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

Spring 2020 Stakeholder Meeting

5/18/2020

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

OPIP
Oregon Pediatric Improvement Partnership

Meeting Objectives:

- To provide **updates on key activities** conducted since the last stakeholder meeting, learnings and implications for next steps
- To provide an **overview of Integrated Care for Kids (InCK) cooperative agreement** and **synergistic** areas related to young children

Agenda

- **Welcome**
- **50,000 Foot View** – Background & Context on the Pathways Project Goals & Activities
- **Brief Updates on Project-Level Activities Conducted Since the Last Meeting**
- **Overview of Integrated Care for Kids (InCK) Cooperative Agreement**
- **Q & A**
- **Next Steps: Next Stakeholder meeting**

Remote Meetings are Hard!

- Requests for engagement of those on the call
  - If you have question, comments or ideas please ask your questions using the chat box.
  - In between each section we will pause to review questions asked.
  - We will also call on folks to get their perspective
- We can do hard things!

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 1st 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 1st 2019 - May 31st 2021*): **Implement pilots meant to improve Follow-up for Children Identified at Risk and to Support Addressing Gaps in Pathways and Capacity**

Phase II Project-Level Activities

- Improve follow-up in **Primary Care Pilot (PCP) Sites (N=4)**
  - Two committed sites (COPA, MOSAIC) who have been expecting implementation support
  - Recruit two additional sites (Madras Medical Group & St. Charles Prineville)
- 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 sites** that focus on at-risk children needing:
  - Services that address **social-emotional delays**
  - **Medical and therapy services** *(Developmental Evaluation, 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**

Acknowledgement of COVID-19 Response

- We honor and recognize priority for many organizations and partners has been on COVID-19 response.
- We also recognize that COVID-19 response has also greatly impacted your ability to see children and provide the services you know that they need.
- Given these impacts and the differential impact of COVID-19 response on **young and vulnerable children**, we are even more dedicated to the goals and supports that are in this project to:
  - **Identify** children with developmental, behavioral and social delays
  - **Provide best match follow-up** services that often are dyadic in nature, supporting the relationship between the parent and the child
  - **Connect children** to community-based services
  - Support **cross-sector collaboration** and communication
  - Consider **upstream approaches** to provide preventive behavioral health

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- **Overview of Integrated Care for Kids Cooperative Agreement**
- **Q & A and Next Steps: Next Stakeholder meeting**

Project Activities

Detailed Updates on Project Activities

1. Primary Care Pilot Sites
2. Early Intervention – Improving Closed Loop Communication
3. Pathways for Children with Social-Emotional Delays (Behavioral Health for Young Children)
4. Pathways for Children Needing Medical and Therapy Services
5. Building Health and Resilience for Children with High Social Complexity – Identify Community-Level Priorities

Activities Since December 2019 Stakeholder Meeting
Pilot Primary Care Sites

Pre-COVID-19 Response
January-Mid March

COPA/Mosaic

- January training of the integrated behavioral health staff on assessments, brief interventions, and referral pathways for children with social-emotional delays
- Monthly site visits to support implementation on priority areas identified
- Data collection for January-March to assess implementation

Madras Medical Group (MMG)/
St. Charles Prineville Family Medicine

- Onboarding
- Baseline data collection (MMG)
- Development of trainings scheduled for April (MMG)

During COVID-19 Response
Mid March-Mid-May

COPA/Mosaic

- Modified operations.
- Completed COVID-Response survey Check ins on implementation issues as they arise
- Pause on data collection given modified operations
- Support on virtual well-child visits & developmental screening

MMG

- Monthly site visits. Completed COVID-Response survey provided by OPIP
- Training rescheduled to end of May

St. Charles Prineville Family Medicine

- Baseline data collection
- Summer training planned

Pre-COVID-19 Response
January-Mid March Focus in COPA & Mosaic

Quality Improvement Opportunities Identified for sites to focus on:

1. **Engagement of families** and **use of the parent shared decision making sheet on best match follow-up**
2. Pathway to a **Developmental Behavioral Evaluation** for children with 3 or more domains in the black, Clarifications on process for referral to PEDAL (Facilitation of PEDAL described later)
3. Pathway to **Early Intervention Evaluation**, Use of Universal Referral Form, Use of communication received back

QI Focus on Documentation in EHR for Monitor & Tracking Purposes

1. Focus on use and documentation of **developmental promotion** within the visit
2. 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

Welcome to
Madras Medical Group and St. Charles Prineville

Activities within Madras Medical Group & St. Charles - Prineville

- **Onboarding assessments completed**
  - Within the assessment we ask about:
    - ✓Current experience with referral sources in our medical decision tree
    - ✓Referral patterns to entities
- **Baseline Data Collected**
  - Madras Medical Group: Completed
  - St. Charles Prineville: In Progress
- **Planned Initial Trainings**
  - Madras Medical Group – End of May 2020 (reschedule of the April training)
  - St. Charles Prineville – Late Summer 2020

Pilot Sites COVID Response and Implications to Work

OPIP conducted a brief survey to assess the impacts of COVID on our primary care pilot sites

Of the 3 sites that have responded:

- All saw a **significant <u>decrease in patient volumes</u>**
- Expressed concerns about **patients who cannot access virtual care** due to lack of internet or capable computers
- Expressed **rising family and economic concerns** among patients <u>AND</u> staff

Pilot Sites' COVID Response and Implications to Work

- Starting in mid-March, due to the uncertainty of COVID-19, ***some pilot sites adjusted availability of well-visit care***
  - If sites are not doing well-visits for young children, sites miss the opportunity to conduct a developmental screen
  - Barriers to developmental screening when visit is virtual
  - Barriers to follow-up if follow-up service is closed
- Even when sites maintained access to well-visits, they saw a ***significant reduction in maintained appointments*** – some as high as 45%
- Since this project is focused on developmental screening to services – we adjusted our areas of quality improvement and facilitation
  - Focused on ***distilling how local resources*** within our medical decision tree were ***adapting in their COVID response*** – which would inform referrals IF children were seen

Hearing from Stakeholder Group

- What **questions** do you have about what we presented?
- What **did you hear** that is exciting relative to the goal of the project to improve best-match follow-up?

Project Activities

Detailed Updates on Project Activities

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Activities Since December 2019 Stakeholder Meeting
Early Intervention

Pre-COVID-19 Response
January-Mid March

- Obtain EI data from EC Web on referrals overall, from pilot sites
- Obtain data from primary care sites about referrals documented in the chart as made to EI and provision of child-level data file to understand outcomes.
- Facilitation and quality improvement support to some of the front-line intake and evaluation providers on communication and document for:
  1. Children referred & not evaluated
  2. For Ineligible Children: Bottom of Universal Referral Form
  3. For Eligible Children: Service Summary

During COVID-19 Response
Mid March-Mid-May

- Meeting with Diane to review HDESD data and implications for QI work with practices
- Meetings to understand and clarify COVID-19 response and implications for our communication and coaching to the pilot primary care sites
- Provision of updated information about EI referrals to pilot primary care sites.
- Modification of training slides to incorporate information about modified operations.

Analysis and Sharing of Data Received by HSESD:

Analysis and Sharing of Data Received by HSESD (Based on EcWeb):

1. Baseline: ’16-’17 SY, ’17-’18 SY (Analyzed, Presented at Meeting)
2. Collection **# 2**: ’18-’19 SY & Collection **#3**: 7/1/19 – 9/30/19
   - Analyzed and provided back to HDESD
   - That said, data is from a time period before the interventions with primary care sites was implemented (primary goal of now analyzing the data)
3. Collection **#4**: 10/1/19 – 12/31/19
   - Show highlights to day, But this data is very preliminary to pilot
   - Game plan for using data with pilot site and EI facilitation
4. **Collection #4**: 1/1/20-4/30/20 (Received 5/13, Present at Next Mtg)
5. Practice-level data on children they documented a referred to EI and EcWeb referral outcomes (In Process, Present at Next Mtg)

