ECSE EVALUATION RESULTS TO REFERRING PROVIDER

<u>EI/ESCE Services:</u> 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: _____

☐ Parent Declined Evaluation ☐ Parent Does Not Have Concerns

☐Unable to contact parent ☐ Attempts_____ ☐ EI/ECSE will close referral on _____/_____/_____.

* The EI/ECSE Referral Form may be duplicated and downloaded at this Oregon Department of Education web page.

MEDICAL CONDITION STATEMENT FOR EARLY INTERVENTION ELIGIBILITY (BIRTH TO AGE 3)

Date: _____ Child's Name:_____ Birthdate: _____

The State of Oregon, through the Oregon Department of Education (ODE), provides Early Intervention (EI) services to infants and young children ages birth to three with significant developmental delays. ODE recognizes that disabilities may not be evident in every young child, but without intervention, there is a strong likelihood a child with unrecognized disabilities may become developmentally delayed.

ODE is requesting your assistance in determining eligibility for Oregon EI services for the child named above. Under Oregon law, a physician, physician assistant, or nurse practitioner licensed in by the appropriate State Board can examine a child and make a determination as to whether he or she has a physical or mental condition that is likely to result in a developmental delay.

Please keep in mind that, while many children may benefit from Oregon's EI services, only those in whom significant developmental delays are evident or very likely to develop are eligible.

Thank you for your time and assistance with this matter.

Medical Condition:

_____

_____

_____

_____

Please indicate if this child has a:

☐ Vision Impairment

☐ Hearing Impairment

☐ Orthopedic Impairment

Comments:

_____

_____

_____

Yes	No	This child has a physical or mental condition that is likely to result in a developmental delay.
☐	☐	

_____ _____

Physician/Physician Assistant/Nurse Practitioner Date

Print Name:_____ Phone:_____

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 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

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.

Tillamook Washington Clatsop Columbia NWR ESD
Toll Free 888-990-7500

NORTHWEST REGIONAL EDUCATION SERVICE DISTRICT
Early Intervention/Early Childhood Special Education

Clatsop Service Center	Columbia Service Center	Tillamook Service Center	Washington Service Center
3194 Marine Drive	800 Port Avenue	2515 Third Street	5825 NE Ray Circle
Astoria, OR 97103	St. Helens, OR 97051	Tillamook, OR 97141	Hillsboro, OR 97124
Phone: 503-325-2862	Phone: 503-366-4100	Phone: 503-842-8423	Phone: 503-614-1428
Fax: 503-325-1297	Fax: 503-397-0796	Fax: 503-842-6272	Fax: 503-614-1290

Date: 08/03/18

Service Summary

Child's Name: _____ Birthdate: _____

CHILD was found eligible for Early Intervention services on: 08/03/18.

She was found eligible under the category:
Developmental Delay

As required under Oregon law, she will be evaluated again before 10/03/19 to determine if she is eligible for Early Childhood Special Education Services.

A new Individual Family Service Plan (IFSP) was developed for CHILD on 08/03/18.

IFSP Goal Areas
☐ Cognitive ☐ Social / Emotional ☒ Motor ☒ Adaptive ☐ Communication

Services Provided

Service	How Often	Provider
Service Coordination	12 hours/years	
Physical Therapy	1 hour/year	
Occupational Therapy	1 hour/month	

This form is submitted annually and any time there is a change in services. Please contact Tina Weeks with any questions.

This document represents services determined by the IFSP to provide educational benefit. *Any services identified or recommended by medical providers are separate and not represented on this form.*

Electronically signed by Michelle Rodriguez on 08/03/18.NAME
,NAME EI/ECSE Specialist, NWRESD (503)XXX-XXXX

Tips for Coordinated Care Organizations (CCOs)

Follow-up to Developmental Screening: Building an Asset Map

Developed by the Oregon Pediatric Improvement Partnership (OPIP) with support from the Oregon Health Authority Transformation Center

Webinar (October 10, 2018) available here:
https://www.oregon.gov/oha/HPA/CSI-TC/Pages/Dev-Screen-Tech-Assist.aspx

Purpose and tips included: This tip sheet provides guidance to coordinated care organizations (CCOs) and their early learning partners on how to distill and summarize the findings from stakeholder engagement into a map of community assets addressing delays identified through developmental screening. The tip sheet is based on learnings OPIP has gathered in developing asset maps in nine counties in Oregon.

