FIRST 5 SONOMA COUNTY AND REDWOOD COMMUNITY HEALTH COALITION

Developmental Screening and Referral Project: 2015 Baseline Report

Submitted by:
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Introduction

The goal of this partnership between First 5 Sonoma County and Redwood Community Health Coalition (RCHC) is to support all children served by our local health centers in developing to their full potential through effective developmental screening and appropriate referral to early intervention services. Over the three year project, Redwood Community Health Coalition is working in collaboration with local community health centers, First 5 Sonoma County, Public Health, local early intervention services and other partners to develop and implement a sustainable system to support developmental screening and referral for children 0-5 years of age served by health centers in Sonoma County. The First 5 funding supports this collaboration, as well as health center pilot projects to develop innovative models for improving developmental screenings and referrals. Collaboration between local partners and the health center pilots is focused on achieving improvements in developmental surveillance and screening in community health centers in Sonoma County, improving the referral process and communication between health centers and early development community services and connecting families to much needed community resources.

RCHC community health centers serve as the health homes for 62% of the Medi-Cal population and the majority of the uninsured in RCHC's 4-county region of Napa, Marin, Sonoma and Yolo counties. We serve over 242,000 patients, including 130,000 Medi-Cal patients and 71,000 uninsured individuals. Fifty-two percent of patients are Latino, 36% are best served in a language other than English, 56% of patients have incomes under 100% FPL and only 5% of patients have incomes over the 200% FPL. According to the 2014 American Community Survey, approximately 32,200 children under 6 years of age lived in Sonoma County[1]. In 2014, community health centers in Sonoma County served about 14,000 children 0 through 5 years of age which represents approximately 43% of Sonoma County children under 6 years of age.

RCHC is committed to improving access to and the quality of care provided for underserved and uninsured people in our communities. Low-income children are at increased risk of developmental challenges, in part due to greater exposure to poverty, family violence, parental substance abuse or other early trauma[2]. In spite of the importance of screening for developmental disabilities and disabling behavioral problems, less than half of children with these issues are identified before the age of five[3]. Children with Medi-Cal have twice the prevalence of developmental disabilities as commercially insured kids. Further, children from families below the federal poverty level have higher rates of developmental disabilities[4]. Latino children are diagnosed with autism an average two and a half years later than White Non-Latino children. In Sonoma County health centers, approximately 94% of patients less than 6 years

[1] Source: U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates

[2] Institute of Medicine. From Neurons to Neighborhoods: The Science of Early Childhood Development. Washington, DC: The National Academies Press, 2000.

[3] Centers for Disease Control and Prevention, "Child Development: Using Developmental Screening To Improve Children's Health," Centers for Disease Control and Prevention. http://www.cdc.gov/ncbddd/child/improve.htm (accessed July 22, 2008).

[4] Shonkoff and Phillips, op. cit.

of age are insured through Medi-Cal and 82% are from households with incomes below the federal poverty level. Identification of developmental and behavioral issues and referral to early intervention services in the first years of life provides the best opportunity for children to reach their health potential.

This report summarizes data and information collected and analyzed by RCHC and is a baseline assessment of developmental screening and referral practices in local community health centers. This baseline assessment includes data on the target health center population and identifies existing health center developmental surveillance, screening and referral practices and challenges. RCHC reviewed current developmental surveillance and screening recommendations of the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the Affordable Care Act (ACA), Medi-Cal, the Child Health and Disability Prevention Program (CHDP) and the United States Preventive Services Task Force (USPSTF). Best practices for improving developmental screening and referrals were reviewed from other health centers, as well as non-health center settings. Information was also gathered on the principal community resources for diagnostic developmental evaluation and early intervention services. RCHC identified baseline billing practices and funding challenges. The baseline assessment helps to inform a logic model and basic SWOT analysis for the Developmental Screening and Referral Project evaluation.

Section I. Developmental Surveillance and Screening Recommendations

Recommendations and Requirements

A. Surveillance and Screening. Surveillance is defined as the process of recognizing children who may be at risk for developmental delay and Screening is defined as the use of standardized tools to identify and refine that recognized risk. See Appendix A for First 5 and Children Now Developmental Screenings Infographic and Appendix B for periodicity and timing recommendations for well child developmental surveillance and screenings.

B. The American Academy of Pediatrics (AAP) recommends routine surveillance for developmental delay at every well child visit. Surveillance includes history, physical evaluation, parental concerns, provider observation, and AAP's Bright Futures well visit questionnaires. AAP recommends routine screening at 9-, 18-, and 24-30 months using the Ages and Stages Questionnaire (ASQ-3), M-CHAT-R for autism at 18 and/or 24 months. Screenings should also be performed any time a parent or clinician has a concern about possible developmental delay. Rationale for this periodicity is that at 9 months, motor and early communication skills are more established, eye contact and response to speech and hearing can be observed. At 18 months, communication and language delays become more evident and social skills are developing. At 24-30 months, most motor, communication and cognitive delays can be identified. See Appendix C for AAP Developmental Surveillance and Screening Algorithm.

C. USPSTF. The U.S. Preventive Services Task Force (USPSTF) recommendations do not address the full spectrum of developmental screening. USPSTF has, however, determined is that there is insufficient evidence to assess the potential benefits and harms of screening for speech and language delay and disorders in asymptomatic

children aged five years and younger whose parents or clinicians do not have specific concerns regarding their speech, language or development.

D. The American Academy of Family Physicians (AAFP). The American Academy of Family Physicians issued a policy statement in 2015 in alignment with USPSTF stating that there is insufficient evidence to recommend routing screening for speech and language delay and disorders in asymptomatic children aged five years and younger whose parents or clinicians do not have specific concerns regarding their speech, language or development. See Appendix D for AAFP Policy Statement.

Well Child Visits and Screening and Surveillance

A. Medi-Cal recommends health centers to use the DHCS Staying Healthy Assessment for surveillance. The Staying Healthy Assessment only has one question regarding child development asking parents if they have any other questions or concerns about their baby's health, development or behavior.

B. CHDP will reimburse routine developmental screening (fee-for-service Medi-Cal only) by providers at 9, 18, and 24 or 30 months. Although CHDP does not reimburse providers for autism screening, screening at 18 and 24 months (following the AAP guidelines) is recommended. Earlier screening is recommended if child has a sibling with autism.

C. Section 2713 of the Affordable Care Act (ACA) requires coverage of specific preventive care benefits including evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). The ACA requires that preventive services in the Bright Futures Guidelines approved by the American Academy of Pediatrics must be provided without a share of cost to Medicaid and commercial patients. The Bright Futures guidelines include developmental screening with well visit questionnaires, as well as screening at 9-, 18-, and 24-30 months, using a standardized tool such as the Ages and Stages Questionnaire (ASQ-3) and M-CHAT-R for autism at 18 and/or 24 months.

