
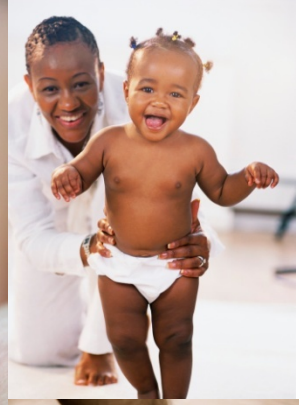



Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-risk Receive Best Match Follow-Up

Community-Based Quality Improvement Effort led by
The Early Learning Hub of Central Oregon in partnership with the
Oregon Pediatric Improvement Partnership

Stakeholder Meeting 12/2/19
12-3 PM

Early Learning & Wellness
LAST A LIFETIME
EARLY LEARNING HUB OF CENTRAL OREGON

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OPIP

WELCOME

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Today's Agenda

- **50,000 Foot View – Project Refresher**
- **Commitment to parent-centered project, guidance and input needed**
- **Detailed Updates and Input on Project Activities**
  - Primary Care Pilot Sites
  - Early Intervention – Improving Closed Loop Communication
  - Pathways for Children with Social-Emotional Delays
  - Pathways for Children Needing Medical and Therapy Surveys
  - Building Health and Resilience for Children with High Social Complexity – Identify Community-Level Priorities
- **Next Steps**

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Acknowledgement of the Complexity of This Work

- This work has important broad and deep goals.
- Many components of the project are novel and this is the first time that this work is being is done focused on this young population.
- These are the complex topics, within a
  - ➢Complex project engaging various stakeholders and systems, for which there are
    - Solutions that may be complex in trying to implement in the course of this project
- The ELHCO and COHC is thankful that OPIP can provide targeted support for this work given their knowledge on the topic, awareness of state policy priorities, and their impartial and neutral role
- **Therefore we ask that we have grace with each other**

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Appreciation for the Complexity of our Pathways Work

- Our common **North Star Goal:** that families of young children are equipped with the resources they need in order for their children to thrive.

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Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk Receive Best Match Follow-Up Meant to Prepare for Them Kindergarten

- Aim: To improve the **receipt of services for young children** who are **identified at-risk** for developmental, behavioral and social-emotional delays.
- Funding – **Central Oregon Health Council** *(Funded by multiple committees within the Central Oregon Health Council (COHC))* to the Early Learning Hub of Central Oregon & from the **Early Learning Hub MIECHV Funding**
  - OPIP is a Subcontractor of the Early Learning Hub of Central Oregon
- Time Period: June 2018- May 31st 2021
  - **Phase 1** (*June 1 2018 - May 31st 2019*): **Across-sector stakeholder engagement** and **baseline data collection** about current processes and where children are lost to follow-up
  - **Phase 2** (*June 1 2019 - May 31st 2021*): **Implement Pilots to Meant to Improve Follow-up for Children Identified at Risk and to Support Addressing Gaps in Pathways and Capacity**

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Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk Receive Best Match Follow-Up Meant to Prepare for Them Kindergarten

- **Phase 1** (*June 1 2018 - May 31st 2019*): **Across-sector stakeholder engagement** and **baseline data collection** about current processes and where children are lost to follow-up
  - Cross-sector engagement, baseline data, and asset mapping (Ended May 31st)
  - Starting point improvement tools developed
  - Development of Phase 2 proposal and community-level priorities identified
- **Phase 2** (*June 1 2019 - May 31st 2021*): **: Implement Pilots to Meant to Improve Follow-up for Children Identified at Risk and to Support Addressing Gaps in Pathways and Capacity**
  - Improve follow-up in **Primary Care Pilot (PCP) Sites (N=4)** receipt
  - Improve follow-up **pathways from PCP pilot sites to increase receipt of services**:
    - Improve **closed loop communication and coordination** in **Early Intervention** (All three counties and Confederated Tribe of Warm Springs)
    - Address **Gaps in Pathways for PCP site** that focus on at-risk children needing:
      - Services that address **social-emotional delays**
      - **Medical and therapy *services*** *(Occupational Therapy, Physical Therapy, Speech)*
  - Identify and confirm community-level priorities on **upstream** approaches that could build health and resilience (aimed to prevent delays): **Proactive Developmental Promotion & Preventive Behavioral Health for Socially Complex Children**

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Commitment to this being a Parent-Centered Project: Guidance and input needed from Parents

Goal: **Receipt of services for young children** who are **identified at-risk** for developmental, behavioral and social-emotional delays.

- Parents/caregivers of young children identified at-risk are the **center of this work**
  - identify/share their needs and barriers
  - diverse perspectives and needs
- A shared value of Early Learning, Health Council and OPIP's mission is to "**ensure that improvement efforts are informed by parents and youth**"

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Parent Engagement to Date and Planned

- Included funds to support parent advisors to provide input throughout the project
- Within pilot sites, role of parent advisors to the improvement efforts
  - E.g. COPA Parent Advisory group provided input on the project
- Test promotion materials and process with partner parent organizations
  - CO Family Support Network, Parent Councils and Affordable Housing Parent Engagement

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Request For You As We Provided Updates and an Overview of Project Activities

- Throughout the meeting we will come back to how to talk about how we can ensure we get **parent input and parent guidance** on the project activities
- If you know of an avenue by which parents could be engaged or recruited, **share your idea**

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Today's Agenda

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- Commitment to parent-centered project, guidance and input needed
- Detailed Updates and Input on Project Activities
  - Primary Care Pilot Sites
  - Early Intervention – Improving Closed Loop Communication
  - Pathways for Children with Social-Emotional Delays
  - Pathways for Children Needing Medical and Therapy Surveys
  - Building Health and Resilience for Children with High Social Complexity – Identify Community-Level Priorities
- Engaging parent voice better
- Next Steps

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Phase II Project-Level Activities

- Improve follow-up in **Primary Care Pilot (PCP) Sites (N=4)**
  - Two committed site (COPA, MOSAIC) who have been expecting implementation support
  - Recruit two additional sites

- Improve follow-up **pathways from PCP pilot sites to increase receipt of services**:
  - Improve **closed loop communication and coordination** in **Early Intervention** (All three counties and Confederated Tribe of Warm Springs)
- Address **Gaps in Pathways for PCP site** that focus on at-risk children needing:
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- Identify and confirm community-level priorities on **upstream** approaches that could build health and resilience (aimed to prevent delays): **Proactive Developmental Promotion & Preventive Behavioral Health for Socially Complex Children**

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Work Completed Since June 2019 (Last Stakeholder Meeting):

1. Training on Best Match Follow Up for Developmental Screening
2. Practice Facilitation and Quality Improvement
3. Electronic Health Record Support
4. Data Collection
   - Follow-Up data collection to assess implementation

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Training on Best Match Follow Up for Developmental Screening

Goal of Training:

Overview of Tools to Help Primary Care with Follow-Up to Developmental Screening Tailored to Referrals Available in Central Oregon

A. Follow-Up to Developmental Screening Decision Tree

- Based on Age, ASQ domain scores, Parent/Provider Concern & Child/Family Risk Factors → Best match resources in your community

B. Supporting Families Referred: Enhanced strategies to close the referral loop

1. **Shared Decision Making and Parent Education** Sheet – Version 1
2. **Phone Follow-up** Script for Families Referred
3. **USING communication received** from Early Intervention when family can't be contacted and/or to provide information on evaluation findings

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Feedback on Training

- WHO: Value in the **Asset Map** as it helped to illuminate the resources for follow up to developmental screening in the region.
  - OPIP is creating Care Coordination Resource Guide that will serve as an appendix of providers.
- HOW: Value in **specific guidance** on **who** to refer for follow up to developmental screening **and where** to refer based on assets in their region and specialty services in Portland.
- Providers articulated the value in understanding **Oregon's strict Early Intervention eligibility criteria**, which validated their professional perceptions that the national recommendations of who to refer to EI.
- Value in parent-centered engagement and navigation tools.

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Overview of Practice Facilitation and Quality Improvement Supports

Monthly check-ins with leaders of the implementation team to support implementation of the following:

1. ***Proactive developmental promotion***
   - ASQ Learning Activities
2. ***Care Coordination Supports***
   - OPIP developed a **one page education sheet**
   - **Phone follow up** that is completed within the two days of a referral being placed.
3. ***Engaging families in Referral to Early Intervention***

   Both sites have begun quality improvement to **collect a Family Education Rights and Privacy Act (FERPA)** signature on EI's URF before sending referral to High Desert ESD.
4. ***Pathway to Internal Behavioral Health***

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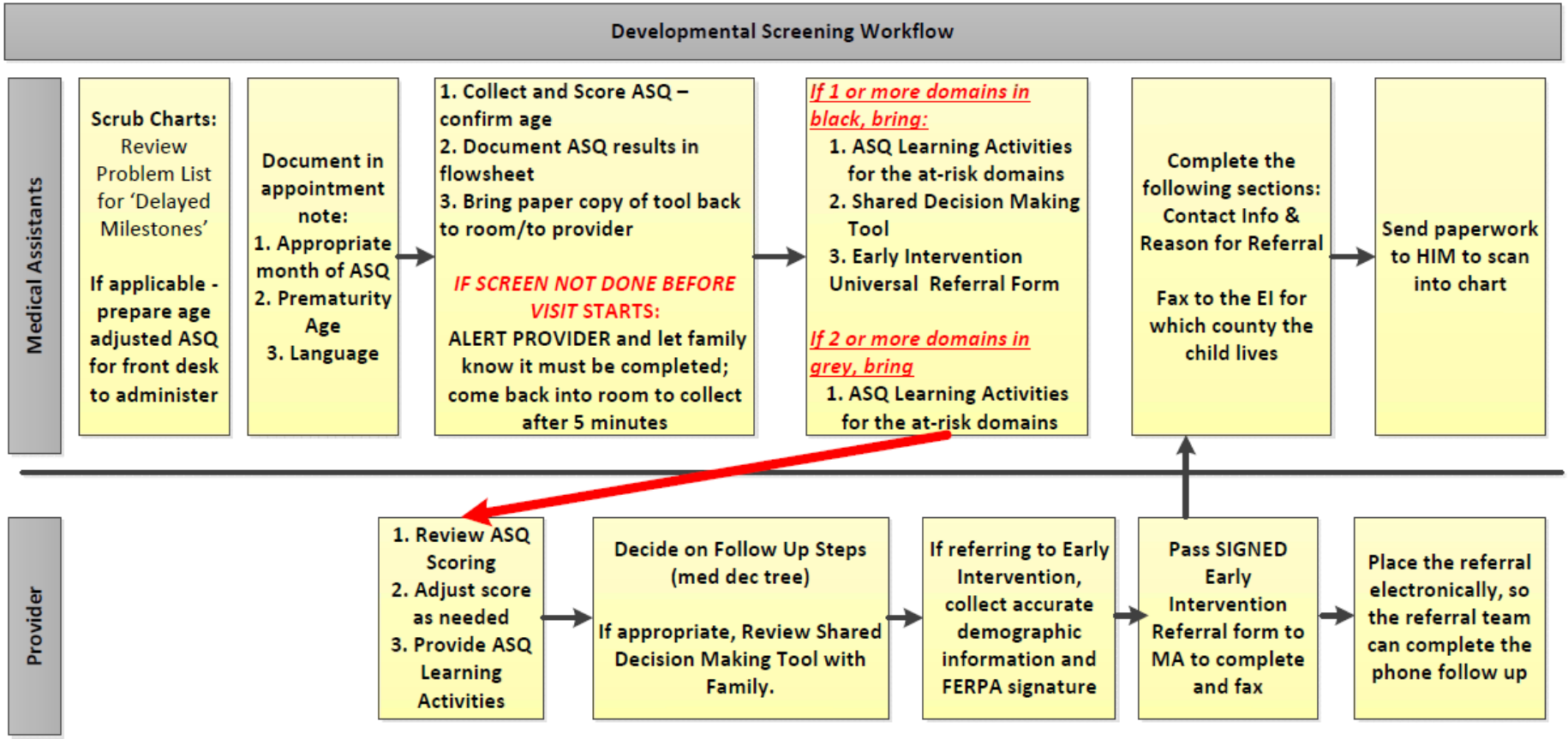
Example of a Proposed Workflow within a Pilot Site



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Activity 1: Improve Follow-Up in Primary Care Practice Pilot Sites Already Engaged in Pilot (COPA and Mosaic)

Work Completed Since June 2019 (Last Stakeholder Meeting):

1. Training
2. Practice Facilitation and Quality Improvement
3. Electronic Health Record Support
4. Data Collection
    - Follow-Up data collection to assess implementation

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Electronic Health Record Support

- COPA switched to Legacy EPIC in the summer of 2018
- Since that transition OPIP has helped to facilitate **cross clinic and region engagement on improving Legacy EPIC's developmental screening templates**, leveraging the potential CCO measure on follow up to developmental screening to prioritize these EHR changes.
- **Proposed changes** will allow COPA to run a report on:
  1. Screens that identify a risk
  2. Follow Up (Intervention) that was Provided in context of visit

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Electronic Health Record Support

- Mosaic was OPIP's first site that was able to pull the entire baseline sample electronically.
- Follow-up steps **not included** in baseline data due to limitations, but OPIP identified as part of our QI were:
  - Developmental Promotion
  - Referrals to other resources: CaCoon/Babies First/Home Visiting
- Since baseline, Mosaics IT was able to:

  1. Create searchable referrals to CaCoon and BabiesFirst!

  2. Create a searchable 'dot phrase' (a documentation prompt that can be used by a provider in the course of a visit) to capture the distribution of developmental promotion

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Work Completed Since June 2019 (Last Stakeholder Meeting):

1. Training
2. Practice Facilitation and Quality Improvement
3. Electronic Health Record Support
4. Data Collection
   - Follow-Up data collection to assess implementation