Components of the Asset Map:

See Appendix A for an example template OPIP has used to visually display the Asset Map.

The Asset Map has **three key parts** that are described on **two pages**.

Part 1: Entities conducting developmental screening and identifying children at-risk for developmental, behavioral and social delays

Within the template are boxes that represent different entities that are conducting developmental screening:

Part 1: Children 0-3 Identified At-Risk via Developmental Screening

1. Primary care practices that are conducting screening
2. Primary care practices that are not currently screening or not screening at high rates
3. Community-based providers who are conducting screening. This often includes:
   a) Home-visiting programs,
   b) Early Head Start, and
   c) Childcare providers.
4. Other developmental screening efforts. This has included screening fairs led by the Early Learning Hub, and parents completing the screening tool directly via https://asqoregon.com/

Part 2: Follow-up pathways for children identified at-risk for developmental, behavioral and/or social delays on the developmental screening tool

Part 2 has two sections:

- Part 2a: Developmental supports and follow-up provided by the entity that screened
- Part 2b: Agencies to which the screening entity can refer at-risk children

Part 2a: Developmental supports provided by entity that screened that addresses identified delays

This section describes the follow-up services to developmental screening that the stakeholders noted they provided internally as a follow-up to screening. These assets and strategies are important to capture, as parents of all children identified at-risk for delays should receive anticipatory guidance and education about how they can address those delays. Additionally, there may be services or follow-up steps that can be provided in the context of the setting in which the child was screened that do not involve a referral to an external agency. The asset map includes boxes for the following:

Part 2a: Developmental Supports Provided by Entity that Screened that Addresses Identified Delays

1. **Developmental promotion:** These materials specifically address the domain(s) of delay identified via the developmental screening tool. This may include providing the Ages and Stages Learning Activities[i] specific to each domain of the child's development, the Center for Disease Control's Act Early Materials[ii], and other anticipatory guidance and parental education materials.
2. **Behavioral health services located within the primary care site:** Some sites conducting developmental screening will have internal behavioral health providers who may be utilized as a follow-up resource for specific children identified at-risk on the developmental screening tools. Before listing this as a resource, it is imperative to confirm that these providers have experience, knowledge, and awareness in seeing children ages 0–3 and can provide follow-up services that address specific delays identified in developmental screening tools.
3. **Monitor and rescreen:** For some children, a standard follow-up process includes setting up a follow-up appointment to rescreen the child to monitor the child's development. The follow-up visit is typically in 2–6 months, and if the delay is still present, this warrants a referral to an external entity.

Part 2b: Agencies to which the screening entity can refer at-risk children

This section describes entities that provide specific follow-up services *OR* evaluate children with delays to determine next steps or eligibility for services. These are the agencies identified in the stakeholder interviews as having a direct service that addresses the five domains of development that are assessed in developmental screening tools. The availability and presence of specific agencies can vary in different communities. It is valuable to:

a) color code the specific service by type of service;
b) use formatting that indicates whether the referral is to a service or if the referral is to an organization that will first evaluate the child to determine eligibility; and
c) track and note where the entity is located.

In past efforts working with CCOs and Early Learning Hubs, OPIP has indicated whether that entity is located within the specific counties served by the CCO and/or Early Learning Hub. Below is a list of the color-coded boxes OPIP has created in the past, knowing that resources may differ by community. Each of these resources was described in the tip sheet on engaging community partners: https://www.oregon.gov/oha/HPA/CSI-TC/Documents/TipSheet-2A-Engaging-Community-Partners.pdf

Part 2b: Agencies to which the Screening Entity can Refer At-Risk Children

1. Developmental Behavioral Pediatrician
2. Occupational Therapy, Physical Therapy, Speech Therapy
3. Early Intervention (*given the focus of this work is on children 0–3, Early Childhood Special Education/ECSE can be included but it is important to note that is for children 3–5*)
4. CaCoon/Babies First Home Visiting Programs
5. Early Head Start
6. Healthy Families
7. Child and Parent Psychotherapy
8. Parent Child Interaction Therapy

The second page of the Asset Map provides a more detailed accounting of availability of each of these direct follow-up resources within each county/community. It is valuable to describe given barriers that exist in families accessing services that are not locally provided. OPIP has consistently found variation in the availability of some services by the specific county in which the child resides.

How do you determine if an entity should be in Part 2 or Part 3?