Section II. Health Center Developmental Screening Target Population

A. Target Population Demographics by health center for measurement period of March 1, 2014 to February 28, 2015 (See Appendix E for tables). RCHC has access to electronic health record (EHR) data for four of our member health centers serving children 0-5 years of age in Sonoma County. This subset of RCHC member health centers serves the majority of children 0-5 in community health centers and is the sample used for the baseline data collection.

   a. Patients by Age. Santa Rosa Community Health Centers (SRCHC) served 6,521 unduplicated patients ages 0-5 in the measurement period, West County Health Centers (WCHC) served 924 children 0-5 years of age, Alexander Valley Healthcare (AVH) served 280 children 0-5 and Petaluma Health Center served 2,187 children 0-5. This subset of RCHC member health centers served a total of 9,912 unduplicated patients 0-5 years of age in the measurement period.

b. Patients by Insurance Class. Of the 6,521 children 0-5 years of age served by SRCHC, 299 or 4.6% were uninsured, 6,112 or 93.7% had Medi-Cal and 110 or 1.7% had private insurance. WCHC served 924 children 0-5 years of age with 134 or 14.5% uninsured, 650 or 70.3% had Medi-Cal and 140 or 15.2% had private insurance. AVH served 280 children 0-5 years of age with 11 or 3.9% uninsured, 250 or 89.3% had Medi-Cal, and 19 or 6.8% had private insurance. PHC served 2,187 children 0-5 years of age with 130 or 5.9% uninsured, 1,910 or 87.3% had Medi-Cal, and 147 or 6.7% had private insurance.

c. Patients by Poverty Level. Of the 9,912 children 0-5 years of age served by this subset of RCHC health centers, 6,088 or 82.1% of patients were living under 100% of the federal poverty level (FPL), 1,177 or 15.9% lived between 100-199% FPL, and 153 or 2.1% lived at 200% FPL and above. The FPL was unknown for 2,494 of the children 0-5 years of age.

B. Comparison to total Sonoma County Population. RCHC member health centers serve 27% or 132,848 of the total Sonoma County residential population and approximately 43% of children under 6 years of age.

C. Electronic Health Record (EHR) information on well-child visits was pulled for a subset of RCHC member health centers using eClinicalWorks (eCW). The majority of RCHC health centers use eCW (Alexander Valley Healthcare, Petaluma Health Center, Santa Rosa Community Health Centers and West County Health Centers), however Alliance Medical Center uses EPIC, Sonoma County Indian Health Project uses a Resource and Patient Management System (RPMS) and Sonoma Valley Community Health Center uses NextGen. We anticipated that RCHC would be able to extract accurate data from the EHRs regarding well child visits to inform the baseline assessment, but that was not the case. We pulled patients by number of visits to a primary care medical provider in the measurement period, however we cannot separate out well child visits from sick visits and other visit types. To maximize access, health centers utilize maximum flexibility in determining which visit to code for. This can lead to underrepresentation of preventive visits and is reflective of more acute conditions for visits. This project is an opportunity to improve the coding in health centers so accurate EHR information will be available in the future. Additionally, referral destinations are entered in text form with referral documentation being scanned into the patient's record which makes it challenging to collect and summarize. RCHC did sift through dozens of referral names to try to find relevant referrals for further developmental assessment, but the variations create difficulties for data collection and analysis. Similar to the well-child visit information, RCHC and member health centers are working towards improving documentation of referrals for accurate data tracking.

D. QIP. Partnership Health Plan of California's pay for performance program, the Quality Improvement Program (QIP) is designed in collaboration with PHC providers and offers substantial financial incentives to providers who serve Medi-Cal members. One of the QIP areas of focus is Well Child Visits for children 3-6 years of age. The measure tracks the percentage of continuously enrolled Medi-Cal members 3-6 years of age who

received one or more well child visits with a PCP during the measurement year. Health centers in Sonoma County performed well-child visits in this age group at varying rates with a range of between 55.8% and 86.2% of children. Working to improve this QIP measure is an area identified as important to the health centers finances and aligns well with this project to improve developmental surveillance, screenings and referrals. RCHC and member health centers are advocating for an additional Well Child Visit QIP measure for children in the 0-3 age range.

Well child and developmental screening visits are done predominantly by family medicine physicians, nurse practitioners and physician assistants. Pediatricians are available at most, but not all Sonoma County Health Centers. There are 70.59 FTE family physicians at the 7 Sonoma County FQHCs versus 7.28 FTE pediatricians (see Appendix F for table).

Summary: RCHC health centers serve a low-income and underserved population at higher risk for developmental delays and concerns due to their socioeconomic status. This highlights the urgent need to improve developmental screenings and referrals and ensure early identification and intervention when needed. RCHC's ability to collect data from health center EHRs is limited and data available is challenging to analyze due to how data is entered as unstructured. This project presents opportunities to improve coding in health centers which will allow us to better track and monitor data related to developmental screenings and referrals. Programs like Partnership Health Plans' QIP incentivize improvements and can be catalysts for positive change. While most health centers employ relatively small pediatricians, the majority of children are being served by family physicians and nurse practitioners. We recognize that provider and staff education about the importance of developmental screenings and referrals will need to include family physicians, pediatricians and all care team members to reinforce system improvements.

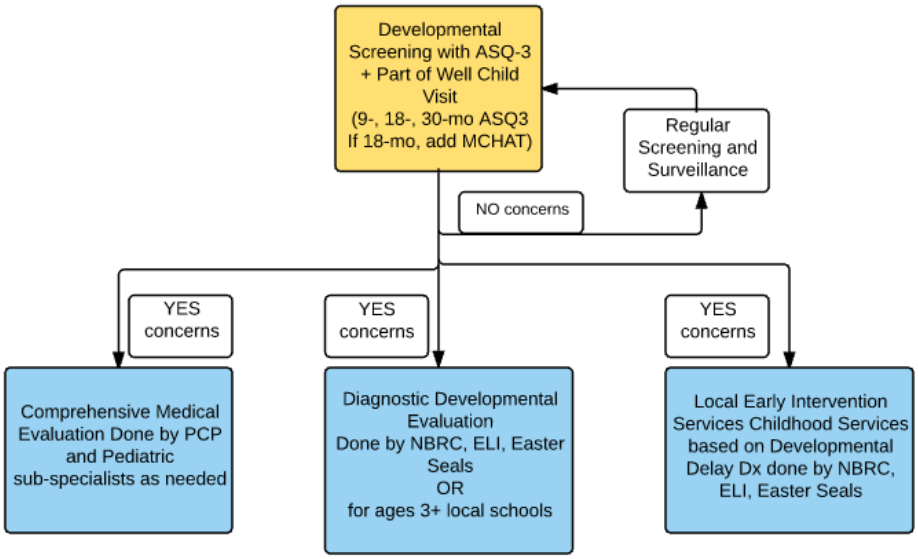
Section III. Health Center Baseline Developmental Screening Practices