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COPA
CENTRAL OREGON
PEDIATRIC ASSOCIATES

Using Data to Inform Rapid Cycle Improvement

Timeframe of data collection for follow-up data collection
10/14/19 – 11/10/19

Age of children examined:
0-35.99 months

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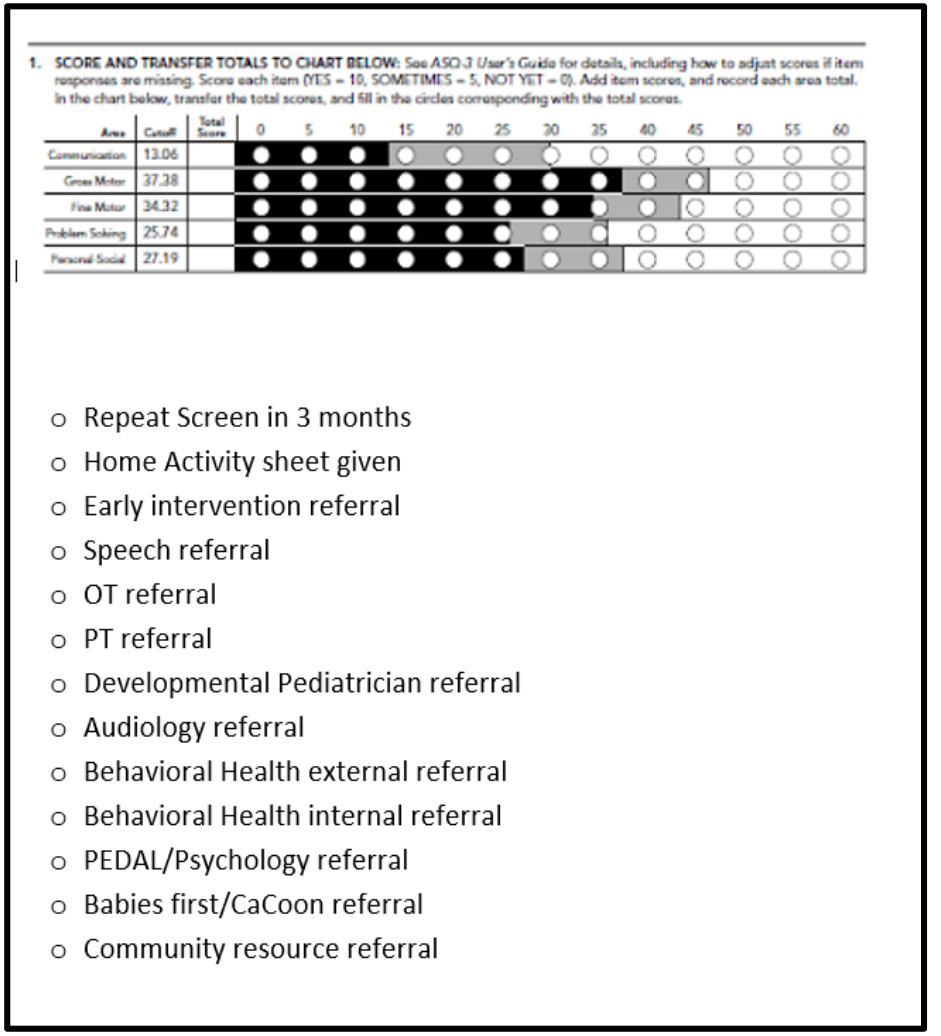
OPIP

COPA Collection 1 Process

Data Collection Process

- Worked with Legacy EPIC team to improve documentation aligned with developmental screening AND follow up
  - Improvements will be 'live' January 2020
- In the meantime, COPA providers piloted updated EMR documentation ON PAPER before roll out to help ensure face validity
  - COPA team then took paper documentation and transferred results to standardized OPIP template



1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	●	○	○	○	○	○	○	○

- Repeat Screen in 3 months
- Home Activity sheet given
- Early intervention referral
- Speech referral
- OT referral
- PT referral
- Developmental Pediatrician referral
- Audiology referral
- Behavioral Health external referral
- Behavioral Health internal referral
- PEDAL/Psychology referral
- Babies first/CaCoon referral
- Community resource referral

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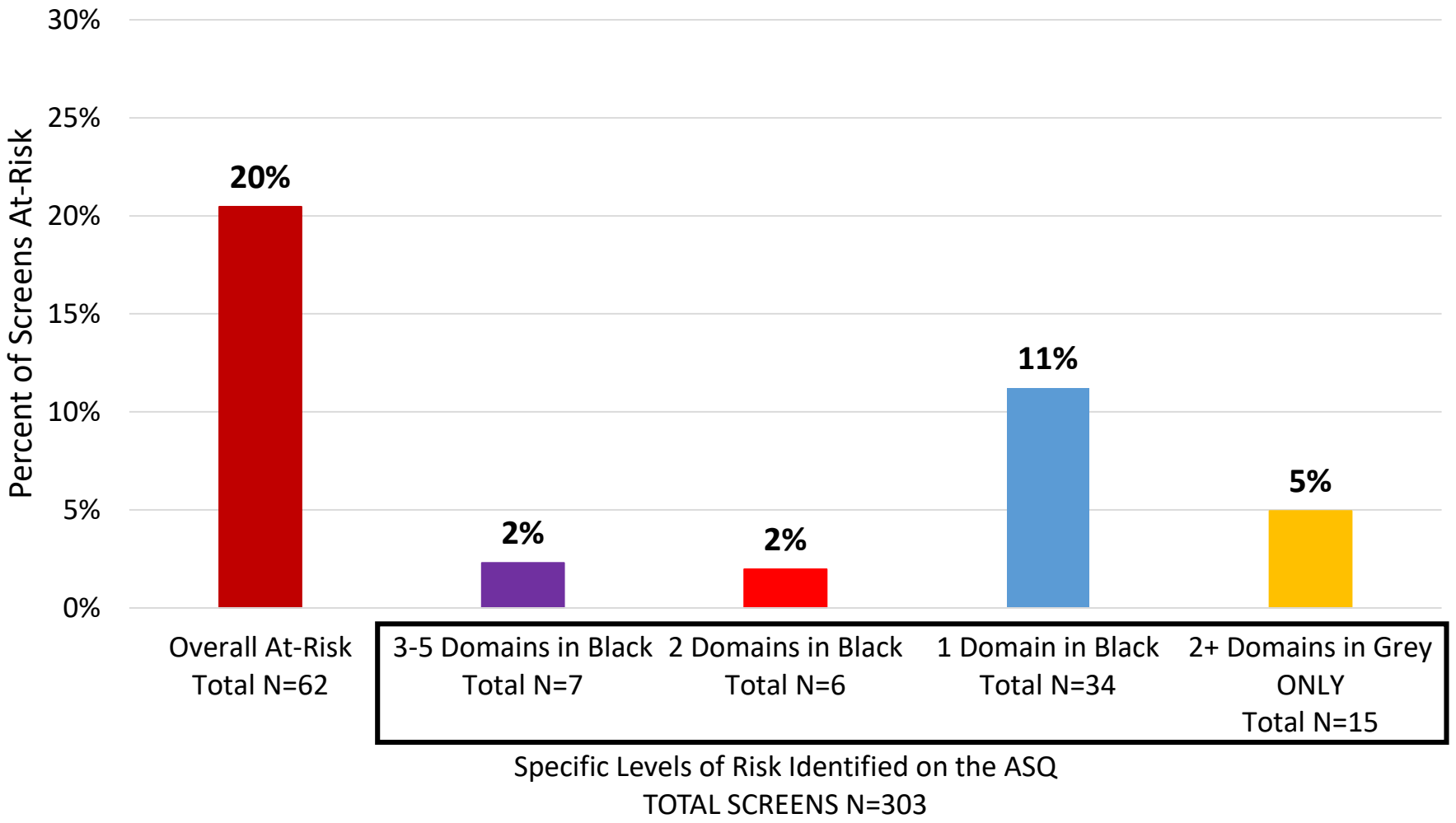
COPA – Children 0-3 Identified on the ASQ as "At-Risk" in Follow-Up Data Collection



Data Source: Provided by COPA Data Team, November 2019. Data for screens (According to EMR) between 10/14/19 – 11/10/19 for children under three.

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OPIP

COPA: FOLLOW-UP TO ASQ SCREENINGS IN FIRST THREE YEARS: MEDICAL DECISION TREE

VERSION 10/31/19

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 (all categories)

STEP 2: REFER *OR* RESCREEN

Category 1

REFER TO:
1. **Developmental Evaluation**
   See cheat sheet on back; If Under 1 – No Referral, but continue to monitor progress
2. **Early Intervention**
   - ***EI Universal Referral Form,*** *sign FERPA*
   - *Give Parent Ed Sheet*

Category 2

Parental Or Provider Concern*?

YES → REFER TO: Early Intervention
- ***EI Universal Referral Form,*** *sign FERPA*
- *Give Parent Ed Sheet*

NO → RESCREEN WITHIN 3 MONTHS:
- *Set up a follow-up if child does not have a visit*

→ If at-risk on rescreen, REFER to EI

Category 3

Parental Or Provider Concern*?

YES → REFER TO: Early Intervention
- ***EI Universal Referral Form,*** *sign FERPA*
- *Give Parent Ed Sheet*

NO → RESCREEN WITHIN 3 MONTHS:
- *Set up a follow-up if child does not have a visit*

→ If at-risk on rescreen, REFER to EI

Category 4

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

Category 1

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

Category 2

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

Category 3

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

STEP 4: BEHAVIORAL HEALTH SUPPORTS

1) At-Risk (in the black) on Personal Social *AND* Problem Solving
2) In the black in Personal Social *OR* Problem Solving *AND* concerns such as oppositional behaviors, aggression, overactive or shy, significant sleep, feeding issues, concerns adjusting to new situations or irritability

→ Refer to **Internal Behavioral Heatlh**
See cheat sheet on the back

STEP 5: COMMUNITY RESOURCES TO CONSIDER

Family Support Services - CaCoon/BabiesFirst! (CAN SERVE CHILDREN BIRTH – 21)
If child has **medical risk factors *AND* social risk factors**
(See cheat sheet on back)

Consider Other Resources Provided in the Asset Map
(Focus of Future OPIP Trainings)

** One example of when a provider should be concerned is if a child is well below the cut-off in the domain(s).*

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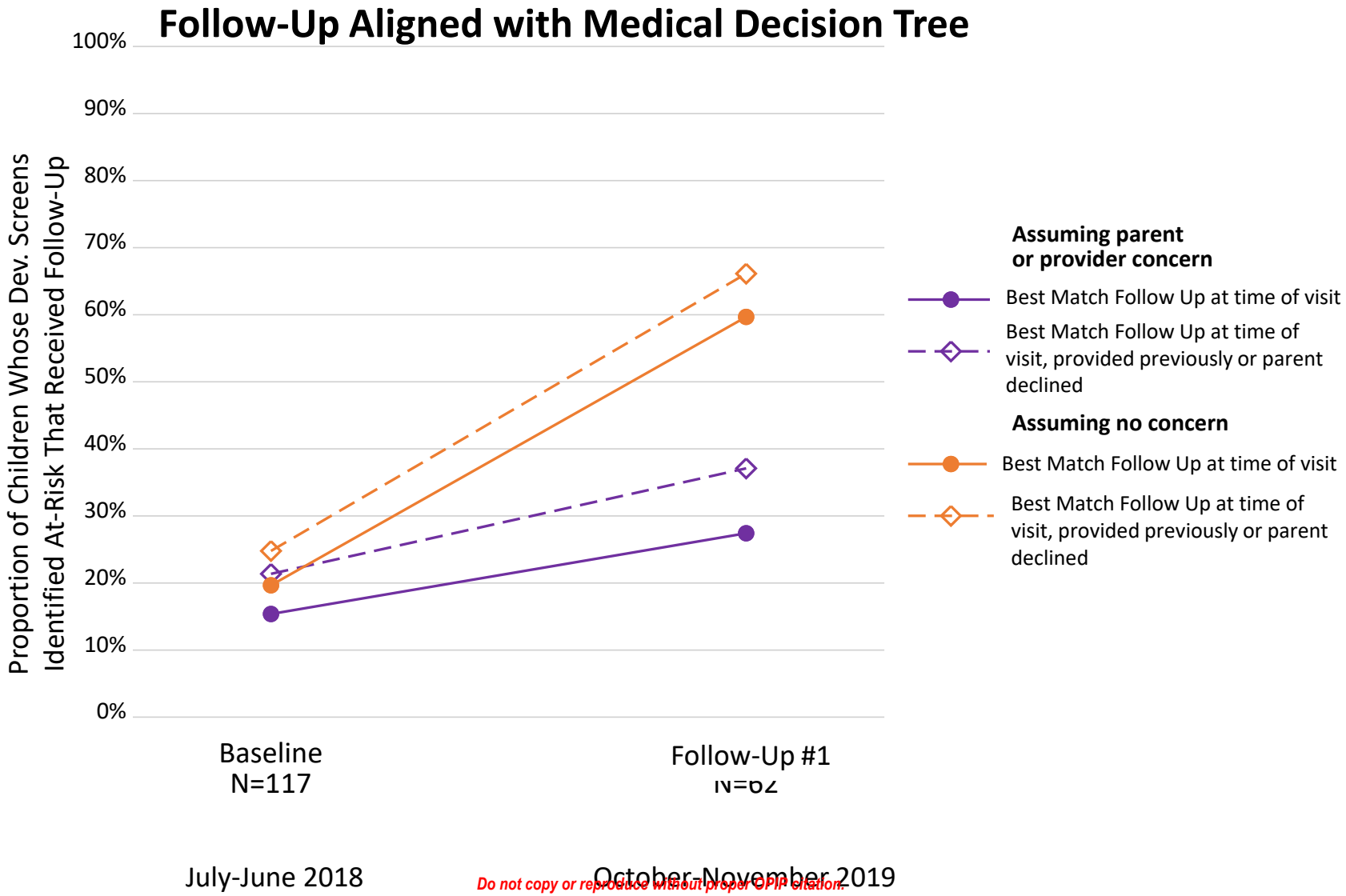
Follow-Up Data Collection to Evaluate if Improvements Occurred: COPA Pediatrics



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Using Data to Inform Rapid Cycle Improvement

Timeframe of data collection for follow-up.
Sept 1st- Oct 15th 2019

Age of children examined:
0-35.99 months

Screens Examined
Since baseline, Mosaic has adjusted their screening periodicity, so this collection reflect their updated procedures to screen at 6,9,12,18, 24, 30 month

Limitations:
Data analysis is ***beholden to what is documented in the chart.*** Parent decline not documented in chart in searchable field.