- An important distinction between Part 2B (grey) and Part 3 (yellow) in the asset map template is that the entities in part 2B are agencies that serve as a **direct** pathway for the specific domains of delays identified on the screening tool, and they can serve children at the ages at which they are identified (often at 9 months, 18 months or between 2 and 3 years old).
- Entities in Part 3 are more general family supports that **may** offer services and/or resources helpful to families of children identified at-risk.
- In some communities, entities were also placed in Part 3 if they were a direct pathway of follow-up for delays, but they had very limited capacity and would not be able to be a direct pathway for the number of children identified.

Part 3: Additional family supports that address child development and promotion

This section is intended to be broad, in that it is meant to document any organization in the community that offers supports or services to families that **may** address delays identified or provide resources and/or supports to families of children at-risk for delays. In short, these organizations and services are not a direct pathway to address potential delays, but rather they have the potential to serve as a supplemental support or stop gap option for families of children experiencing delays. Often these supports and services include options that may be broad in scope and focus or are inconsistent in what service or support is offered. This section may also include entities that would conceptually be considered a direct pathway, but due to capacity restrictions are not able to consistently serve children 0–3 identified at-risk for delays. Examples of entities mapped in part 3 in previous communities include:

Part 3: Additional Family Supports that Address Child Development and Promotion

1. **Oregon Parenting Education Collaborative (OPEC) Parenting Hubs** and other organizations that provide parenting education focused on early childhood. For some children with moderate delays, the parent can benefit from classes that teach specific ways they can engage with their child and promote their child's development.
2. **Department of Human Services programs, including Self Sufficiency and Child Welfare**: These programs may be serving the child already and this context in relation to the child's development may be valuable. Conversely, the family may have some needs for supports and resources to address social determinants of health related to the child's home environment and nutritional health that may be impacting the child's development.
3. **Childcare Resource and Referral**: For some children it may be valuable to explore high quality childcare environments that may be supportive and helpful in supporting the child's development and addressing delays identified.
4. **Oregon Family Support Network (http://www.ofsn.org/)**
5. Interdisciplinary teams such as **Care Coordination Networks (CCN)** and **Service Integration Teams (SIT)**
6. **Relief Nurseries:** Some families and children with delays may benefit globally from Relief Nurseries. These programs provide supports to families for positive parenting experiences and building resiliency in young children.
7. **Head Start:** While children who are the focus of this work are often screened at 9, 18 and 24/30 months and therefore too young to be eligible for Head Start, it may be valuable to note the importance of this resource for children screened at the 30 month visit. Secondly, if the child screened has siblings who are in Head Start, there may be ways the Head Start staff can provide supports and coaching on developmental promotion as part of their comprehensive home visits.
8. **Libraries** with children's story hours and other activities for children under three can be helpful in promoting development and targeting activities that boost specific areas of development.
9. **Other Family Support Organizations:** These organizations provide supports to families raising children with special needs, connect these families with resources, and support families to network with other families with children with special needs.

10. **Organizations supporting women with young children who are experiencing or have experienced domestic abuse:** For some children, their parent may be experiencing other events that may be impacting the child's development, such as domestic abuse. Therefore, it may be important to provide supports to address these important events that can have an adverse impact on the child's development.
11. **211:** A platform meant to provide a central hub of information and connection to resources to help people identify, navigate and connect with the local resources they need.
12. **ASQ Online:** An online version of the Ages and Stages Questionnaires (ASQ) that allows parents to complete the ASQ, track their child's development, and receive customized feedback and tips based on the score. In specific communities, an identified provider receives the completed scores and reaches out to families of children identified at risk (if contact information and permission to contact was provided by the parent).
13. **Others**: Every community is different and various resources and supports exist. It is expected that each community will identify resources beyond the ones listed above.

The completed Asset Map:

OPIP has found that this template provides a useful way to document resources and assets in a community. Once completed, it illustrates pathways and secondary pathways from screening to services in a way that makes the information easy to follow and digest at a community level. While more complex than a simple list or accounting of resources in a given community, it requires the documentation of context critical to differentiating true pathways from general supports that may or may not meet a specific need. It has been our experience that this level of detail is critical to both identifying opportunities for improvement, and to identifying gaps in services and capacity within communities.

