Testimony February 23, 2017- Dr. Monique Carroll

Chair Lively and members the Early Childhood and Family Supports Committee, my name is Monique Carroll. I am a board certified pediatrician and have practiced medicine in Oregon for the past 9 years, including 6 at the Community Health Centers of Lane County. Prior to that, I served as a pediatrician in the Air Force for 7 years. I currently provide medical care for mainly OHP patients or the uninsured as a safety net provider. Our clinic population has high levels of poverty and family disruption.

In clinic, pediatricians provide developmental surveillance at each visit, particularly well-child check-ups. Per the American Academy of Pediatrics guidelines, we are instructed to administer a standardized developmental screening tool at 9 months, 18 months and 24-30 months. We use a standardized screening tool because otherwise up to 70% of subtle developmental delays are missed in a routine well check-up. In Oregon, the Oregon Heath Authority requirements follow the American Academy of Pediatrics (AAP) guidelines with a preference for the use of the Ages and Stages Questionnaire (ASQ). One of our CCO incentive metrics over the past 3 years has been annual developmental screenings for children under 3 years. The use of the Ages and Stages Questionnaire is standard across our community, so medical providers use the same tool as Early Childhood Intervention, daycare providers and online referrals. This allows for easily communicated information from the medical provider to the service provider.

Once a developmental abnormality is identified, either through standardized screen or routine surveillance, I am mandated by the Individuals with Disabilities Education Act (IDEA) and federal guidelines to refer to an ECI contracted program in 7 days or less.

Generally, this means that I fax a referral to my local ECI office (EC Cares in Lane County). ECI helps coordinate what services are needed, often refers to outside organizations and returns feedback to me. The process is well understood by all the referral sources in the county, so there is little lag time in referrals or services. Children who receive necessary therapies are more likely to graduate from high school, live independently, avoid teen pregnancy delinquency and violent crime. The CDC estimates that the long term cost savings per referral is over $30,000 per child. I estimate that I referred 35-40 children last year, or a savings of over 1 million dollars.

AT the CHC, we track whether ASQ's are performed. In 2014, 185 children were screened. In 2015, 201 were screened. In 2016, 277 were screened out of approximately 500 children. This represents a 28% increase in screening over the past year, but still only about 50% of our eligible population. For 2017, our CCO benchmark is to screen 60.1% of this population. I wish that I knew the percentage of our population that we refer exactly, but I estimate it is at least 20%. As we improve our screening processes, the number of referrals will increase. Accordingly, I expect the need for services to increase as well. In turn, this will result in improved lives and decreased long term costs.

Thank you for the opportunity to speak on this very important topic for my most at-risk patients.