During baseline collection (1 year of data), we were able to see if a ***rescreen*** occurred and count that as recommended follow up. With a shorter data cycle, we were not able to capture that data in the same way.

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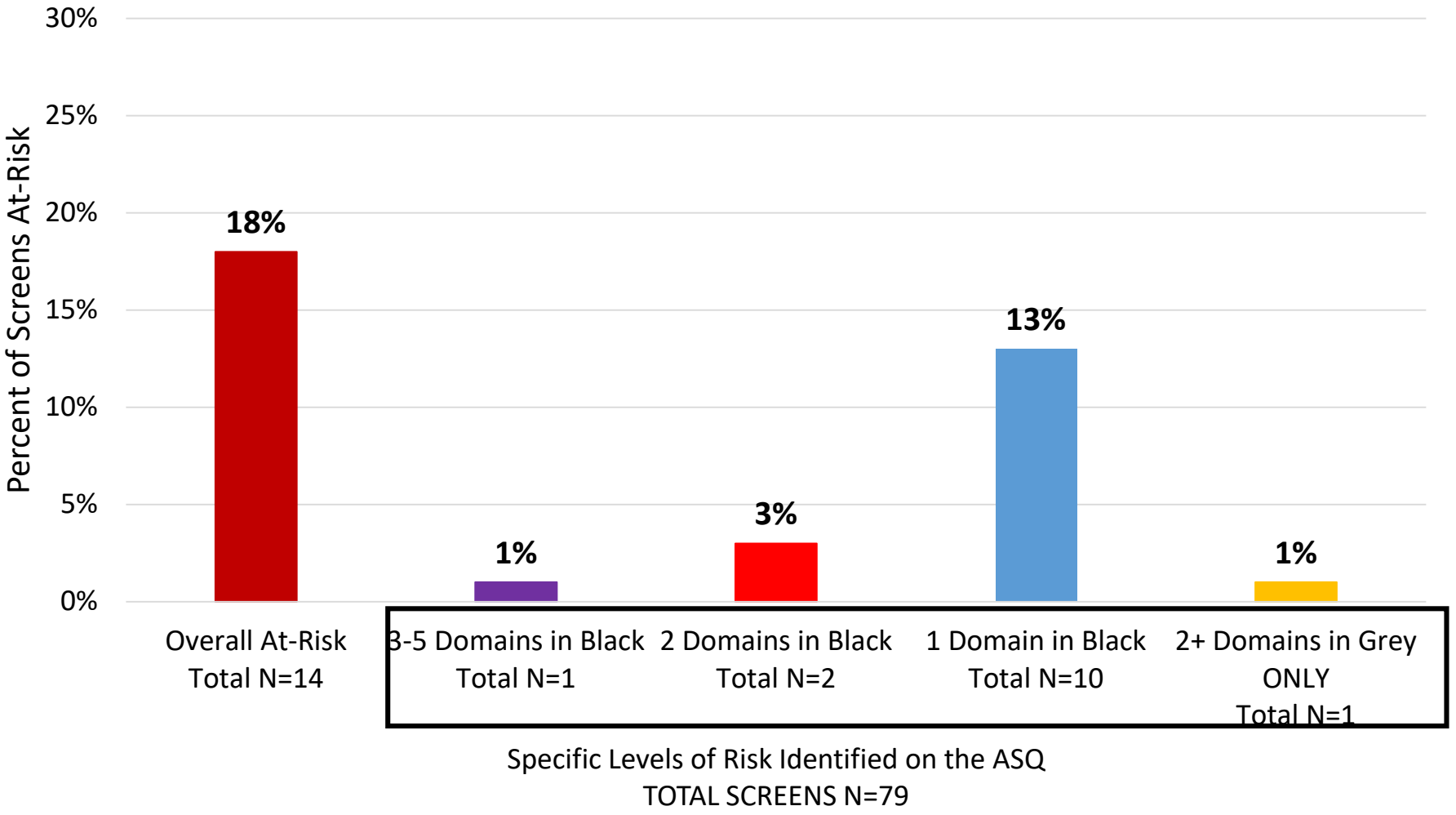
Mosaic East Bend – Children 0-3 Identified on the ASQ as "At-Risk" (Denominator for a Follow-Up Metric)



Data Source: Provided by Mosaic Data Team, November 2019. Data for screens (According to EMR Flowsheet) between 9/2/19 – 10/31/19 for children under three years.

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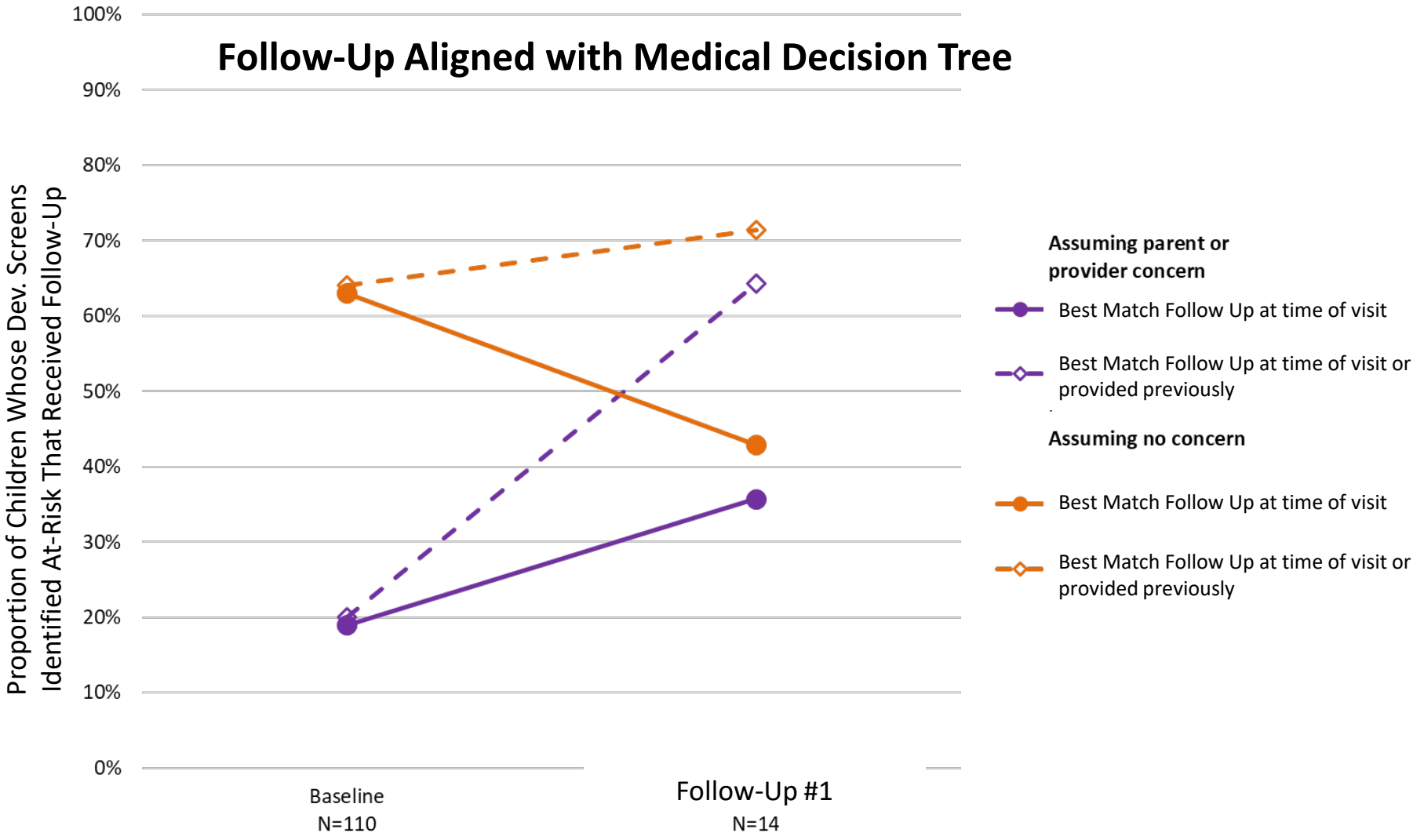
Follow-Up Data Collection to Evaluate if Improvements Occurred: MOSAIC



October-November 2019

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Subsequent Medical Chart Review for Follow-Up Data Period #1 To Determine Parental Concern

- **Mosaic conducted manual chart reviews to determine if there was documentation of parent or provider concern**

- **Based on this information:**
  - **10/14 children (71%) of children had appropriate follow up:** Using the version that counts referrals provided at **time of visit or at previous visit (Solid Line on Previous Report)**
  - **7/14 children (50%) of children had appropriate follow up:** Using the version that counts referrals **provided at time of visit (Dotted Line on Previous Report)**

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Data Takeaways from COPA and Mosaic

Implementation has started!!

Both sites have spent the last six months working hard on improving their data collection processes and internal workflows for implementation

Quality Improvement Opportunities Identified for sites to focus on in next quarter:

1. Focus on use and documentation of developmental promotion within the visit
2. Pathway to a Developmental Behavior Evaluation for children 3 or more domains in the black
3. Pathway to Early Intervention Evaluation
4. Brainstorm strategies on documenting rescreen
   - Specific focus on children who are being “rescreened” who have multiple domains “at-risk” to establish workflow to ensure they are not watchful waited

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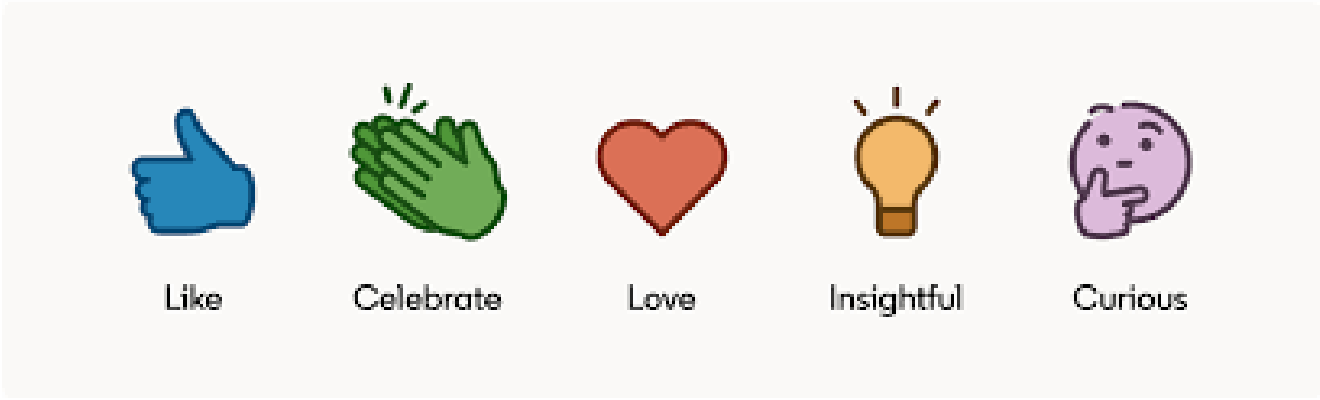

Pilot Site Reactions

- What has been the most impactful change since starting this project?
- What are some key successes and lessons learned to date?
- What are your biggest barriers?
- What are you most looking forward to as we continue our work together?

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Components of Funded Phase 2 Improvement Efforts

A) Improve Follow-Up in Primary Care Practice Pilot Sites conducting developmental screening

- Activity 1: Two committed site (COPA, MOSAIC) who have been expecting implementation support
- **Activity 2:** Recruit two additional sites

B) Activity 3: Improve Follow-Up in Early Intervention:

- Support implementation of component of the PCP pilots is best match referrals to EI.
- Support EI implementation enhanced care coordination for referrals, enhance coordination and communication with the entity that referred the child **and PCP use of that information**
- If feasible Potential secondary referral pathways

C) Improve Follow-Up to Priority Areas Identified by the community

1. Activity 4: Addressing children with social-emotional delays (integrated behavioral health, specialty mental health)
2. Activity 5: Pathways to medical and therapy services

D) Activity 6: Proactive Developmental Promotion & Preventive Behavioral Health meant to build resiliency for children in socially complex families

** Across these efforts **ensure equity lens** and that intentionally addresses areas of disparities

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Activity 2: Recruit two additional sites to Improve Follow-Up to Developmental Screening

Identifying the Two Additional Sites – Design Parameters

- Goal is to recruit additional practices that intentionally address the regional (by county) variations observed and that address the variations observed by race-ethnicity

Factors to Consider in Reaching Out to Applicable Practices:

- County-level location of practice
- Number of children 0-3 attributed to practice, seen by practice
- Number of children 0-3 attributed to practice by race and ethnicity
- Screenings rates for practice
- System in which the practice is located

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Phase 2 Activities:
Improve Follow-Up in Primary Care Practice Pilot Sites conducting developmental screening

Clinic Name : *Sites in Green Are Already Pilot Sites*	Number of Children Screened, Number 0-3 Assigned to Clinic 11 months (7/1/18 – 5/31/19) N=3741	Site Selection Design Criteria for Additional Sites			
		Sufficient # of kids, Screen Rate	Clinic in Crook, Jefferson	Non- Mosaic of COPA clinic (Given existing sites)	Noted by Stakeholders
6c. Mosaic Medical – (CROOK)	(86/106)	●	●		
6d. **St Charles Family Care Prineville (CROOK)**	**(48/95)**	●	●	●	●
6a. Cascade Direct Care (CROOK)	(1/3)				
6b. Crook County Health Department (CROOK)	(0/0)				
6o. St Charles Medical Group – Bend, Redmond (DESCHUTES)	(258/444)	●			
6l. Mosaic Medical – Deschutes County Clinic (DESCHUTES)	**(205/277)**	●			
6f. Bend Memorial Clinic (DESCHUTES)	(60/157)				
6p. Weeks Family Medicine (DESCHUTES)	(126/152)	●			
6g. Burket, Bradley MD (in Bend) (DESCHUTES)	(72/99)	●			
6k. Lapine Community Health Center (DESCHUTES)	(68/95)	●			●
6m. Praxis Medical – Central Oregon (DESCHUTES)	(32/76)				
6e. Unassigned Deschutes (DESCHUTES)	(13/21)				
6q. West Bend Family Medicine (DESCHUTES)	(0/7)				
6i. Family Care Center (DESCHUTES)	(1/2)				
6n. Redmond Family Medicine Center (DESCHUTES)	(0/1)				
6s. Mosaic Medical – Jefferson County Clinic (JEFFERSON)	(46/125)	●	●		
6r. **Madras Medical Group (JEFFERSON)**	**(85/105)**	●	●	●	●
6t. St Charles Medical Group – Madras (JEFFERSON)	(26/57)		●		
6j. John K Ross MD (JEFFERSON)	(0/0)				
6u. Warm Springs Clinic (IHS – Clinic) (WARM SPRINGS)	(0/8)				
6h. Central Oregon Pediatrics Associates (Multiple Clinics)	(1506/1907)				

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Sites Identified Meeting Design Parameters

1. Madras Medical Group (Confirmed)
2. Prineville St. Charles Primary Care Clinic* (Tentative agreement)

* Engagement of the Population Health team within St. Charles that supports all of the primary care sites.