Preliminary Data Evaluating Impact of Pilot Site Training

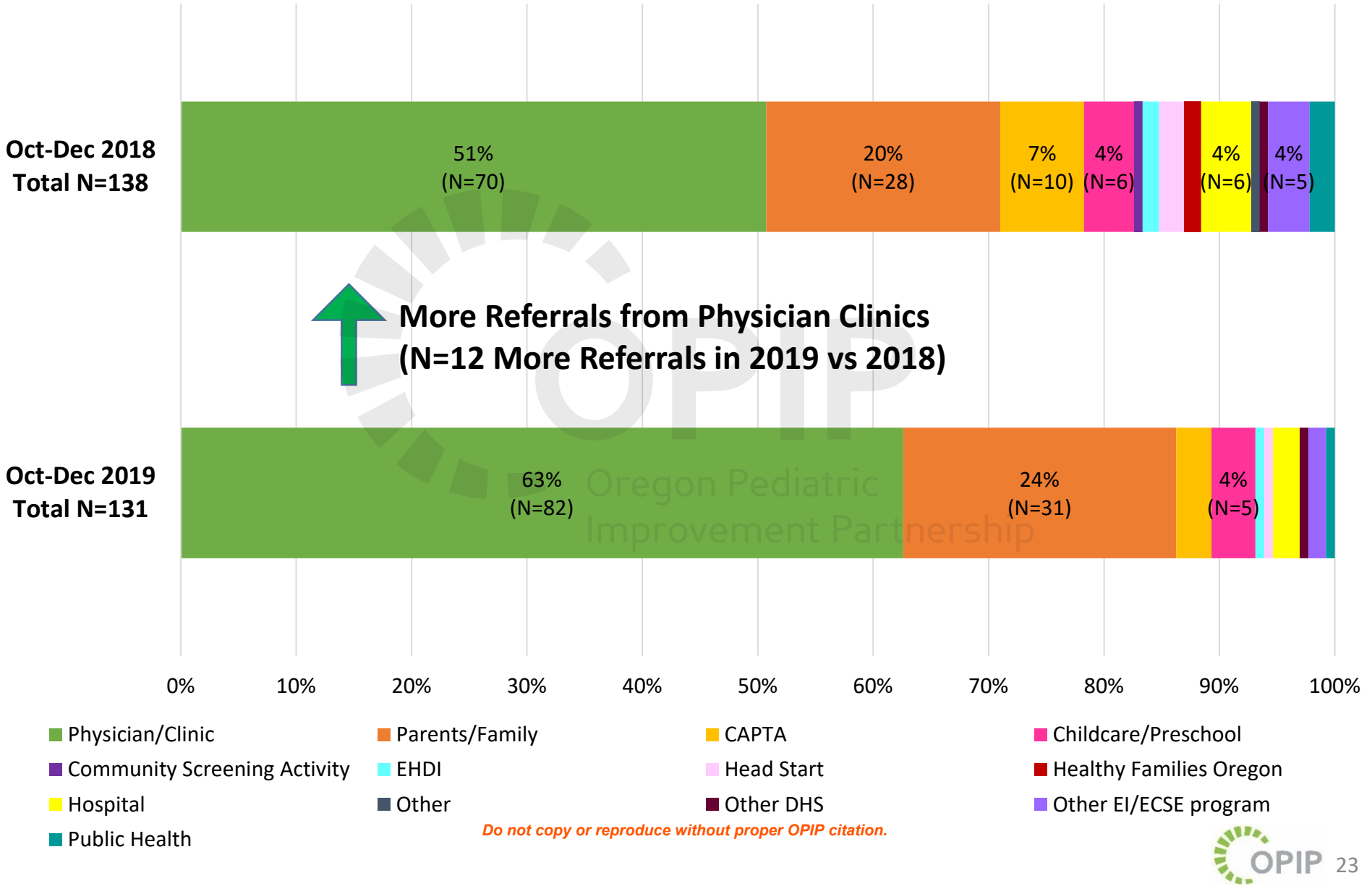
- Trainings of the pilot primary care sites was in June (for COPA) and September (for Mosaic).
  - Therefore, we are examining data from 10/1/19 – 12/31/19
  - To assess if there is a difference, comparing to 10/1/18 – 12/31/18
  - Analysis specific to physician/clinic referrals
- Therefore, don't expect to see full changes in behavior, it takes time for full implementation
  - ✓ Very normal to see variations in uptake – VERY normal to see slow at first and then it increases
  - ✓ Value of ongoing data collection that periodically gathered and used as part of the facilitation efforts
- Facilitation supports: Use the data to guide and inform
  - ✓ Monthly calls with the sites
  - ✓ Calls with EI intake and evaluation sites