A. Methods. The methods used to assess baseline practices in health centers included surveys (see appendix G for survey instrument) and site visit interviews with Medical Directors and child health leads to better understand current practices for developmental screenings and referrals in community health centers. Drs. Mary Maddux-González and Mark Sloan conducted site visit interviews with all seven Sonoma County Health Centers in March 2015 to review current health center practices for developmental surveillance, screenings and referrals. Additional site visit interviews were conducted in August 2015 to review perceived barriers and challenges with the current process. Interviews were conducted with the following health centers:
   - Alexander Valley Healthcare (AVH)
   - Alliance Medical Center (AMC)
   - Petaluma Health Centers (PHC)

- Santa Rosa Community Health Centers (SRCHC)
- Sonoma Valley Community Health Centers (SVCHC)
- Sonoma County Indian Health Project (SCIHP)
- West County Health Centers (WCHC)

B. Results. Findings include that Sonoma County health centers are the health homes for the population of children in Sonoma County at highest risk of developmental delay and late diagnosis of autism. This means developmental screening and early interventions are of upmost importance for the children served by health centers and need to be improved. Many barriers were identified by the health centers related to improving developmental surveillance, screening, and referrals for further assessment. The ACA expansion presents challenges to increasing well child visits due to the influx of new patients being served by health centers. CHDP periodicity and related payment are seen as challenge to funding the recommended number and timing of developmental and autism screenings. There is a significant disconnect between health centers and community developmental services in perception of available resources and level of bidirectional communication. The referral process is complex and confusing for families and providers to navigate. The health centers recognize the need for a routine, streamlined referral process. Although there are individual providers using evidence-based screening tools for developmental surveillance and screening, routine standardized developmental screening with a validated tool is not occurring across all providers in all health centers.

C. Referral Process. Currently all Sonoma County community health centers utilize their specialty referral coordinators to manage the referrals for further developmental assessment. RCHC has identified perceived barriers to the referral process that we are working to address such as the perception that there are not adequate services in the community for developmental assessments and the lack of bidirectional communication. RCHC health centers have successfully implemented a direct health information exchange platform call Provider to Provider (P2P) where specialists and providers can exchange secure e-mails and patient record information that in some cases are embedded into the EHRs. This platform is starting to be used between health centers and the referral agencies for further evaluation and intervention services which replaces the traditional faxing of referrals. The Advisory Group is continuing to explore how this tool can be spread to improve communication for care coordination and tracking of referrals and facilitate a more efficient referral process. Below is a basic flowchart of the referral process.



Section IV. Resources for Diagnostic Developmental Evaluation

A. North Bay Regional Center: http://nbrc.net/about-us/who-we-serve/
North Bay Regional Center (NBRC) provides services and support to individuals diagnosed with a developmental disability including Early Start for children ages birth to 3 years focusing on early intervention services.

B. Early Learning Institute: http://earlylearninginstitute.com/
Early Learning Institute (ELI) provides and promotes developmental services, education and support to young children, their families and their community. ELI's Watch Me Grow program provides social and developmental screenings to children in Sonoma County from birth through age 5 and not yet in Kindergarten, who would otherwise not be screened. Watch Me Grow staff connects families to services in the community and will make referrals to mental health or developmental services as needed to assist the family.

C. Easter Seals: http://www.easterseals.com/connect-locally/service-center-locations/bay-area-santa-rosa.html
Easter Seals Bay Area, Santa Rosa provides early intervention services to help young children with disabilities achieve their goals in cognitive, social/emotional, communicative, adaptive and physical development. Services may include occupational therapy and most early intervention services take place in the home or, in the case of working parents, at child care facilities in the local community.

D. Sonoma County Office of Education (SCOE):
http://www.scoe.org/pub/htdocs/specialed.html
The SCOE's Special Education department offers specialized instructional services for children ages 3 to 22 who have physical, emotional, cognitive, or instructional

disabilities. The department operates a countywide early childhood education program, provides daily classroom instruction for the county's most severely disabled school-age students.

E. Sonoma County Special Education Local Plan Area (SELPA): http://www.sonomaselpa.org/
The SELPA is a state-mandated association that oversees and facilitates educational services for students with disabilities in Sonoma County. The Early Start Infant Preschool Program (See Appendix H) is a free, federally funded program that provides assessment and intervention services to children from birth through two years of age with vision, hearing, or orthopedic impairments. A complete assessment and intake by a multi-disciplinary team begins the process of determining eligibility for services. SELPA offers additional programs for children between 2 and 5 years of age depending on specific needs of the child.

D. Additional Early Intervention Community Resources. There are many services and programs in Sonoma County promoting developmental education for children and families. Representatives from several of these community service providers are participating in the Advisory Group to ensure health centers are aware of the available services. The partners include Child Parent Institute (CPI) and Public Health Nursing. RCHC continues to identify additional community stakeholders and when services provided by community-based organizations are relevant, an invitation to participate in the Advisory Group is extended.

Summary Since August 2014, RCHC has been convening an advisory group to help guide the efforts to develop an effective system to support developmental and social emotional screening and referral to early intervention services for children 0-5 years of age who receive health care services at community health centers. Members of the Advisory Group include representatives from RCHC member health centers, First 5 Sonoma County, North Bay Regional Center, Early Learning Institute, Sonoma County Office of Education, Sonoma County Special Education Local Plan Area (SELPA), the Child Parent Institute, Public Health Nursing and community pediatricians. Easter Seals and Child Parent Institute were added to the Advisory Group after the first year, once we identified that their participation was important due to the early intervention services they provide in the community. The community Advisory Group has been valuable in improving our assessments, pilots and program as we strive to develop a financially sustainable model that impacts the children and families of our community in positive ways. See Appendix I for Advisory Group Roster. As part of the sharing of best practices in the Advisory group, Marin Community Health Centers presented their successful model for developmental screenings and referrals which utilizes a centralized screening and referral process for all clinic sites (See Appendix I for PPT presentation).