- OPIP will meet periodically with the team to share learnings, tools and strategies to ensure future spread across the system
- The team will support centralized functions and modifications:
  - EHR template modifications
  - Centralized care coordination
  - If applicable, internal behavioral health

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Next Steps with Two New Additional Sites

1. Onboarding and understanding current workflow & processes
2. Engagement of parent advisor(s)
3. Baseline data collection
4. Training on best match follow-up for developmental screening

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Phase II Project-Level Activities

- Improve follow-up in **Primary Care Pilot (PCP) Sites (N=4)**
  - Two committed site (COPA, MOSAIC) who have been expecting implementation support
  - Recruit two additional sites

- Improve follow-up **pathways from PCP pilot sites to increase receipt of services**:
  - Improve **closed loop communication and coordination** in **Early Intervention** (All three counties and Confederated Tribe of Warm Springs)

- Address **Gaps in Pathways for PCP site** that focus on at-risk children needing:
  - Services that address **social-emotional delays**
  - **Medical and therapy *services*** *(Occupational Therapy, Physical Therapy, Speech)*
- Identify and confirm community-level priorities on **upstream** approaches that could build health and resilience (aimed to prevent delays): **Proactive Developmental Promotion & Preventive Behavioral Health for Socially Complex Children**

Do not copy or reproduce without proper OPIP citation.

Activity 3:
Improve Follow-Up in Early Intervention

Work Completed Since June 2019 (Last Stakeholder Meeting):

1. Summer Kick Off Training
2. Facilitation and Quality Improvement
   - Roll out of Service Summary
   - Documentation Aligned with QI within ecWeb
3. Data Collection

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Goal of Early Intervention Summer Kick Off Training

- Review the **enhanced processes for communication and coordination** aligned with Oregon Department of Education's (ODE) updated recommendations
  - Providing enhanced communication and coordination for children referred & not evaluated using the bottom of the Universal Referral Form

  Communication about evaluation results
  - For Ineligible Children: Bottom of Universal Referral Form
  - For Eligible Children: Service Summary

- Review Scope of Primary Cares Training
- Review Oregon's Updated OAR for Screening

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Component of the QI Work Related to Primary Care and EI Impacted by the New URF

Pilot Primary Care Sites

1) Enhanced developmental promotion for all at-risk children
2) Enhanced follow-up to developmental screening supported by:

a) Development of a follow-up medical decision tree, including secondary follow-up, anchored to: i) ASQ scores, ii) Child and family factors, iii) Resources within the community

b) Parent education sheet to support shared decision making, care coordination support strategies

c) PacificSource summary of follow-up services

d) Pilot new methods for connection to mental health

Training on the new URF, standardized use and completion part of QI process, training & implementation supports

USE of the information EI provides back is part of the PCP QI process and supports for:

1) Children not able to be evaluated
2) Children ineligible
3) Children eligible

Early Intervention

1) Enhanced communication and coordination for children referred & not evaluated
2) Communication about evaluation results
   - For Ineligible Children: Communication Back to PCP to Inform Secondary Steps; If Applicable, Referral to Early Learning supports, Pilots of referral to CBH.
   - For Eligible Children: Communication about EI services being provided to inform secondary steps

NEW URF Supports Processes Related to Communication. Revisions informed by past project related to:

1) Children not able to be evaluated
   - Commination BEFORE case closed to PCP can outreach
   - Communication when not able evaluate

2) Children ineligible
   - You were already doing this, new work is how PCP is using info
   - Potential EI referral (future focus)

3) Children eligible and a summary PCPs will use better
   - New Summary of Service

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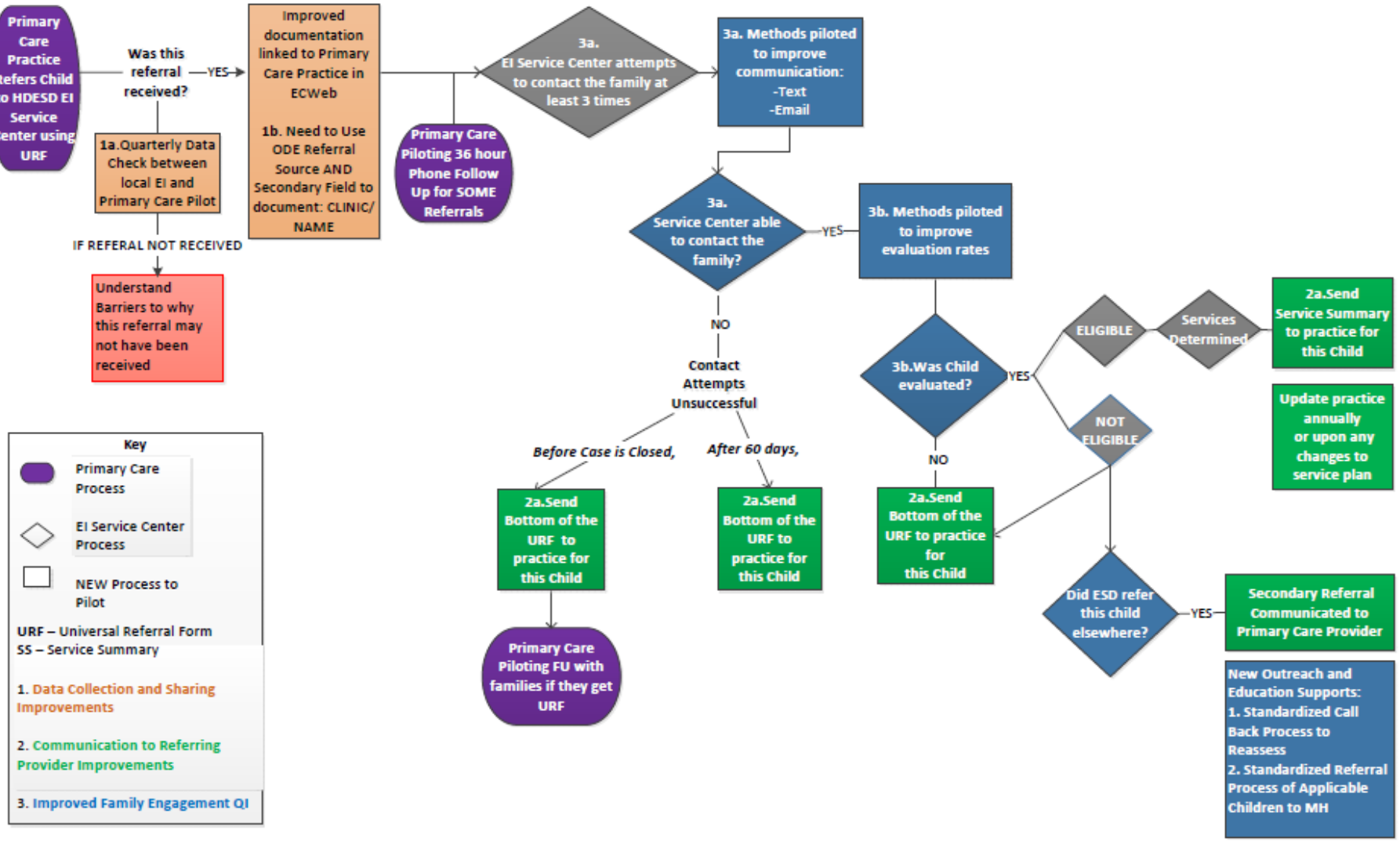
High level Improvement Workflows



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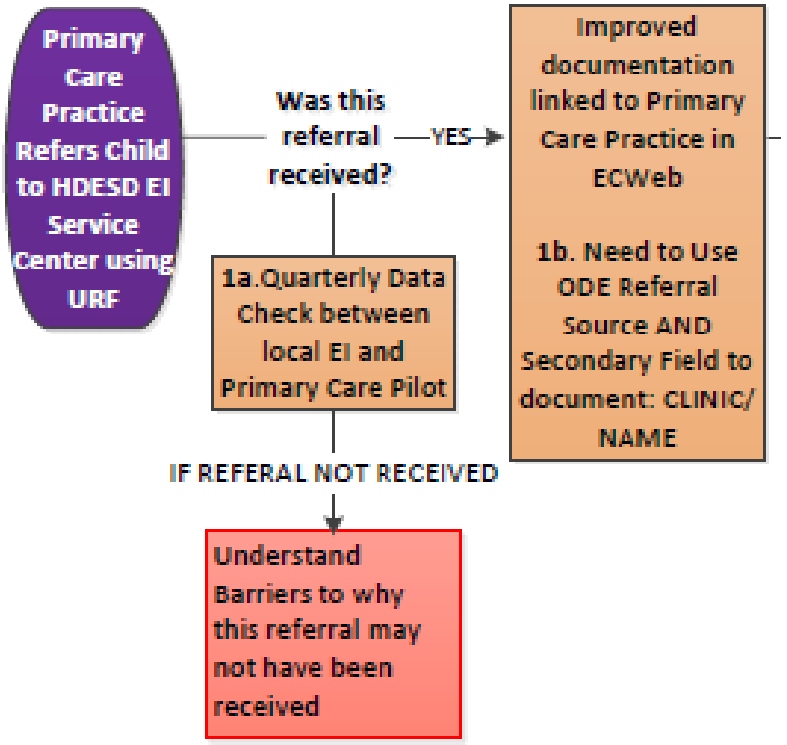
Improved Referral from PCP and Documentation



Working with *PRIMARY CARE PILOT* to improve the quality of the referral by:

- *Use the new URF*
- *Have documented ASQ domain scores*
- *FERPA signature*

Already started DATA IMPROVEMENTS with EI to document in ECWeb :

Linking Referral to Primary Care

Will Pilot Quarterly data validations to ensure all referrals were 'caught'

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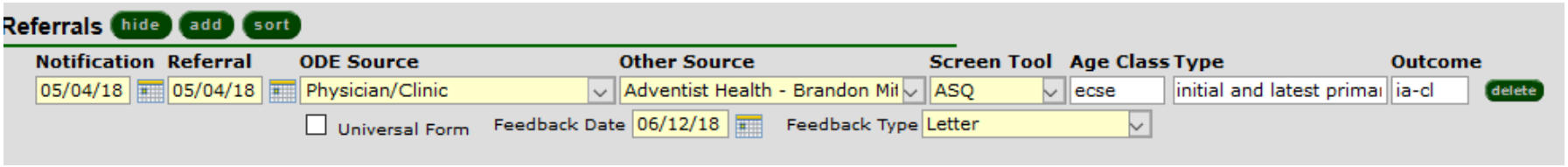
Improved Documentation Aligned with Pilots



DATA IMPROVEMENTS with EI to document in ECWeb :

- *Linking Referral to Primary Care (Site, Provider)*
- *Documentation of Use of Universal Referral Form*
- *Feedback Type*

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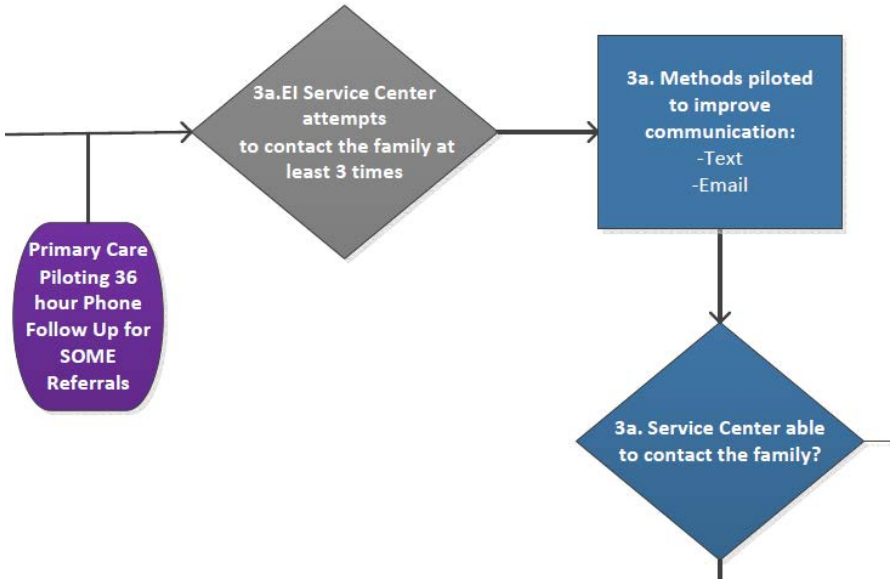
Improving Outreach in Primary Care and EI



Based on the literature, OPIP will be working with *PRIMARY CARE PILOTS* *to implement 36 hour phone follow ups for children referred to Early Intervention*

Will work with Pilot EI Sites to expand and improve upon outreach techniques based on changes to the URF

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Activity 3:
Improve Follow-Up in Early Intervention

Data Collection

- Analyzed another year of data – prior to primary care implementation
- Future Data Collection:
  - Child level file between primary care and EI to assess referral exchange process
  - Data will also help assess if medical decision tree increases eligibility

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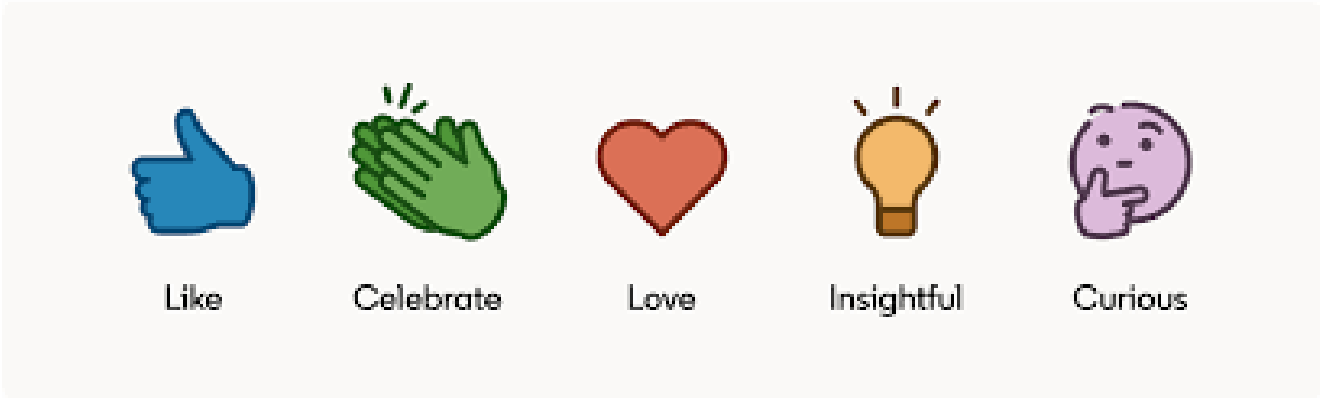

Early Intervention Reactions

- What has been the most impactful change since starting this project?
- What are some key successes and lessons learned to date?
- What are your biggest barriers?
- What are you most looking forward to as we continue our work together?