[i] https://products.brookespublishing.com/ASQ-3-Learning-Activities-P624.aspx
[ii] https://www.cdc.gov/ncbddd/actearly/index.html

PATHWAYS FOR DEVELOPMENTAL SCREENING OF CHILDREN 0-3

KEY STEPS

Part 1: Children 0-3 Identified At-Risk via Developmental Screening

Primary Practices Conducting Screening at Rec. Periodicity (Based on CCO Claims) :	Primary Practices Who Appear Not to be Screening to Recommendation (Based on CCO Claims):	Community-Based Providers:	Other:
1) 2) 3) 4) 5) 6) 7)	1) 2) 3) 4) 5) 6) 7)	1) 2) 3) 4)	

Part 2a: Developmental Supports Provided by Entity that Screened that Addresses Identified Delays

Developmental Promotion Activities	Internal Behavioral Health Within Primary Care Sites	Follow-Up Visit to Rescreen the Child	Other

Part 2b: Agencies to which the Screening Entity Can Refer At-Risk Children

Devel. Behavioral Pediatrician*	OT/PT/ Speech	EI/ECSE (all)	CaCoon/ Babies First!	Early Head Start	Child/Parent Psychotherapy	PCIT	Other Identified
1) OHSU-CDRC 2) Providence (all)							

Part 3: Additional Family Supports that Address Child Development and Promotion

LEGEND

COLOR CODING BY SERVICE TYPE

Medical & Therapy Services:

- **Developmental & Behavioral Pediatrician: Referral is for an Evaluation**
- **Private OT/PT & Speech Therapy**

Early Intervention: Referral is for an Evaluation

CaCoon/Babies First!

Early Head Start

Infant/Early Childhood Mental Health, including:

- **Internal behavioral health within primary care**
- **Mental Health – Referral is for an assessment:**
  - **-- Child/Parent Psychotherapy**
  - **-- Parent and Child Interaction Therapy**

Referral to evaluation, not necessarily services

*Located outside the community

Part 2B – Expanded View:
Referral to Agency to Address Delays Identified

	Devel. Behavioral Pediatrician	OT/PT/Speech	Early Intervention	CaCoon/ Babies First/ Maternity Case Management	Early Head Start	Healthy Families	Child/Parent Psychotherapy	Parent & Child Interaction Therapy
County A		X	X	X	X	X		X
County B			X	X	X	X		
County C			X	X	X	X		
County D			X		X			
Outside Community	OHSU CDRC Providence							

EXAMPLE ASSET MAP:

PATHWAY FOR DEVELOPMENTAL SCREENING & REFERRAL FOR CHILDREN 0-3 IDENTIFIED AT-RISK IN COLUMBIA COUNTY

KEY STEPS

Part 1: Children 0-3 Identified At-Risk via Developmental Screening	**Primary Practices Conducting Screening at Recommended Periodicity:** 1) OHSU Scappoose (Pilot Site) 2) Legacy St. Helens	**Primary Practices Who Appear Not to be Screening to Recommendation:** 1) Peacehealth Longview 2) CHC of Clatskanie	**Community-Based Providers:** 1) Home Visiting Programs 2) Public Health	**Screening Fairs** (Children 2-6)	
Part 2a: Developmental Supports to Address Delays Identified By Entity Who Screened	**Developmental Promotion Activities**	**Potential Internal Behavioral Health**			
Part 2b: Referral to Agency to Address Delays Identified	**In Columbia County**	**EI** NW Regional ESD Columbia EI/ECSE	**Public Health Home Visiting**	**Child/Parent Psychotherapy/ PCIT** Columbia County Mental Health (CCMH)	
	Outside Columbia County	**Developmental Behavioral Pediatrician** 1) OHSU-CDRC 2) Providence	**OT/PT/ Speech Therapy**		
Part 3: Additional Family Supports that Address Child Development and Promotion	**On Community Action Team (CAT) Contact Us Platform** http://nworheadstart.org/index.html	**NW Parenting**	**NW Regional Childcare Resources & Referral at 211**	**Maternity Case Management**	**Healthy Families**
	St. Helens High School Child Development and Teen Parent Program	**WIC**	**Head Start**		
	Other Local Agencies that Provide Supports for Specific Families that Referrals and/or Communication About Child's Development May be Helpful	**Child Welfare, DHS**	**Options, Inc.** (Behavioral Health and family preservation services)	**Amani Center** (when abuse is a factor)	

NOTE: Childcare sites not included in map as ages served puts them out of scope of the project. Numerous childcare sites are screening in this community.