Section VI: Developmental Screening Funding and Billing in Health Centers

RCHC has met with the Chief Financial Officer and the Chief Operations Officer from the largest RCHC health center, Santa Rosa Community Health Centers, as well as with representatives of

Partnership Health Plan, to identify opportunities for developing a more sustainable model for developmental screening and referral. The incentive of an additional Medi-Cal payment for using a developmental screening tool, does not result in improved reimbursement for Federally Qualified Health Centers (FQHC) due to the constraints of the federal Prospective Payment System (PPS) that governs FQHC payment. Two other strategies were identified to increase revenue associated with developmental screening. First, the addition of more pediatric preventive medicine visits for to the CHDP and Partnership reimbursable visit schedule would provide the opportunity for additional reimbursement for developmental screening at AAP recommended intervals. An additional opportunity to increase reimbursement to health centers for developmental screening would be to add a developmental screening measure to Partnership HealthPlan's Quality Improvement Program (QIP), their pay-for-performance program. The FQHC Prospective Payment System (PPS) allows health centers to receive quality payments, such as the QIP payments, in addition to their PPS payments. Also, the Partnership QIP program is an important revenue source for health centers and impacts the prioritization of their clinical improvement efforts. RCHC will bring the issue forward of a new/modified QIP measure that would incentivize well child visits and/or developmental screening for children 0-3 years of age.

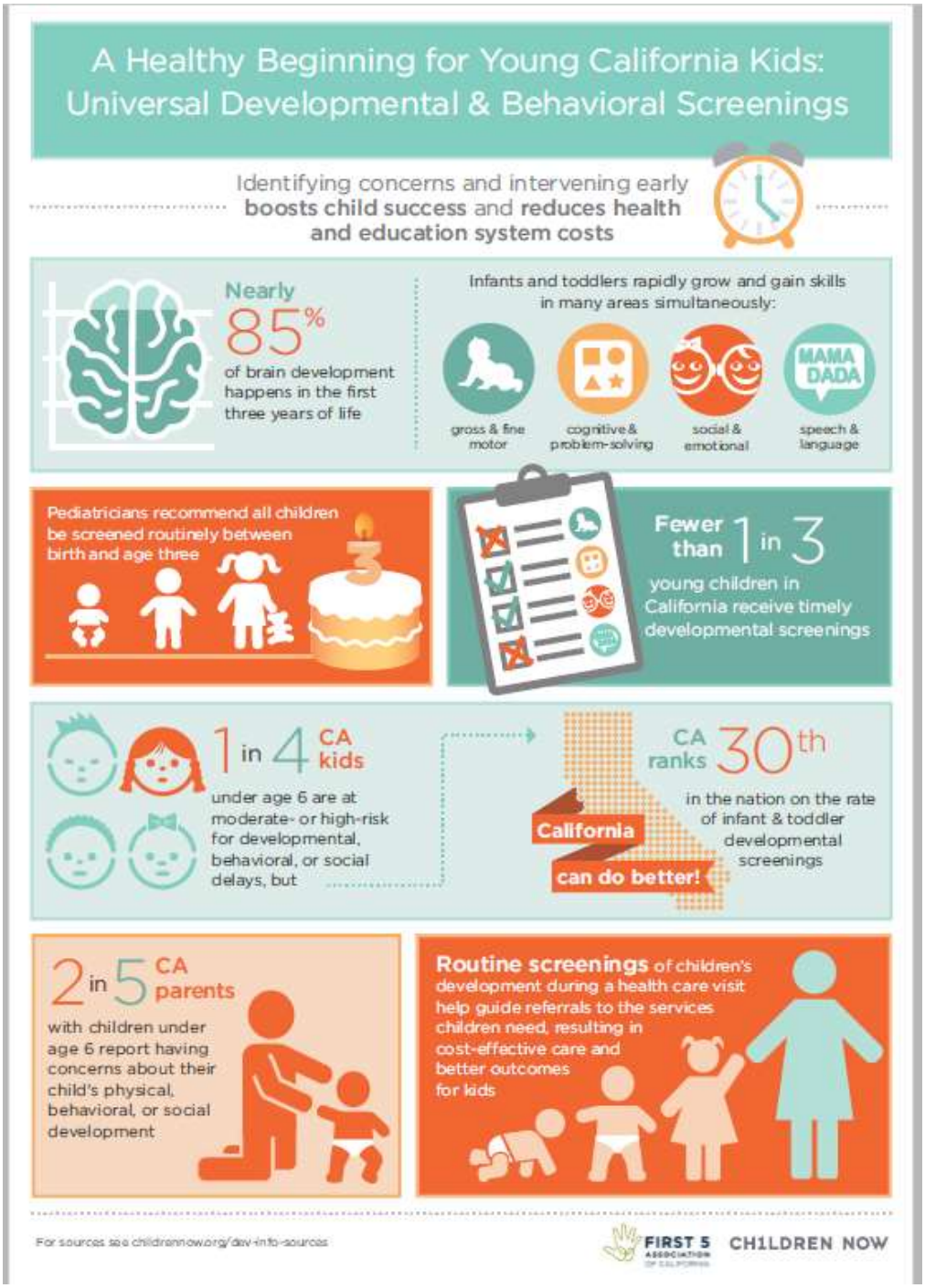
Section VII: SWOT Analysis and Evaluation

A. SWOT Analysis of Baseline Screening and Referral Practices

Strengths	Weaknesses	Opportunities	Threats
Strong commitment of health center providers, staff and community partners to improve the early identification of developmental delays in children 0-5 years of age	Lack of ability to track data useful for this project in the health center EHRs. The rate of screenings and referrals currently occurring in health centers is not what we expect based on statewide prevalence data and there is room for improvement. Referral process is complex and confusing to navigate.	RCHC's Provider to Provider (P2P) direct health information exchange to streamline the referral process and implement electronic referrals and improved data sharing with community partners. This process is underway with North Bay Regional Center and Early Learning Institute now P2P enabled for referrals. Health Center Improvement Pilots.	The possibility that community development services will have capacity impacts due to increased screenings and referrals in health centers, however our partners have stated that increase in demand will trigger increase in funding to meet demand.

B. Evaluation Plan (See Appendix J for Logic Model)

Appendix A: First 5 California and Children Now Developmental Screenings Infographic