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Family Engagement

- How can we can ensure we get **parent input and parent guidance** on Early Intervention's project activities
  - Benefit of getting family feedback from people who have engaged in the process
- What avenues currently exist for which parents could be engaged or recruited, **share your ideas**

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Phase II Project-Level Activities

- Improve follow-up in **Primary Care Pilot (PCP) Sites (N=4)**
  - Two committed site (COPA, MOSAIC) who have been expecting implementation support
  - Recruit two additional sites
- Improve follow-up **pathways from PCP pilot sites to increase receipt of services**:
  - Improve **closed loop communication and coordination** in **Early Intervention** (All three counties and Confederated Tribe of Warm Springs)
- Address **Gaps in Pathways for PCP site** that focus on at-risk children needing:
  - Services that address **social-emotional delays**
  - **Medical and therapy *services*** *(Occupational Therapy, Physical Therapy, Speech)*
- Identify and confirm community-level priorities on **upstream** approaches that could build health and resilience (aimed to prevent delays): **Proactive Developmental Promotion & Preventive Behavioral Health for Socially Complex Children**

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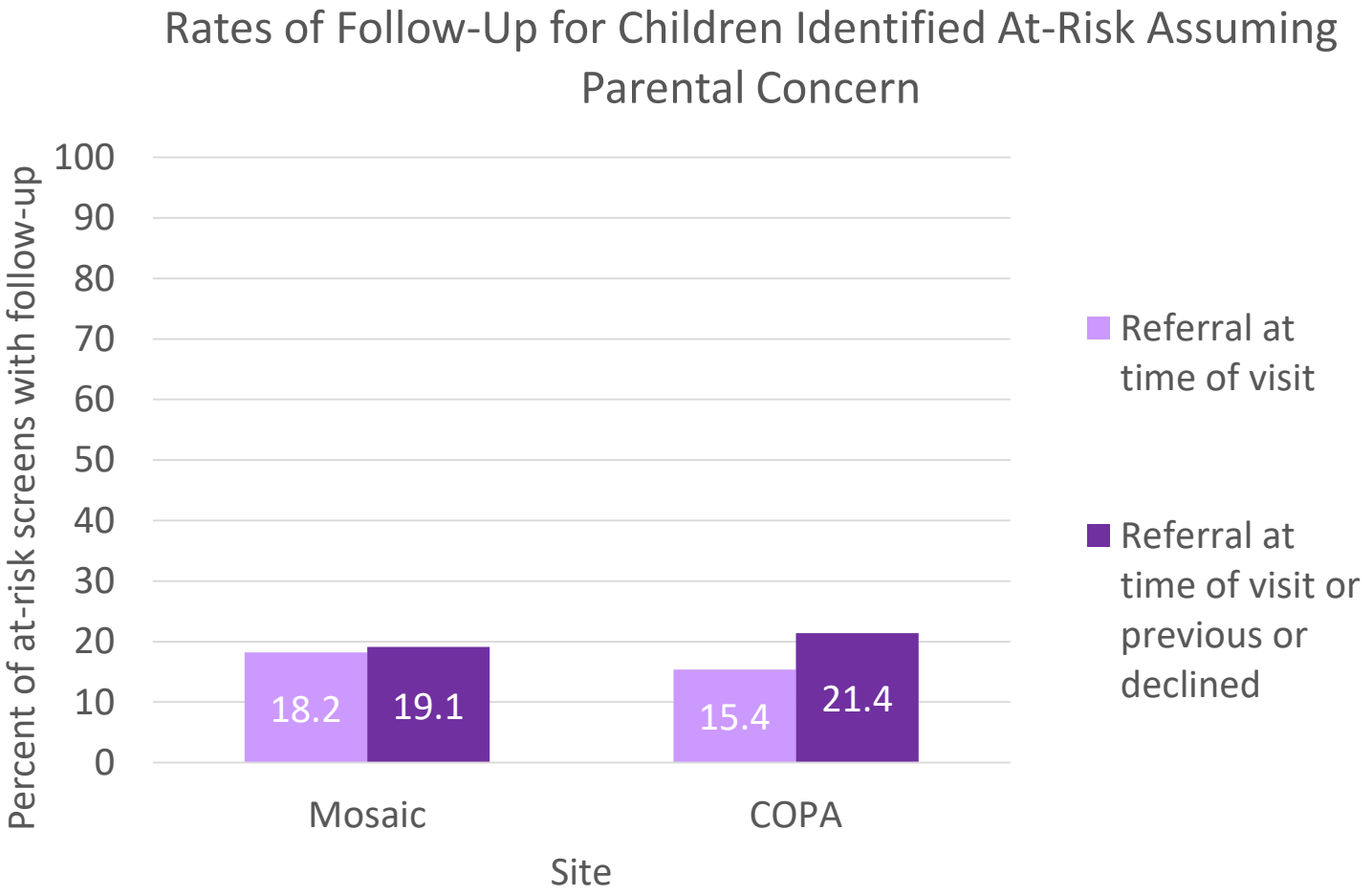
Overall Follow-Up to Developmental Screening Rates in Current Pilot Sites



Mosaic Data Source: Provided by Mosaic Data Team, November 2018. Data for screens (According to EMR Flowsheet) between 7/1/17 - 6/30/18 for children under three years. N=20 for bar 1 and N=21 for bar 2.

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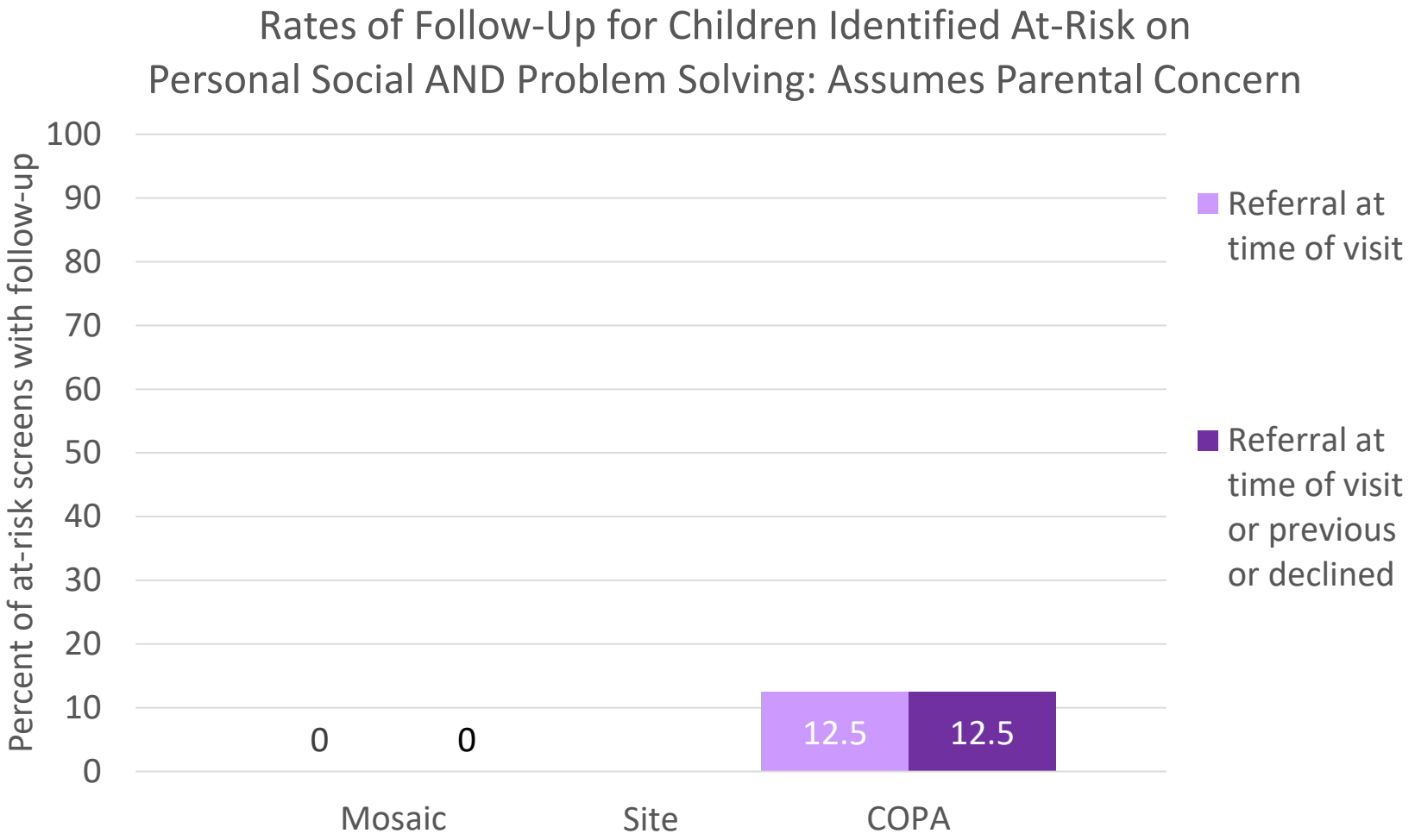
COPA Data Source: Provided by COPA Data Team, November 2018. Data for screens (According to EMR) between 7/1/17 - 6/30/18 for children under three years. N=72 for bar 1 and N=100 for bar 2.

Specific to Our Meeting Today: Follow-Up to Developmental Screening for Children with Social-Emotional Delays



Mosaic Data Source: Provided by Mosaic Data Team, November 2018. Data for screens (According to EMR Flowsheet) between 7/1/17 - 6/30/18 for children under three years. N=0 for both bar 1 and bar 2.

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COPA Data Source: Provided by COPA Data Team, November 2018. Data for screens (According to EMR) between 7/1/17 - 6/30/18 for children under three years. N=4 for both bar 1 and bar 2.

Specific Community-Level Feedback for Phase 2 Activities Focused on Pathways for Children with Social-Emotional Delays

1. **Within Pilot Primary Care Sites, Improve identification and internal follow-up**
2. **Identify behavioral health providers that serve 0-5**
   - Update asset map provided in Phase I, apply an Equity Lens
   - Address community concern about the current lack of providers or lack of capacity within existing providers, facilitate community-level conversation on gap in availability of services
3. **If there is capacity and opportunity, pilot improvement referrals from pilot primary care sites to external behavioral health providers.**
   - **Ensure that these pilots include tools and workflows for improved communication and coordination across service providers**
     - **Standardized processes** (agreements, tools, workflows)
     - **Two-way communication**, including whether the family made it to the referral, services provided (assessment results, service type and frequency)

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Within Pilot Primary Care Sites:

- Need for **training medical decision tree specific to social-emotional delays** and what are best match supports.
- Need for **training on what behavioral health services are for young children,** concern about whether there are people to refer to
- Need for **better and standardized processes** (work flows & tracking) around best match promotion and referrals (who, what, where, how) aligned with community-level assets
- Need for **specific strategies integrated behavioral health** can use with young children with social-emotional delays
- Need for **educational materials for parents** of children identified that encourage and facilitate shared decision making
- Need for **tools and strategies to engage families** in accessing the referrals

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Pathways for Children with Social-Emotional Delays within Primary Care Pilot Sites

- COPA, MOSAIC primary care providers trained on the **follow-up to developmental screening medical decision tree,** which includes a specific focus on children with social emotional delays
- January 22nd **Training of Internal Behavioral Staff in COPA & MOSAIC** in Early 2020 focused on:
  - Child development as it relates to social-emotional health and self-regulation and overview of clinical constructs meant to assess delays.
  - **Additional Assessments** related to social-emotional health, parental attachment, other factors that impact a child's social emotional health
  - **Brief Interventions**
- **Clinical expertise and review provided by** Andrew Riley Ph.D. Pediatric Clinical Psychologist who specializes in integrated behavioral health care

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January 22nd, 2020 Training

- ***Audience*:** Mosaic Medical Group staff who serve as the integrated behavioral health; St. Charles Behavioral Health Staff who are Co-Located in Central Oregon Pediatric Associates.
- ***Scope of Training:*** Ensure that the pilot primary care site behavioral health staff are able to conduct key follow-up steps for children identified via developmental screening on problem solving, personal social delays that will be referred to them based on the OPIP Medical Decision Tree.
- **Objectives:**

✓ To provide an overview of the children 0-3 who have been trained to be referred to the pilot primary care site behavioral health staff.

✓ To provide an overview of social-emotional development and why the indicators are flags of potential delays.

✓ To provide an overview of follow-up steps that pilot primary care site behavioral health staff can conduct to understand child and family needs and brief interventions.

✓ To provide an overview of children who may benefit from external mental health services.

✓ To provide an overview of currently available external mental health services in Central Oregon.

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✓ To provide an overview of future proposed training topics and obtain feedback.

Pathways for Children with Social-Emotional Delays within Primary Care Pilot Sites

- Refresher and "deep dive training" of the behavioral health pathways
  - Behaviors that are flags for social-emotional health, Screens beyond developmental screening that relate to social-emotional delays (maternal depression, M-CHAT)
  - Behavioral health services in the community and overview of the modalities and best match services
  - How to engage families in referrals
- Implementation Support
  - Within the practice
  - If pilots to behavioral health providers are identified. Could include:
    - ❖Referral forms
    - ❖Communication feedback loops

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Specific Community-Level Feedback for Phase 2 Activities Focused on Pathways for Children with Social-Emotional Delays

1. **Within Pilot Primary Care Sites, Improve identification and internal follow-up**
2. **Identify behavioral health providers that serve 0-5**
   - Update asset map provided in Phase I, apply an Equity Lens
   - Address community concern about the current lack of providers or lack of capacity within existing providers, facilitate community-level conversation on gap in availability of services
3. **If there is capacity and opportunity, pilot improvement referrals from pilot primary care sites to external behavioral health providers.**
   - **Ensure that these pilots include tools and workflows for improved communication and coordination across service providers**
     - Desire for better **two-way communication** with resources to which families are referred.
     - Need for **better and standardized processes** (agreements, tools, workflows)
     - Need for **timely communication** between service providers, including whether the family made it to the referral, services provided (assessment results, service type and frequency)

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Facilitation of conversations about current capacity of needed infant and early childhood mental health services, addressing gaps.

On **October 22nd** we convened a group of behavioral health stakeholders with the following objectives:

- To obtain a shared understanding of the **behavioral health services currently available** for young children (0-5), their **capacity** and the **implications for potential pilot activities**
- To understand **barriers to organizations addressing gaps** in available **behavioral health services** for young children (0-5)
- To facilitate a community-level conversation about potential options and opportunities to address gaps in **behavioral health services** for young children (0-5)

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Disclaimers of Asset Maps Created, Ongoing Work Needed

- **Anchored to the interviews and with a primary lens of the children that the pilot primary care practices served** AND input obtained at the **10/22 meeting of behavioral health providers**
- **Focus is specifically on services for young children**
  - Project is specific to **follow-up to developmental screening** for children 0-3 and delays identified on these global tools: Personal social & problem solving delays identified on ASQ
  - Work focused on **social emotional delays** can expand to be children 0 and up to 5 (before kindergarten)
    - Other flags and indicators seen within primary care pilot sites (*Behaviors observed and reported, Maternal Depression, MCHAT, Exposure to Aces)*
  - **Socially complex children** (Anchored to health complexity data) – May not be specific to pilot primary care sites

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Behavioral Health Services for 0-5: What Exists Now

- **Identified services** across the region.
  - Identified **WHO** can see children 0-3
  - Identified the **specific modalities** provided by the service providers given they impact who and what are best match services
- Understand **capacity of services**
- **Apply an equity lens**:
  - ✓Region
  - ✓Race –Ethnicity, Tribal Designation
  - ✓Languages spoken
  - ✓Payor

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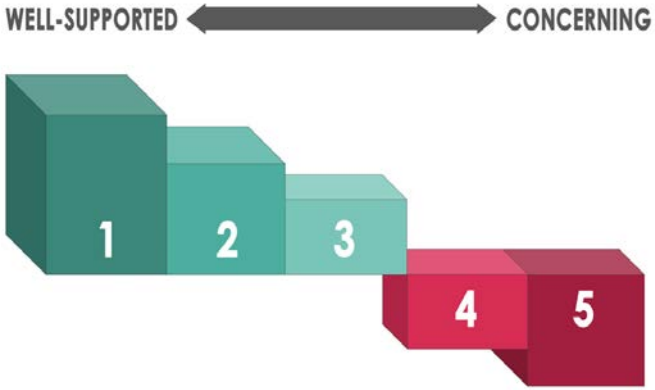
OPIP Examination of Behavioral Health Services for 0-5: Framework Used

- **Type of social-emotional delays or factors the service targets**
  - If the goal is to get kids in to the right "best match" services, what are the best services for specific factors the pilot sites and project will focus on
- **Delivery method**
  - Dyadic or group
  - Can be factor in consider options for spread or location of services
  - Can be factor in consider parent engagement
- **Scientific Rating - Evidence Base for Various Modalities:**



  - **Summarized services by those that are a level 1-3, but per community feedback documenting other services and openness to exploring services that may have less that Scientific Rating of 3 AND that community finds value**
  - **Resources: Various websites and summaries of services and clinical experts.**

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Framework Used for Assessing Modalities Focused on Population Focus for this Project

Version 8: November 26, 2019

Behavioral Health Services for Children Under Five with Social Emotional Delays

Selected Parent-Child Programs for Children Under 5 with a Scientific Rating of 1-3 Focused on (1) Positive parenting, (2) Effective limit setting and safe discipline, and (3)Child-parent relationship building

Therapy/Program Name	Delivery Method[1]	Age of Child	Scientific Rating
SERVICES TARGETED TO CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS			
Parent Child Interaction Therapy (PCIT)* ** PCIT is also an effective program for children with known trauma history*	Dyadic	1-7	1
Triple P (Positive Parenting Program)	Group	0-12	2
Generation-PMTO	Dyadic, Family & Group	2-18	1
Theraplay	Dyadic	0-18	3
Helping the Non-compliant Child	Dyadic	3-8	3
Collaborative Problem Solving	Family, Individual	3-21	2
Play Therapy	Family, Individual	3-12	3
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY			
Trauma Focused CBT	Dyadic	3-18	1
Child Parent Psychotherapy (CPP)	Dyadic	0-5	2
Eye Movement Desensitization and Reprocessing (EMDR)	Individual	2-17	1
Attachment Regulation and Competency (ARC)	Dyadic, Family, Individual	0-21	NR
SERVICES TARGETED TO CHILDREN WITH AT-RISK PARENTS/ FAMILIES			
Family Check-Up	Dyadic	2-17	1
Incredible Years* ** Incredible Years is also good for children with disruptive behavior problems*	Group	4-8	1
Attachment and Biobehavioral Catch-up (ABC)	Dyadic	0-2	1

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October – 2019 Developed by the Oregon Pediatric Improvement Partnership based on information derived from https://www.cebc4cw.org and consultation from Andrew Riley and Laurie Theodorou

Modalities Available in Central Oregon

Version 8: November 26, 2019

Anchored to OPIP's Framework of Services:
Behavioral Health Services for Children Under Five with Social Emotional Delays
In Central Oregon

The summary below is based on interviews OPIP has conducted with providers in the region June 2018-November 2019. Further information is still needed on services available in Warm Spring and in Polk County due to recent changes.
Overall, there are 35 providers, some are able to provide different modalities.

Therapy	Organization (s)	Number of Providers
SERVICES TARGETED TO CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS		
Parent Child Interaction Therapy (PCIT) ** PCIT is also an effective program for children with known trauma history*	Brightways, Cherie Skillings, Deschutes County, Starfish Counseling	10
Triple P (Positive Parenting Program)		0
Generation-PMTO		0
Theraplay	Treehouse Therapies	1
Helping the Non-compliant Child		0
Collaborative Problem Solving	Forever Family Therapy	4
Play Therapy	Deschutes County, Jefferson County Best Care, Starfish Counseling, Life Source	15
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY		
Trauma Focused CBT	Jefferson County BestCare, Treehouse Therapies, Rimrock Trails, Deschutes County, Brightways, Forever Family Therapy, Life Source Therapy	19**
Child Parent Psychotherapy (CPP)	Cherie Skillings	1
Eye Movement Desensitization and Reprocessing (EMDR)	Deschutes County, Starfish Counseling	14
Attachment Regulation and Competency (ARC)	Deschutes County	1
SERVICES TARGETED TO CHILDREN WITH AT-RISK PARENTS/ FAMILIES		
Family Check-Up		0
Incredible Years ** Incredible Years is also good for children with disruptive behavior problems*	Deschutes County	1
Attachment and Biobehavioral Catch-up (ABC)		0
OTHER SERVICES PROVIDED WITHIN THE COMMUNITY:		
Child and Family Marriage and Therapist Counseling	Jefferson County Best Care, Cherie Skillings, Deschutes County	16
Other Modalities without evidence base (Dance Therapy, Art Therapy, Equine Therapy, Baby Doll Circles)	Warm Springs*, Treehouse Therapies, Life Source Therapy	2

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**Counts need to be verified in follow, up interviews*
*** Individuals were trained but not certified*

Capacity of Current Providers Who See Young Children in Central Oregon

Draft Version 5.0 November 26, 2019	Current Assessment of Specialty Mental Health Providers Who See Children 0-5 in Central Oregon									
	Deschutes County	**Treehouse Therapies**	**Brightways Counseling**	**Cherie Skillings**	**Jefferson County BestCare**	**Rimrock Trails**	**Forever Family Therapy**	**Life Source Therapy**	**Starfish Counseling**	Identified at 10/22 Meeting, OPIP is currently setting up the follow-up interviews. - The Child Center - IHS Warm Springs - Lutheran Community Services - Youth Villages - Now and Zen
Location	**Deschutes**	**Deschutes**	**Deschutes**	**Deschutes**	**Jefferson**	**Deschutes & Crook**	**Deschutes**	**Deschutes**	**Deschutes**	
Number of Providers	**15**	**1**	**2**	**1**	**3**	**2**	**4**	**1**	**1**	
Current Case Load (per week)	**114***	**28**	**62**	**24**	*****	**50**	**40**	**30**	**25**	
Capacity to take on New referrals (# of families)	**25**	**5**	**8**	**12**	**20**	**25**	**16**	**Limited, but could be flexible**	**0**	

***OPIP needs to follow up to get this specific information**

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Applying an Equity Lens

Draft Version 5.0 November 26, 2019	Current Assessment of Specialty Mental Health Providers Who See Children 0-5 in Central Oregon									
	Deschutes County N=15	**Treehouse Therapies N=2**	**Brightways Counseling N=2**	**Cherie Skillings N=1**	**Jefferson County BestCare N=3**	**Rimrock Trails N=2**	**Forever Family Therapy N=4**	**Life Source Therapy N=1**	**Starfish Counseling N=1**	Identified at 10/22 Meeting, OPIP is currently setting up the follow-up interviews. - The Child Center - IHS Warm Springs - Lutheran Community Services - Youth Villages - Now and Zen
Location of Therapy										
Deschutes	**X** (6 in Redmond,6 in Bend, 3 in LaPine)	**X** (Bend)	**X** (Redmond)	**X** (Bend)		**X** (Bend)	**X** (Bend)	**X** (Redmond)	**X** (Bend)	
Crook						**X** (Prineville)				
Jefferson					**X** (Madras)					
Therapy Provider Race, Ethnicity or Tribal Affiliation	14 Identified as White (1 White/ Hisp, 1 Hispanic)	Identified as White	Identified as White	Identified as White	Identified as White	Identified as White	3 Identified as White, 1 as African American	Identified as White	Identified as White	
Therapy Provider Language Spoken	14 English only, 1 Spanish/ English	English	English	English	English	English	English	English	English	
Payor	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP Only	OHP/ Private	OHP/ Private	OHP/ Private	

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***OPIP needs to follow up to get this specific information**

Addressing the Gaps:
Staring Point Conversation Held on 10/22
About Opportunities and Options and Gathering Community-Level Input and Insight

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Hearing from Engaged Community Partners: Barriers and Solutions

Themes:

1. Workforce Capacity
2. Addressing Equity of Service Availability
3. Provider Perceptions and Perceived Personal Influencers
4. Family Engagement – Family Not Coming to Visit
5. Billing & Reimbursement

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Barriers and Solutions for Workforce Capacity: Example of Ideas Generated

Barriers	Solutions
• Lack of available workforce to hire with appropriate training • Requires unfunded time to train and certify staff before they can provide services and bill services • Various levels of requirements and costs • Some modalities require physical structures to be modified • Licensure requires time under supervision, barriers to availability of supervisors in the region • Lack of demand- Currently not flooded by referrals for services for children 0-5	• A State and community-level approach that supports capacity building • Right now community-level providers feels like the weight is on individuals in individual organizations • Priority placed on reviewing applications for behavioral health providers serving young children as part of contracting • Creative ways to leverage space to achieve PCIT • Creative thinking about the location where services are provided and family-centered access points (group-level courses, co-location models, others) • Go into colleges and identify the needs of the community and pair students with where they may be able to secure a job post-graduation

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Barriers and Solutions for Equity by Race, Ethnicity, Language, Region: Example of Ideas Generated

Barriers	Solutions

• Lack of work force to ensure equitable access by region, race/ethnicity, language
• Perception that for providers that identify as non-white that they will be tokenized in the workplace
• Difficulties with interpreters, especially over the phone and the ability to understand therapy nuances
	• Grant funding to support training and certification requirements, specific funding to address gaps in equity
	• Creative recruitment strategies for providers
	• "Grow your own" providers
	• Recruit members of the cultural community – not just those that speak the language
	• Creative ways to leverage local region-specific training programs, create a specific focus on specific populations
	• Utilizing interpreters during therapy sessions
	  ◦ In person provides the most cohesive session, but video or phone interpreters may be utilized
	  ◦ However the training of the interpreter may need to be specific for MH services

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Ideas/Options OPIP Brainstormed and Proposed Per the Conversation

Parameters We Used:

- **Existing providers** who noted a commitment to expanding services
- **Gap in services** that **target specific risk factors** relative to data on risk factors
- Gaps in **types of delivery method**s through which services are provided
- **Strategies that could address areas where we observe inequities**
- Training opportunities available, "**Lift" it would take to build provider capacity**
  - ✓ **Training requirements and locations**
  - ✓ **Education requirement**

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Ideas/Options OPIP Brainstormed and Proposed Per the Conversation

Current Providers Considering Expansions:

1. Treehouse Therapies: Planned Expansion
   - ❖ Intentional recruitment for evidence based therapies identified
   - ❖ Trauma focused CBT
   - ❖ Family Check- Up
2. Rimrock
   - ❖ Consider training for a therapist in dyadic based modalities for teen parents receiving services for themselves
3. Best Care for Kids: Consideration of 0-5 in future hiring, additional sites
4. All existing providers apply for grant to be trained on Generation PMTO

Consider grant funding to address equity gaps:

5. Consider Triple P- Community Based Intervention in Jefferson

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Need for Parent Input & Guidance

How we can ensure we get **parent input and parent guidance** on the project activities related to Social-Emotional Health?