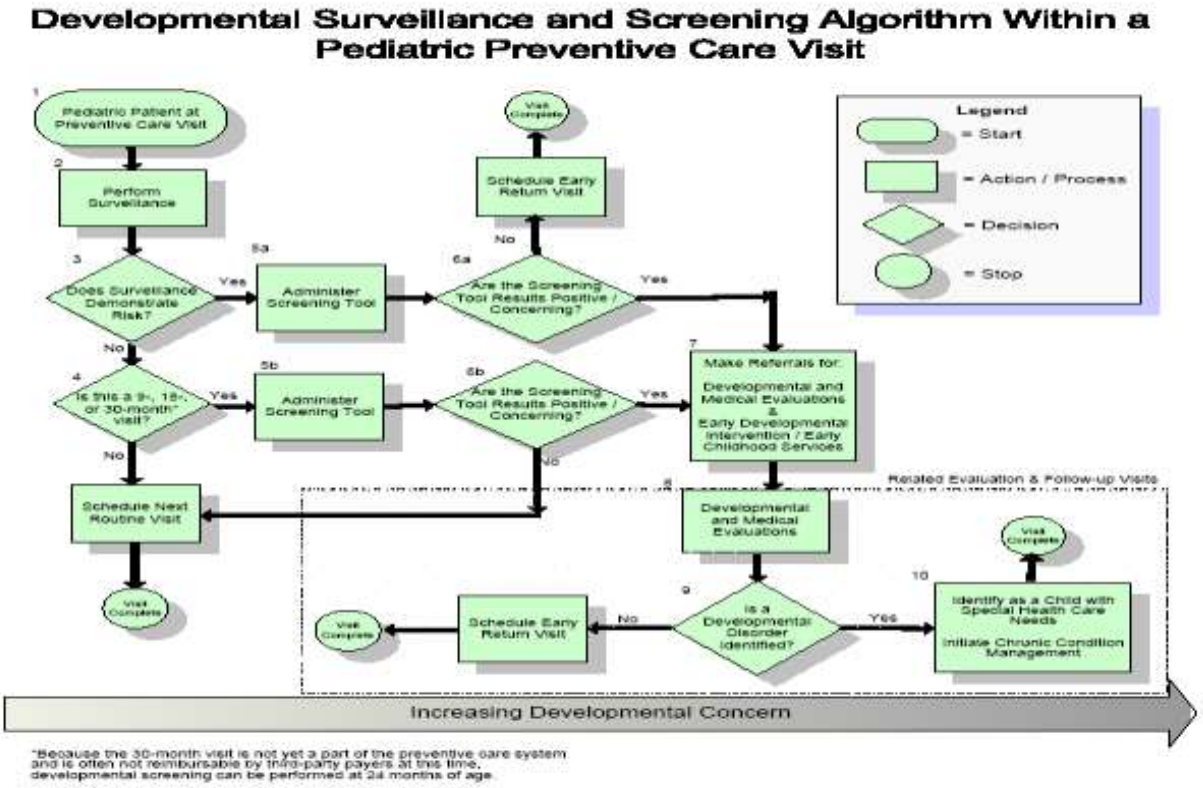


Appendix B: Periodicity and Timing for Well Child Developmental Screenings

Organization	Recommendation	Website
The American Academy of Pediatrics (AAP)	Recommends general screening at 9, 18 and 30 months. Autism screening is recommended at 18 and 24 months.	http://pediatrics.aappublications.org/content/118/1/405.full
Child Health and Disability Prevention program (CHDP)	Will reimburse routine developmental screening (fee-for-service Medi-Cal only) by providers at 9, 18, and 24 or 30 months. Although CHDP does not reimburse providers for autism screening, screening at 18 and 24 months (following the AAP guidelines) is recommended. Earlier screening is recommended if child has a sibling with autism.	http://www.dhcs.ca.gov/services/chdp/Documents/Letters/chdppin0914.pdf
The American Academy of Family Physicians (AAFP)	Appears to follow AAP guidelines, although their statement policy is a bit vague	http://www.aafp.org/afp/2011/0901/p544.html#afp20110901p544-t3
The Center for Disease Control and Prevention (CDC)	Agree with AAP guidelines	http://www.cdc.gov/ncbddd/autism/hcp-recommendations.html

Kaiser developmental screening program	• Bright Futures III (BF-III) parent questionnaire is distributed at each well child visit (4 mos-5 years)• Follow-up with Ages and Stages Questionnaire form (ASQ-3) for children with any failed developmental milestone on BF-III questionnaire. • ASQ-3 formed is then mailed to Kaiser's Vacaville Early Developmental Screening Program (EDSP)• Within 3 weeks of receipt of ASQ-3, LCSW associated with EDSP generates referrals as needed, both in- and outside of Kaiser system.• CHAT screen is performed at 18 month visit; MCHAT-R is to clarify any concerns noted on CHAT.• Both M-CHAT and ASQ are performed and forwarded to EDSP for children with any concerns for delay on BF-IIIIn addition (and regardless of ASQ-3 results), referrals to child development resources are made for:• behavioral or developmental concern by parent or provider expressed by message or at a well visit• any high risk factor for delay in birth, family, or medical historyIn summary, Kaiser does not do universal developmental screening with the ASQ-3 and MCHAT-R at any age, as this would add about 60 questions to well child visits and is thus not reasonable for low-risk children. Rather, this more extensive screening is performed at any age, and only on children who miss at least one developmental milestone on the BF-III.There is a plan for universal screening with another tool in the future, and I will follow up on that as the information becomes available.

Appendix C: American Academy of Pediatrics (AAP) Developmental Surveillance and Screening Algorithm



Appendix D: American Academy of Family Physicians (AAFP) Screening for Developmental Delay Policy Statement

Speech and Language Delay and Disorders in Children Age 5 and Younger

GRADE: I RECOMMENDATION

The AAFP concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for speech and language delay and disorders in children aged 5 years or younger. (2015).

Grade Definition(www.uspreventiveservicestaskforce.org)

Clinical Considerations(www.uspreventiveservicestaskforce.org)

Appendix E: Patient Profile Demographics

Patient Profile: Demographics

Unduplicated patients seen by a primary care medical provider from 3/1/2014 to 2/28/2015

Patients by age (number)

Age at End of February	Santa Rosa Community Health Centers	West County Health Centers	Alexander Valley Healthcare	Petaluma Health Center	All patients
Under 1 year	1,172	176	42	391	1,781
1	1,167	175	43	388	1,773
2	1,123	149	51	368	1,691
3	1,024	139	47	328	1,538
4	1,064	145	45	357	1,611
5	971	140	52	355	1,518
Grand Total	6,521	924	280	2,187	9,912

Patients by insurance class (number)

Insurance class	Santa Rosa Community Health Centers	West County Health Centers	Alexander Valley Healthcare	Petaluma Health Center	All patients
Uninsured	299	134	11	130	574
Medi-Cal and other public	6,112	650	250	1,910	8,922
Private	110	140	19	147	416
Grand Total	6,521	924	280	2,187	9,912

Patients by insurance class (percentage)

Insurance class	Santa Rosa Community Health Centers	West County Health Centers	Alexander Valley Healthcare	Petaluma Health Center	All patients
Uninsured	4.6%	14.5%	3.9%	5.9%	5.8%
Medi-Cal and other public	93.7%	70.3%	89.3%	87.3%	90.0%
Private	1.7%	15.2%	6.8%	6.7%	4.2%

Patients by poverty level (number)

Insurance class	Santa Rosa Community Health Centers	West County Health Centers	Alexander Valley Healthcare	Petaluma Health Center	All patients
Unknown	68	779	280	1,367	2,494
Under 100%	5,589	73	0	426	6,088
100-199%	772	49	0	356	1,177
200% and over	92	23	0	38	153
	6,521	924	280	2,187	9,912

Patients by poverty level (percentage of known)

Insurance class	Santa Rosa Community Health Centers	West County Health Centers	Alexander Valley Healthcare	Petaluma Health Center	All patients
Under 100%	86.6%	50.3%	0.0%	52.0%	82.1%
100-199%	12.0%	33.8%	0.0%	43.4%	15.9%
200% and over	1.4%	15.9%	0.0%	4.6%	2.1%

Appendix F: UDS FTE Counts for 2014

Uniform Data Set (UDS) Data for 2014

Health Center	Family Physicians	Pediatricians	NPs and PAs	Total # Children 0-5
AVH	4.42 FTE	.05 FTE	1.27 FTE	352
AMC	2.14 FTE	1.24 FTE	3.07 FTE	1,555
PHC	9.47 FTE	0	11.84 FTE	2,825
SRCHC	33.07 FTE	5.14 FTE	30.01 FTE	7,197
SVCHC	2.67 FTE	.54 FTE	2.03 FTE	853
SCIHP*	7.14 FTE	0	3.83 FTE	513
WCHC	11.68 FTE	.31 FTE	5.50 FTE	863

*Does not report to UDS –numbers based on OSHPD data for children 0-4 years of age, but missing number of 5 year olds.

Appendix G: Health Center Survey Instrument

First 5 Sonoma County is funding a 3-year project to improve developmental screening and referrals in Sonoma County FQHCs. We want to assess your current practices and better understand current procedures and barriers you face as primary care providers when screening children 0-3 years of age and referring to community services and programs. This survey will take approximately 10 minutes to complete. Thank you in advance for taking time to complete this survey.

Welcome to the RCHC Developmental Screening and Referral Survey

Developmental Screening and Referral

1. Name of Health Center:
Alexander Valley Healthcare
Alliance Medical Center
Coastal Health Alliance
CommuniCare Health Centers
Community Health Clinic Ole
Petaluma Health Center
Marin City Health and Wellness
Marin Community Clinics
Santa Rosa Community Health Centers
Sonoma Valley Community Health Center
St. Joseph Health System Sonoma County - Community Health Clinics and Programs
Winters Healthcare Foundation
West County Health Centers
Other (please specify)

2. What is your name, title and e-mail address? (We may want to contact you for additional information)
Questions regarding developmental screening for children ages 0 to 36 months

Developmental Screening and Referral

3. Does your health center have a written protocol for developmental assessments for children ages 0 to 36 months?
Yes
No
Not certain

4. Which method(s) do providers in your health center use to track the development of your pediatric patients ages 0 to 36 months? (Please select all that apply)
Review clinical history with family
Observations of child's behavior in the office visit
A checklist of milestones created by health center
A checklist of milestones on a well-child check-up visit template

A checklist of milestones that came with EHR
None of the above, we do not routinely track the development of our pediatric patients
Other (please specify)

5. In your health center, do you use a validated developmental screening tool for children ages 0 to 36 months (for example, ASQ-3, MCHAT, PEDS)?
Yes
No
I don't know

Developmental Screening and Referral
6. Under what circumstances do you use a validated developmental screening tool in your health center? For example: ASQ-3, MCHAT, PEDS (Please select all that apply)
Once per year in the first three years of life
When child is 9-, 18-, 30- (or 24-) months of age
When parents indicate concern about child's development
When child exhibits "red flag" behavior
Based on clinical judgement and/or surveillance
When we are concerned about the results of developmental checklist
Other (please specify)
Routinely at 9-, 18-, 30- (or 24-) month old visits
When we need additional information
As a confirmation of surveillance
When parents request that screening tool is used

7. Which of the following validated developmental screening tools do you use and under what circumstances? (Please select all that apply)
ASQ
ASQ-3
ASQ-SE
PDDST-II
SCQ
CSBS-DP
M-CHAT
PEDS
EDS:DM
EMPP
Other (please specify)

8. For Medi-Cal patients, what codes or code combinations are billed when a validated developmental screening tool is used during a visit for a child ages 0-36 months? (Please list all that apply)

Questions regarding referrals for children ages 0-36 months for further developmental assessments
Developmental Screening and Referral
9. Which community agencies do you refer to for further developmental evaluation when a child 0-36 months has a positive or concerning score/screening? (Select all that apply)

Early Learning Institute (ELI)
North Bay Regional Center (NBRC)
Easter Seals in Santa Rosa
Other (please specify)

10. What process does your health center use to manage referrals for further developmental evaluation when a child ages 0-36 months has a positive or concerning screening/score?
Process managed by care team
Centralized referral process using existing specialty care referral coordinators
Centralized referral process using a child development coordinator
Not certain
Other (please specify)

11. Does your current referral process in your health center for children ages 0-36 months include any of the following? (Select all that apply)
Guideline and/or algorithm
Written protocol
Standardized referral form
Timeline for referral follow up
Tracking process for referral follow up
None
Other (please specify)

12. When a child has a positive or concerning screening/score in your health center, what are the next steps? (Please select all that apply)
Family is given the contact number for the appropriate office and instructed to call for an appointment
We call the appropriate referral office while the family is present and schedule an appointment
We fax the referral to the appropriate office
Internal referral to in-house services offered by health center
Other (please specify)

13. After you refer a family for further evaluation, how frequently do you receive information from the service provider (ELI, SELPA, NBRC) in a timely manner about whether the child was eligible for the program?
Never
Rarely (about 10% of cases)
Occasionally (about 30% of the cases)
Sometimes (about 50% of the cases)
Frequently (about 70% of the cases)
Very Often (about 90% of the cases)
Every time
We do not refer patients to local services for further evaluation or services
14. When your health center receives information about the results of the referral, how does this usually happen? (Please select only one)
Informed by parent/guardian at subsequent visit
Phone call from the referral service provider

Health center staff contacts the parent/guardian about the referral outcome
Standard fax form from the referral service provider
We do not usually receive information back from referral service provider
Other (please specify)

15. When a child referred to a local service provider is not eligible/does not qualify for services, what do you usually do in response? (Please select all that apply)
We do not receive information from the service provider when we refer a child for services
Reassess development at the next well-child visit
Refer child/family to in-house case management staff
Refer child/family to other supportive community services
Other (please specify)

16. What are the current barriers to conducting developmental screenings in your health center and making referrals to appropriate services?

17. What is working well in your health center process for developmental screening * and referrals?
Additional Questions

Developmental Screening and Referral
18. Please list the community resources you use most often.
Other (please specify)

19. How much time do you devote to assisting families with the referral process per week?
Never
Less than 15 minutes
15-30 minutes
31-60 minutes
61-90 minutes
More than 90 minutes
Other (please specify)

20. Do you believe the amount of time you devote to assisting families with the referral process to community resources is…?
Too much
Just about right
Too little

21. What is the ideal amount of time to spend assisting families with the referral process?

22. Where do you get information about the referral resources available in the community?

23. What way(s) do you prefer to initiate referrals to community resources and to receive information about the referral outcome?