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Phase II Project-Level Activities

- **I**mprove follow-up in **Primary Care Pilot (PCP) Sites (N=4)**
  - Two committed site (COPA, MOSAIC) who have been expecting implementation support
  - Recruit two additional sites
- Improve follow-up **pathways from PCP pilot sites to increase receipt of services**:
  - Improve **closed loop communication and coordination** in **Early Intervention** (All three counties and Confederated Tribe of Warm Springs)
- Address **Gaps in Pathways for PCP site** that focus on at-risk children needing:
  - Services that address **social-emotional delays**
  - **Medical and therapy *services*** *(Occupational Therapy, Physical Therapy, Speech)*
- Identify and confirm community-level priorities on **upstream** approaches that could build health and resilience (aimed to prevent delays): **Proactive Developmental Promotion & Preventive Behavioral Health for Socially Complex Children**

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Pathways from Primary Care to Medical and Therapy Services

1. **Provide Supports on Pathways to Developmental and Behavioral Health Pathway**
   - Deep dive of work with PEDAL referrals given primary care site feedback on confusion around pathway and process
2. **Update the Asset Map Developed in Phase 1, Apply an Equity Lens (Spring 2020)**
3. **Convene a meeting of medical and therapy providers (Spring or Summer 2020)**
   a) Review new HERC Coverage
   b) Review training to PCP Pilot

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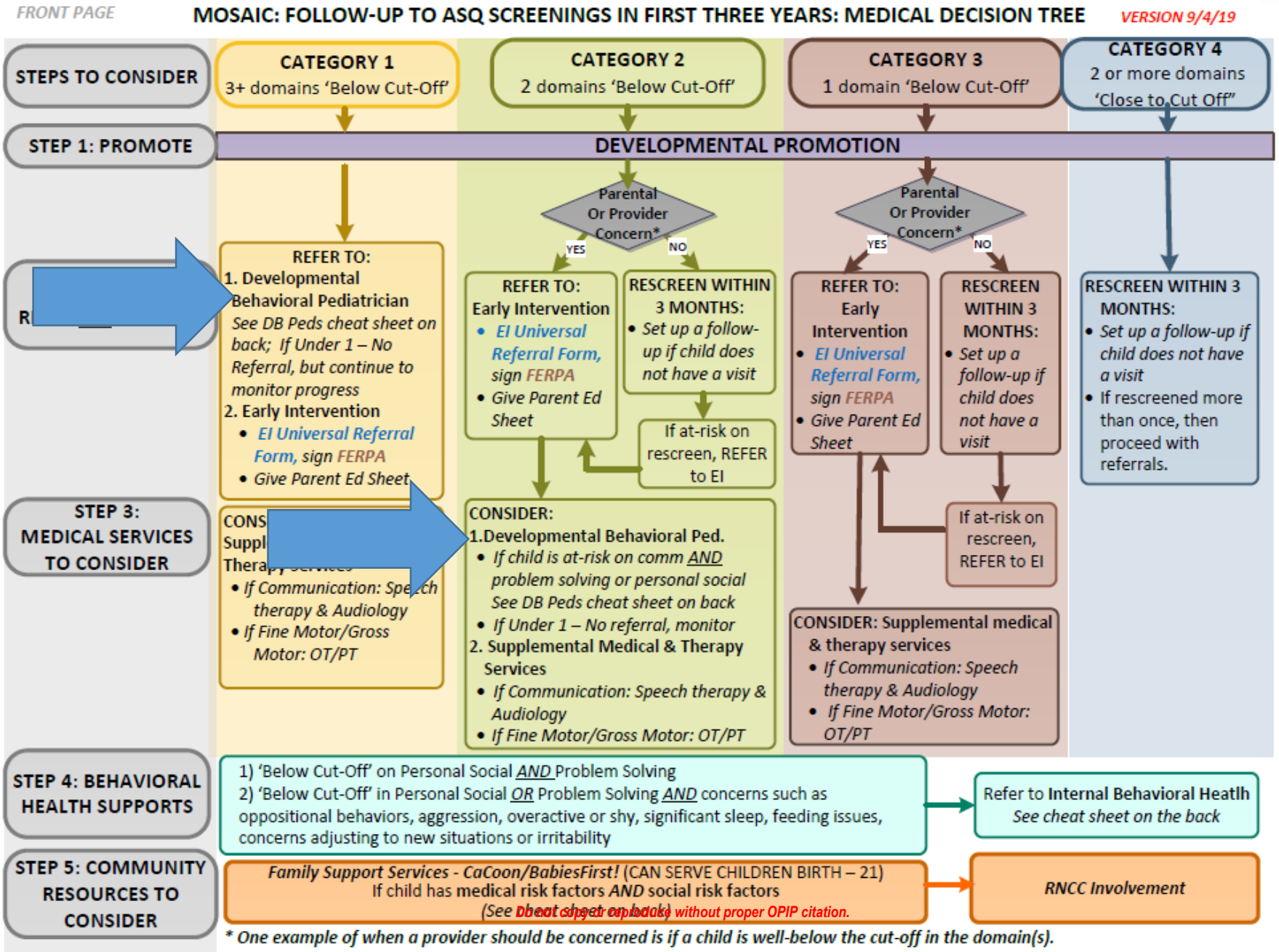
Follow-Up to Screening Decision Tree (FRONT)



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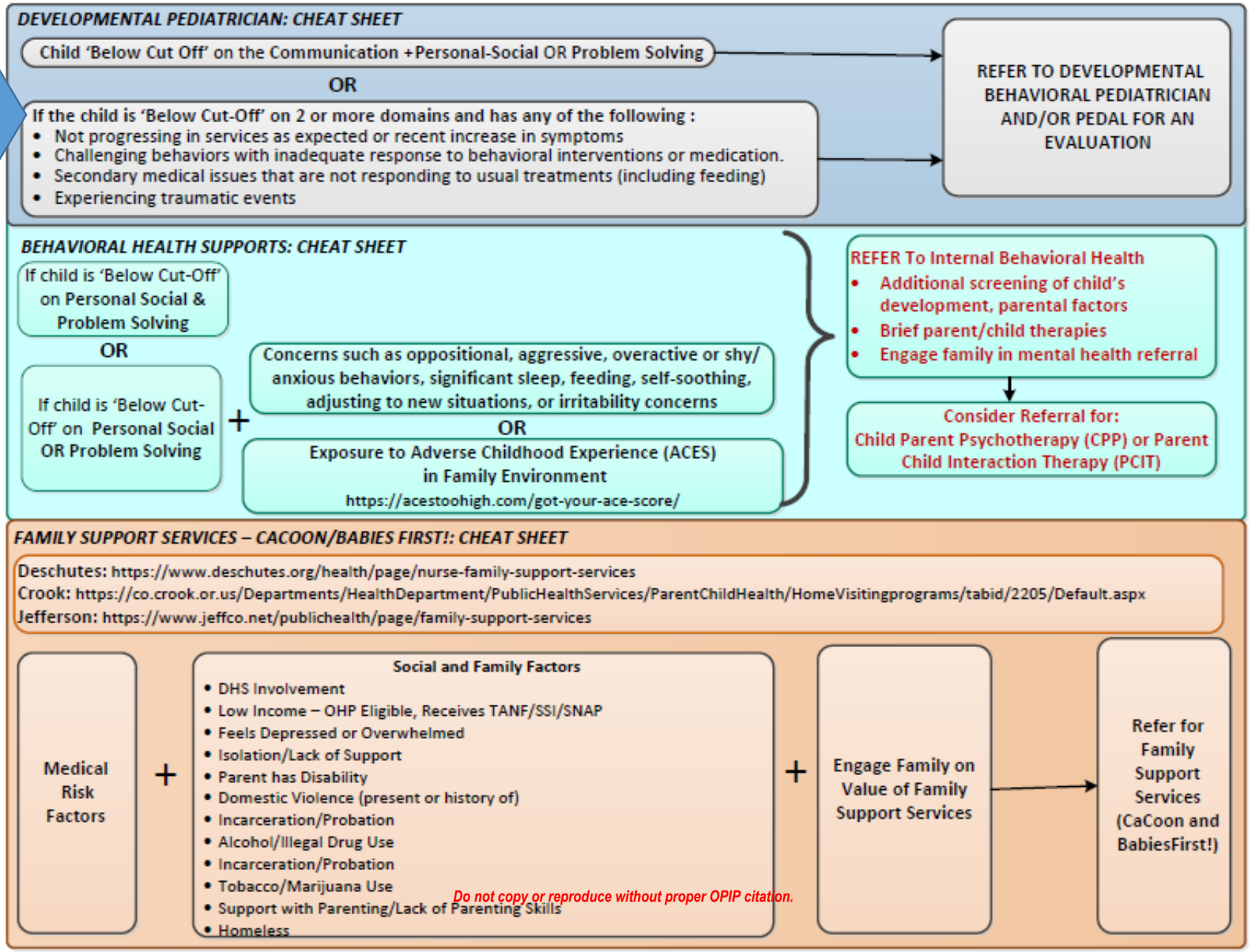
Follow-Up to Screening Decision Tree (BACK)

BACK PAGE



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Work with PEDAL Team

- **Meetings with PEDAL Leadership**
  - Referral flow and process
  - Developed a summary of baseline quantitative and qualitative information to guide and inform discussion about need for local Developmental and Behavioral Pediatrician
- **Meeting with Sondra & Jessica on referral pathways**
  - Understand referral process
  - Understand how OPIP could enhance our training and key factors/flags for referrals to PEDAL

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Key Learnings and Updates to Primary Care Materials and Training

- **Developmental and behavioral evaluation**
  - Improved language on Medical Decision Tree from Developmental Behavioral Pediatrician to a Developmental Evaluation
  - Triage process based on risk factors, use of services, and balancing limited availability and slots for full team evaluation
  - First evaluation often does not include a developmental and behavioral pediatrician
- **Updates to Primary Care Tools**
  - Update asset map – all referrals to PEDAL
  - Training on factors to consider for referral
  - Enhanced provision of information at time of referral (services already receiving, risk factors)

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Phase II Project-Level Activities

- Improve follow-up in **Primary Care Pilot (PCP) Sites (N=4)**
  - Two committed site (COPA, MOSAIC) who have been expecting implementation support
  - Recruit two additional sites
- Improve follow-up **pathways from PCP pilot sites to increase receipt of services**:
  - Improve **closed loop communication and coordination** in **Early Intervention** (All three counties and Confederated Tribe of Warm Springs)
- Address **Gaps in Pathways for PCP site** that focus on at-risk children needing:
  - Services that address **social-emotional delays**
  - **Medical and therapy *services*** *(Occupational Therapy, Physical Therapy, Speech)*
- Identify and confirm community-level priorities on **upstream** approaches that could build health and resilience (aimed to prevent delays): **Proactive Developmental Promotion & Preventive Behavioral Health for Socially Complex Children**

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Social Complexity for Children age 0-5: Pacific Source of Central Oregon

Children 0-5 (N=5,519)	Child Factor	Parent Factor
Poverty –TANF (For Child and For Either/Both Parent)	**26.3%** (1,450)	**31.7%** (1,747)
Foster care – Child received foster care services	**5.2%** (286)	
Parent death – Death of parent/primary caregiver in OR		**0.8%** (42)
Parental incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon		**18.7%** (1,034)
Mental Health: Child – Received mental health services through DHS/OHA	**10.2%** (565)	
Mental Health: Parent – Received mental health services through DHS/OHA		**42.3%** (2,334)
Substance Abuse: Child – Substance abuse treatment through DHS/OHA	**Data Suppressed: Less than 10**	
Substance Abuse: Parent – Substance abuse treatment through DHS/OHA		**22.5%** (1,240)
Child abuse/neglect: ICD-9, ICD-10 dx codes related used by provider	**6.1%** (339)	
Potential Language Barrier: Language other than English listed in the primary language field		**10.2%** (562)
Parent Disability: Parent is eligible for Medicaid due to recognized disability		**3.4%** (185)

One in three (29.7%) children 0-5 had **3 or more** social complexity factors.

Population: Children in sample Medicaid/CHIP insured in Pacific Source of Central Oregon as of August 2019.