24. What way(s) do you prefer to initiate referrals to community resources and to receive information about the referral outcome?

25. Do you use CDS tools including templates and alerts for well-child visits? How often are the templates used?

26. How would you describe your current financial model for screening, referral and support for navigation and 2nd layer screening?

27. When a child is referred for further assessment at ELI, SELPA or NBRC and is not eligible for services, what do you usually do in response?
I do not receive information back from NBRC, ELI or SEPLA
Reassess development at the next well-child visit
Refer child/family to in-house services
Refer child to other services in the community
Other (please specify)

28. On a scale of 1-7 (7 being most knowledgeable and 1 being not at all knowledgeable), how knowledgeable is your health center staff on how to navigate the referral process for further developmental assessments when a child has a positive or concerning score?
1- Most knowledgable
2-
3-
4-
5-
6-
7- Not at all knowledgeable

29. On a scale of 1-7 (7 being an essential priority and 1 being not a priority), how important of a priority is it for provider and staff at your health center to complete early developmental screenings in your health center?
1- Essential priority
2-
3-
4-
5-
6-
7- Not a priority

Concerned about an infant, toddler, or preschooler's development, language, or learning?

Here's how you can get information and help:

Infants and Toddlers

(Birth to Age 3)

Call the Early Start Warmline at:
707-569-2022 or 800-646-326
(se habla español)
Leave your contact information on the Warmline Voice Message System and receive a return call typically within 1-3 days and will be able to learn more about the free Early Start services for children with physical (including orthopedic impairments, vision and hearing) or developmental disabilities.

Preschoolers

(Age 3 through Pre-Kindergarten)

Referral Process: Parents of preschool-aged children with possible language and/or learning needs can call or visit their local elementary school for information and support on next steps to determine eligibility for preschool special education services.

If you're unsure which school is your local elementary school, call or visit the school closest to your home and they can help you determine where to go for help.

You may click this link to learn which is your school district:

https://secure.sonoma-county.org/vote/districtlookup.aspx?sid=1070#StreetAddress

More questions? Call SELPA Early Start at 707-524-2763
(se habla español)

Appendix I: Advisory Group Roster

Developmental Screening and Referral Advisory Group

Area of Expertise	Name	Title
Clinical Informatics	Danielle Oryn	RCHC Chief Medical Informatics Officer/Physician at PHC
Early Development	Nona Koroluk	North Bay Regional Center, Early Start Supervisor
Ealry Development	Michele Rogers	Early Learning Institute
Partnership HealthPlan	Joyce Aldred	Case Manager Special Programs
SELPA	Catherine Conrado	Sonoma County Special Education Local Area Plan (SELPA) Director
SCOE	Debbie Blanton	Sonoma County Office of Education (SCOE)
Pediatrics	Jeff Miller	Former Kaiser Pediatrician
Pediatrics	Mark Sloan	Former Kaiser Pediatrician, MPH
Public Health	Elisabeth Chicoine	Director of Public Health Nursing
RCHC	Michelle Rosaschi	RCHC Population Health Coordinator
RCHC	Mary Maddux-Gonzalez	RCHC Chief Medical Officer
First 5	Leah Benz	First 5
First 5	Carla Denner	First 5
East	Jerome Smith	Sonoma Valley CHC Pediatrician
West	Meri Storino	West County Health Centers
South	Pedro Toledo	Petaluma Health Center
Santa Rosa	Meredith Kieschnick	Pediatrician SRCHC

Appendix J: Marin Community Clinics (MCC) Best Practices Presentation

Developmental and Behavioral Screening Program

Marin Community Clinics

Lyndsie Baker, MA, LMFT

Pediatric Developmental Specialist

marin community clinics

History of the Child Find Program

- 1998- Prop 10 was passed in California – Tobacco tax that would be used to fund various programs relating to community and health benefits for families with children under the age of 6.
- 1999-First 5 Marin (California Children and Families Commission) became the lead agency in establishing universal screening, identification and referrals for all children in Marin County aka: "Child Find"
- 2004- Easter Seals of Northern California took the lead in the Child Find Program and determined that the Ages and Stages screening tool would be the most appropriate screening to implement
- Choosing Ages and Stages as screening tool
  - Parent Friendly (administered in English, Spanish, Vietnamese)
  - Quick to Complete (5-15 min depending on literacy levels and knowledge of child)
  - Easy to Score (5 minutes)
  - ASQ has a behavioral screening component (ASQ:SE)
- 2006–Developmental Screening Partnership Extended to Marin Community Clinics
- 2008- Developmental Screening Partnership Extended to Kaiser- North Bay
- 2012- ASQ Developmental Screening Program was embedded in the structure of MCC's primary care visits and has become a model for how to successfully implement this type of screening program in a clinic setting.

Transition to Marin Community Clinics

- On site screenings (completed primarily at well child visits)
  - 9-10 months, 15 months, 2 years, 3 years, 4 years, 5 years
  - Can also be completed out of periodicity when concerns are voiced by parents or provider
- Visit length is 45-60 min. (primarily a specialist visit with the last several minutes reserved for PCP check-in)

- Increase in collaboration utilizing a shared visit model
- Supports a primary care, empanelment model with benefit of specialist services
- Streamlined system using the ASQ Enterprise system and tablets for ASQ completion

ASQ Pro/Enterprise System

ASQ Pro (single site programs) /ASQ Enterprise (Multiple site programs)

- Organize and manage all English and Spanish ASQ screenings and data as well as create and manage child and program records
- Select the right questionnaire every time with automated questionnaire selection
- Eliminate scoring errors and improve over- and under referral rates
- Store results and follow-up decisions in child records
- Easily track when children need to be screened again
- Analyze results with child and program reports
- Quickly access activities parents can try at home to encourage child progress
- Generate aggregate reports that show trends across multiple screening programs (ASQ Enterprise only).
- Can be utilized with both paper ASQs as well as ASQs filled out via tablet

* information gathered from http://www.brookespublishing.com/resource-center/screening-and-assessment/asq/asq-online/asq-pro-and-asq-enterprise/

Ages and Stages Enterprise System

Tablets: Pros and Cons

Pros

- User friendly (for some)
- Instantly submitted to ASQ Enterprise System
- Less time spend on database input, deciphering handwriting
- Less of a paper trail, costs of copying, time spend copying, etc.