Data Source: ICS and Medicaid /CHIP data sourced from Medicaid Management Information System (MMIS)

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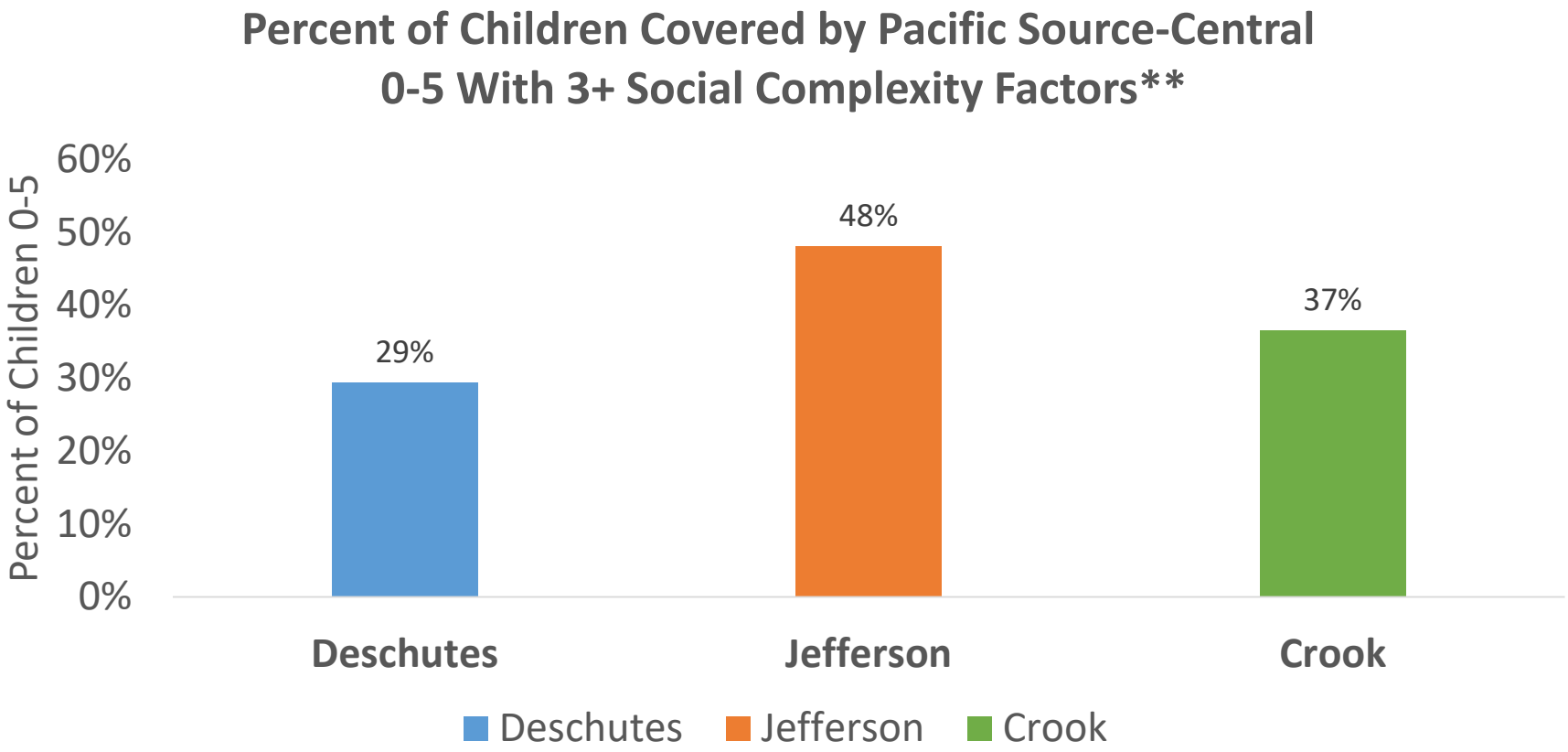
Applying the Equity Lens:
Region Specific Health Complexity Data
March 2019 Reports



**Based on OHA Transformation Center Health Complexity Data, which only takes into account publicly insured children, and does not quantify Warm Springs as a separate region.

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https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Child-Health-Complexity-Data.aspx

Social Complexity for Children Age 0-5: By Region

Note: Due to reporting rules from DHS Integrated Client Services, populations with low counts (n ≤ 10) are masked and reported as NA.

Indicator	Deschutes County N=5,888		Jefferson County N=1,433		Crook County N=970	
	Child Factor	Parent Factor	Child Factor	Parent Factor	Child Factor	Parent Factor
Poverty –TANF (For Child and For Either/Both Parent), Below 37% of Poverty Level (ICS, data available 2000-2017)	**20.4%** (1,199)	**23.9%** (1,408)	**40.6%** (582)	**46.8%** (671)	**28.7%** (278)	**35.1%** (340)
Foster care – Child received foster care services (ICS, data available 2000-2017)	**4.4%** (259)		**9.6%** (137)		**5.3%** (51)	
Parent death – Death of parent/primary caregiver in OR (ICS-Death Certificate in Oregon, data available 1989-2017)		**0.6%** (36)		**1.2%** (17)		**1.1 %** (11)
Parental incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon (ICS Dept. of Corrections for state felony charges, not including county/municipal charges, data available 2000-2017)		**15.1%** (888)		**21.6%** (310)		**18.5%** (179)
Mental Health: Child – Received mental health services through DHS/OHA (ICS-NMH caseloads, data available 2000-2017)	**10.3%** (605)		**8.2%** (117)		**6.9%** (67)	
Mental Health: Parent – Received mental health services through DHS/OHA (ICS-NMH caseloads, data available 2000-2017)		**36.4%** (2,144)		**45.4%** (651)		**42.8%** (415)
Substance Abuse: Child – Substance abuse treatment through DHS/OHA (ICS-AD Caseloads, data available 2000-2018)	Data blocked		**Data blocked**		**Data Blocked**	
Substance Abuse: Parent – Substance abuse treatment through DHS/OHA (ICS-AD Caseloads, data available 2000-2018)		**18.1%** (1,064)		**31.0%** (444)		**24.8 %** (241)
Child abuse/neglect: ICD-9, ICD-10 dx codes related used by provider (OHA Medicaid Claims Data, data available 2002-2017)	**5.1%** (298)		**7.0%** (101)		**5.8%** (56)	
Potential Language Barrier: Language other than English listed in the primary language field (OHA Medicaid enrollment, most current data for family)		**8.8%** (519)		**10.1%** (145)		**5.6%** (54)
Parent Disability: Parent is eligible for Medicaid due to recognized disability (OHA Medicaid Enrollment, data available 2002-2019)		**2.5%** (146)		**3.5%** (50)		**5.1%** (49)

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Population: Children in sample Medicaid/CHIP insured in Jefferson, Deschutes, or Crook County as of August 2019.
Data Source: ICS and Medicaid /CHIP data sourced from Medicaid Management Information System (MMIS)

Proactive Developmental Promotion & Preventive Behavioral Health for High-Risk Children

Starting Point Proposal of Components of This Track of Activity

- **Engage key community level partners in coordination with CCO leaders** to **identify specific populations of children** with high social complexity would be focus of this effort.
  - This could include children with high social complexity indicators on the health complexity data, children whose parents had accessed substance use services, and/or children whose parents have mental health issues, including maternal depression.
- In collaboration with these stakeholders, **identify potential pathways** and **proactive developmental and behavioral health** supports that may be valuable.
- In collaboration with these stakeholders, **develop strategies** by which **behavioral and developmental promotion touches** could be provided and referral points to behavioral health supports.
- **Work collaboratively with the AIC efforts** to identify if there are resources to address this pathway or if there are capacity and workforce barriers that need to be addressed within those and the CCO-level efforts.

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Proactive Developmental Promotion & Preventive Behavioral Health for High-Risk Children

Progress since our last gathering

- Met with Pacific Source leadership on October 10th to discuss health complexity data at large and specific opportunities for populations that may be of focus.
  - Kate Wells; Mike Franz; Alison Little; Jeanette Simms; Sarah Kingston; Anna Hsu-Rincon; Mark Hanus; Emma Littlejohn.
- Meeting with individuals from the TRACES Central Oregon (Trauma Resilience and Adverse Childhood Experiences) group to begin discussing **community engagement in resiliency and trauma-informed care**.
  - Discussed potential opportunity to present to the work group focused on foster care and prevention of foster care.

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Proactive Developmental Promotion & Preventive Behavioral Health for High-Risk Children

Some Ideas That Have been Generated:

a) Data Analytic Request

- ✓ Data on the number of children, overall and by region, who have the following three risk factors: parent incarceration, parental substance abuse, parent mental health
- ✓Potential request of a blinded flag of whether the child has one of the three (If feasible)

b) Engagement of providers of the adult services and inquiry of whether interest in proactive pathways for their children

1. Adult substance abuse providers
2. Providers of adults with serious and persistent mental illness

c) Given health complexity, value of target pilot in Jefferson County

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Proactive Developmental Promotion & Preventive Behavioral Health for High-Risk Children

If our goal is to **identify potential pathways** and **proactive developmental and behavioral health** supports that may be valuable. We need to:

1. Identify which socially complex children we may target assessments
2. Engage families on their experiences and their proposed solutions
3. Understand WHAT **behavioral and developmental promotion touches** could be provided and pathways to those services
4. Engage potential communities and pilot site

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Given Goals and In Scope Opportunities: What Areas Would You Prioritize and Why

Children 0-5 (N=5,519)	Child Factor	Parent Factor
Poverty –TANF (For Child and For Either/Both Parent)	**26.3%** (1,450)	**31.7%** (1,747)
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Data Source: ICS and Medicaid /CHIP data sourced from Medicaid Management Information System (MMIS)

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Need for Parent Input & Guidance

How we can ensure we get **parent input and parent guidance** on building health and resilience for socially complex children?

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Looking Forward – Summary of Next Steps

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Summary of Priority Next Steps

1) Specific Work and Follow-Up Steps for each of the activity areas:

a) Improve follow-up in **Primary Care Pilot (PCP) Sites (N=4)**

b) Improve **closed loop communication and coordination** in **Early Intervention** (All three counties and Confederated Tribe of Warm Springs)

c) Address **Gaps in Pathways for PCP site** that focus on at-risk children needing:

- Services that address **social-emotional delays**
- **Medical and therapy *services*** *(Occupational Therapy, Physical Therapy, Speech)*

d) Support **upstream** approaches that could build health and resilience (aimed to prevent delays): **Proactive Developmental Promotion & Preventive Behavioral Health for Socially Complex Children**

2) Late Spring/Early Summer 2020 Meeting

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Questions? Want to Provide Input? You Are Key to the Meaningfulness of This Work To This Community

- Door is always open!
- Hub Lead
  - Brenda Comini: brenda.comini@hdesd.org
  - 541-693-5784 (office)
- OPIP Contract Lead
  - Colleen Reuland: reulandc@ohsu.edu
  - 503-494-0456

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Leveraging the Health Complexity Model to Inform Oregon Approach to the Integrated Care for Kids (InCK) Cooperative Agreement Application

- Focuses **integrated, family-centered care coordination** for publicly insured children across **physical, behavioral, and other local service providers.**
- Focus on **multi-generational and dyadic approaches** to care
- InCK Goals to target reductions in
  1. Out of home placements
  2. Costs for prolonged hospital stays or multiple readmissions
- **Core Elements of InCK Model and Oregon Approach**
  - **Leverage Health Complexity data** to identify children who may benefit from enhanced care coordination and community connection ("risk stratification")
  - Implement **child-level needs assessments** to better identify health and care coordination needs
  - Provide training and disseminate **best practices for care coordination**, including a focus on culturally and linguistically responsive care
  - Hire **Service Integration Coordinator** and **enhance health information exchange** capability in reach region
  - Develop and implement **value-based payment (VBP)** models in alignment with CCO 2.0

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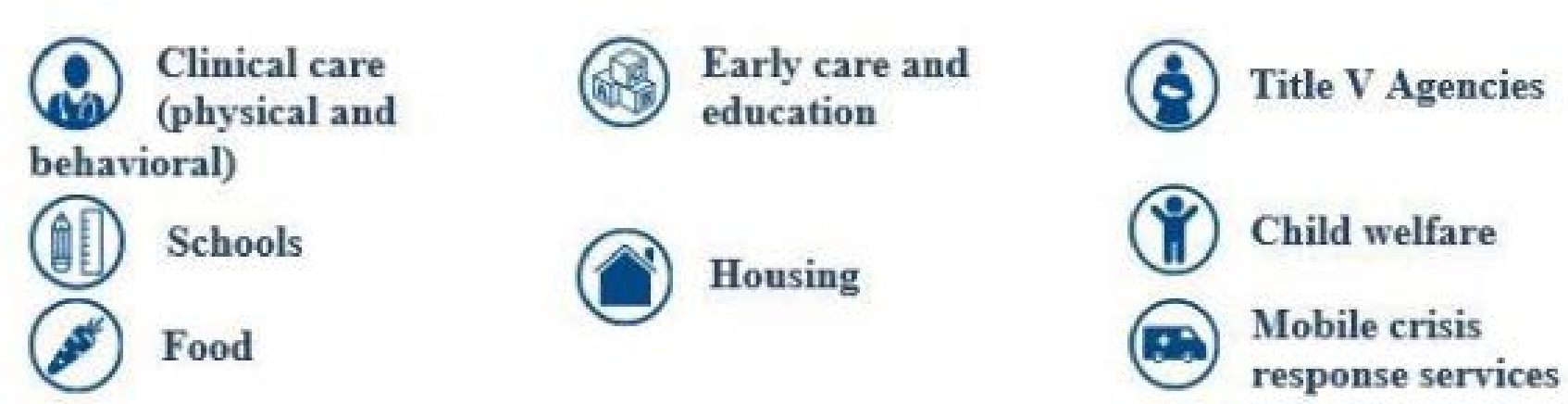
Leveraging the Health Complexity Model to Inform Oregon Approach to the Integrated Care for Kids (InCK) Cooperative Agreement Application

- OPIP, as Lead Organization, convene Regional Partnership Councils in each region.
- Comprised of key local child service representatives with an integral role in service delivery, care coordination and case management.



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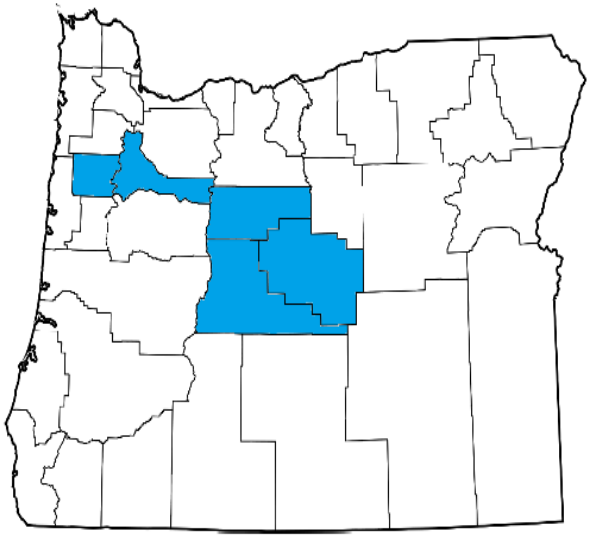
Proposed InCK Model Areas

OHA will propose the two following regions for Oregon's InCK model over the next seven years including: Marion/Polk counties, and Crook/Deschutes/Jefferson counties. The targeted population for this application will include all publicly insured children and youth ages 0-21 in these regions, with a strong focus on integrated, family-centered care coordination across physical behavioral health and other local service providers as well as multi-generational/dyadic approaches to care.



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