Cons

- Requires a certain level of tech-knowledge
- Wifi connectivity issues (can interrupt ASQ completion)
- Start-up costs (can vary depending on quality/price of tablet)
- Cost to replace (in 2.5 years we've had 1 out of 8 break, 3 stolen)

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ASQ Screening from Start to Finish

- Parent/caregiver is given an ASQ screening to fill out at well child visits (9-10 mo., 15 mo., 2 yrs, 3 yrs, 4 yrs, and 5 yrs.)
- ASQ is submitted via tablet or responses are input into Enterprise system by ASQ Coordinator/Medical Assistant and billed (ASQ has to be billed on the same day it was completed)
- ASQ is reviewed by the Pediatric Developmental Specialist and determination is made whether or not a follow-up visit is needed
- Child is given a Green, Yellow or Red Flag depending on scores and parental/provider concerns (need for f/u varies)
- Scores are input into "Developmental Screening" section of database within child's Electronic Health Record (EHR)
- Score Summary sheet is printed and given to medical records for scanning into EHR
- Follow-up visit is scheduled if necessary (with priority given to children with significant needs)

Pediatric Developmental Screening Room - PDSC - San Rafael

What does a typical Developmental Visit look like?

- Introduction to ASQ screening program
- Review of ASQ scores, various developmental domains, child's strengths and weaknesses (starting with strengths)
- Discussion of parent's concerns (if any)
- Observation of child, completion of developmental tasks and activities
- Psycho-education, implementing activities at home
- Discussion of community resources, qualification for support services, finalizing "treatment plan"
- Filling out consent forms as needed
- Packet with activities, handouts and resources given to parent along with contact information for follow-up
- Collaboration with PCP, shared visit to discuss plan and answer any additional questions, scheduling of any follow-up visits if needed (billing by PCP)

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Billing Process

- Billing for ASQs can happen at each of the 6 different age intervals or within 1-2 months on either end (as long as it's within periodicity)
  - Billing code (CPT) for an ASQ is 96110
  - Reimbursement rate is approximately $60.00 per completed ASQ or ASQ:SE
  - Only one screening can be billed per visit
- Billing for Developmental follow up visits can happen only if a billable provider has spent face-to-face time with the patient
  - Reimbursement is in accordance with our wrap rate per provider visit
  - A "billable provider" can be an MD, DO, FNP or LCSW. LMFT's are now considered "billable" under Partnership's new regulations but they will not receive the wrap rate that the other providers do. However, if the LMFT completes a shared visit with a qualified provider, then that provider can bill at the regular wrap rate.
    - This may also allow time spent by MFT and SW interns completing follow-up visits to be billable if supervised by a licensed provider and completing shared visits.

Case Management

- Referrals
  - Regional Centers (0-3)
  - School Districts (3+)
  - Hospitals (CHO, UCSF, CPMC)
  - Service Agencies (Community Action Marin, Matrix, APPLE)
  - Mental Health Agencies (FSA, JFCS, NYC, Kalmanovitz CDC)
  - CPS (Children and Family Services)
  - Childcare/Preschool Assistance (Early Head Start, Head Start, other low cost, subsidized programs)
  - Housing Assistance (Marin Housing Authority, Homeward Bound, Shelters)
- Collaboration
  - MCEIT Meetings (Marin County Early Intervention Team)
  - Case Management with Marin Family Connections (MFC)
  - Release to Exchange Information (including all relevant programs/agencies)
- Continued Follow-up
  - Follow-up visits scheduled as needed (usually within 1-2 months if severe, 3-4 months if monitoring)
  - Ongoing monitoring using ASQ system (for Green and Yellow flags)
- Areas of Improvement
  - Referral tracking
  - Once referrals have been initiated, have kids qualified and/or been accepted into various services? Have evaluations been completed and sent back to the clinic to scan into EHR.

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Program Expansion

- Workshops
  - Child development workshops (English and Spanish)
  - Parenting Workshops (English and Spanish)
  - Triple P Workshops (training LCSWs/providers or offering to host established program at clinic site for our patients)
- Collaboration with outside resources
  - Kalmanovitz CDC- Offering parent consults to clinic patients
  - APPLE Family Works (Parenting classes on site at the clinics)
  - Ongoing multi-agency collaboration

- Intern training programs
  - UCSF- Pediatric nursing students
  - Dominican University
    - O/T interns (shadow visits and develop sensory handouts/resources in English and Spanish)
    - Child Development students (assist with screenings and workshops planning and implementation)

Parent Packets and Resources

Individualized packets tailored to each child's unique developmental needs/situation can include:

- Most recent ASQ and Score Summary Sheet
- Developmentally and/or age appropriate activities and exercises
- Pamphlets on various local service agencies
- Applications for preschool programs/services
- Contact information for clinic/health center
- Information on upcoming workshops, parenting classes, playgroups, etc.

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Q & A

If you have any additional questions, please feel free to contact me at:

lbaker@marinclinic.org
(415) 798-3132

Thank you for your participation!

Appendix K: Logic Model

Evaluation Planning
Logic Model

Project: First 5 Sonoma County Developmental Screening and Referral Project
Goal: Standardize developmental screenings and referral process in FQHCs for children 0-5 to improve early identification and treatment of developmental concerns.

INPUTS	ACTIVITIES		OUTCOMES		
What we invest	**What we do**	**Who we reach**	**Why this project: short-term results**	**Why this project: intermediate results**	**Why this project: long-term results**
RCHC staff time CHC staff time F5 Funding CDS development to support efforts Quality Improvement and Population Health Support (reports and training) Time from community partners Technology including iPads to facilitate screenings conducted while in waiting room Navigator positions added to clinic staff	Assessment of current practice at CHC for development screening and referral Facilitate sharing of best practices Identify ideal model for developmental screening and referrals Standardize CDS for well-child visits Improve workflow to more accurately collect data and track referrals Add Navigator position to health center staff in pilots	Children 0-5 and children and families served by FQHCs CHC providers and staff Community partners Service providers in the community	Increased knowledge for health center providers and staff about community resources for further assessment and treatment (pre/post surveys) Increased comfort levels for health center providers and staff about the referral process in the community (pre/post surveys) Increased understanding of how early interventions contribute to educational success for children and improved health outcomes (pre/post surveys) Improved cross-agency coordination (pre/post surveys)	Increased access to developmental assessment and treatment services in community Increased number of referrals initiated in FQHCs including referrals to social services	Coordinated and integrated system of care that supports the needs of families with children 0-5 years of age in Sonoma County Impact to Triple Aim concepts

Assumptions	**External Factors**
Increased focus on addressing social determinants of health to reduce health disparities There is capacity in our community to provide services to all children in need Standardizing developmental screening and referral models in FQHCs will lead to improved patient experiences, improved outcomes and reduce costs	Increase in patients served by FQHCs due to implementation of ACA 2-1-1 Developmental Screening and Care Coordination Pilot, April - June 2015