Preliminary EI Data Evaluating Impact of Pilot Site Training

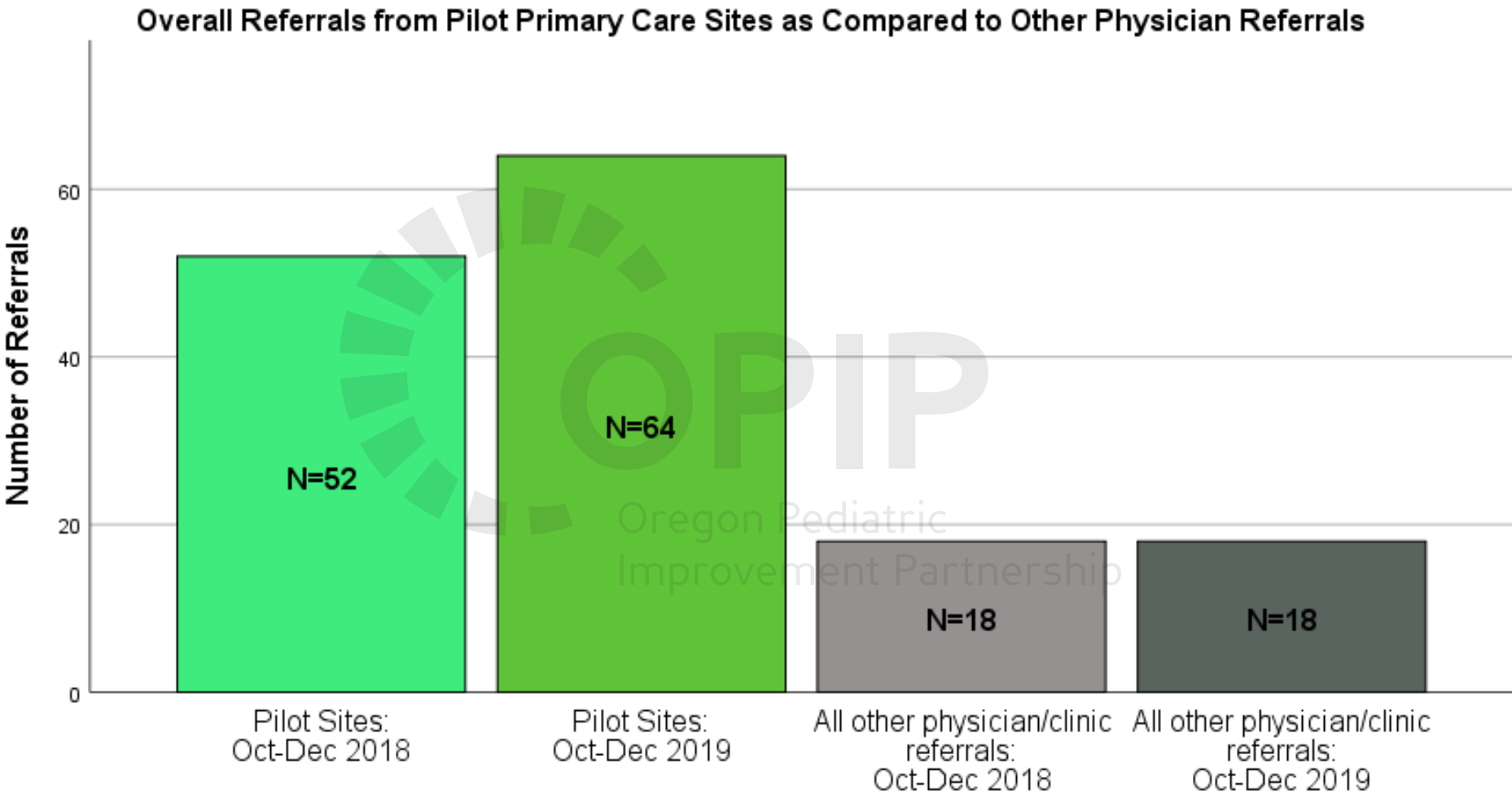
Factors we are examining to assess impact of the improvement efforts on the pilot sites:

- Numbers of Referrals
  - **Goal** of the project is to **increase best match referrals.**
    - ✓ Therefore, we may not overall increase referrals, we want to increase GOOD referrals
    - ✓ That said, in both of the current pilot sites, there was an identified **need to increase referrals to EI.**
- Number of Referrals Able to be Contacted AND Evaluated
  - **Goal** of the project is to increase referrals from the pilot primary care sites that are **able to be contacted and evaluated**
- Outcome of referrals (Eligible, Ineligible)
  - **Goal** of the project is to increase best-match referrals from the pilot primary care sites → so more of their referrals **are eligible**

Referrals by Referring Entity: Oct – Dec 2018 and Oct – Dec 2019



Examining Referrals for the Primary Care Pilot Sites in Oct-Dec 2018 and Oct-Dec 2019



All increased referrals are from the Pilot Sites

Key Findings in What Is the Data Telling Us…

Numbers of Referrals

- **Referrals have gone up**
- Driven by COPA Pediatrics
- All referrals made by COPA and Mosaic were to Deschutes and Crook Service Centers

Planned Facilitation Supports:

1) COPA- Enhanced Booster, Still Opportunity for Improved Referrals
2) MOSAIC- Booster on medical decision tree. Child-level screen review and identifying children that should have been referred

Preliminary Data Evaluating Impact of Pilot Site Training

Factors we are examining to assess impact of the improvement efforts on the pilot sites:

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- Outcome of referrals (Eligible, Ineligible)
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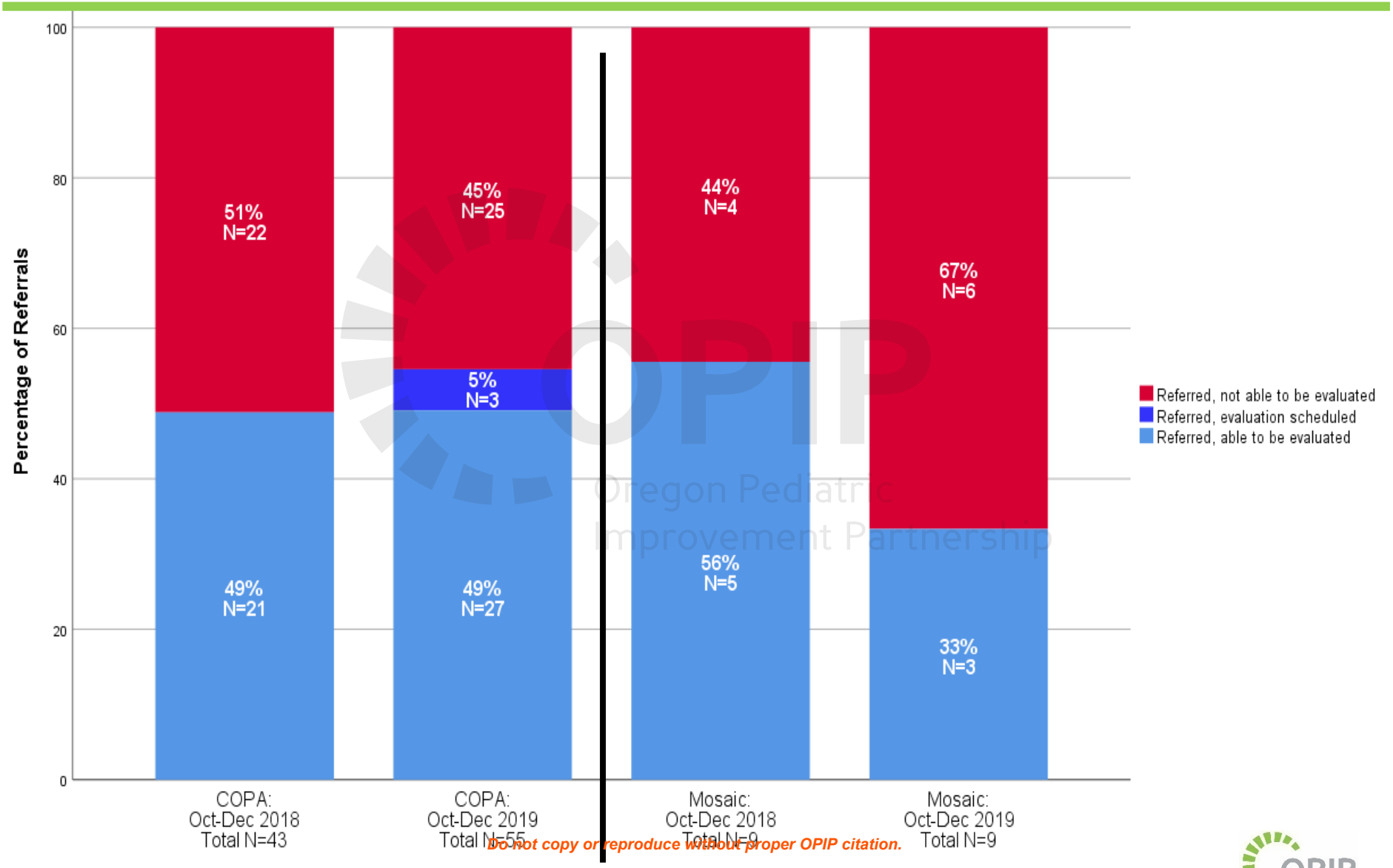
Impact of Improvement Project on Referrals from the Pilot Primary Care Sites Able to be Evaluated



Key Findings in What Is the Data Telling Us…

No significant changes have been made to HDESD's ability to contact and evaluate families

Target Facilitation supports will be provided to pilot sites on ensuring implementation of 36 hour phone follow up script

- In October COPA lost their referral coordinator doing the calls
- Mosaic had yet to assign role
- Both sites were completing these calls in early 2020 – hoping to see improvements

HDESD's Early Intervention COVID-19 Response

HDESD Early Intervention Service Center's Approach to COVID-19			
	Deschutes/Crook Service Center	**Jefferson Service Center**	**Warm Springs**
New Referrals	Referrals have ***decreased***	Referrals have ***decreased***	Work still on going to assess implications due to COVID-19
Evaluations	Evaluations will be done over Zoom • Challenges include inability to honor standardization • Parent reports for a great deal of testing	***No evaluations are being processed at this time***	
Services for Eligible Children	**Services will continue**, where feasible, **using telehealth**	**Services will continue**, where feasible, **using telehealth**	

HDESD's Early Intervention COVID Response

Implications OPIP is closely monitoring:

- Parent/Family fear of accessing care/services
- Use of telehealth for evaluations – monitoring eligibility over time
- Within Jefferson County, providers will have to enhance developmental promotion and coordination for families once services become available again

Hearing from Stakeholder Group

- What **questions** do you have about what we presented?
- What **did you hear** that is exciting relative to the goal of the project to improve best-match follow-up?

Project Activities

Detailed Updates on Project Activities

1. Primary Care Pilot Sites
2. Early Intervention – Improving Closed Loop Communication
3. Pathways for Children with Social-Emotional Delays via Behavioral Health for Young Children
4. Pathways for Children Needing Medical and Therapy Services
5. Building Health and Resilience for Children with High Social Complexity – Identify Community-Level Priorities

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 assessments & intervention by **internal behavioral health staff**
2. **Identify behavioral health providers in specialty settings 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 meeting of providers
     - Provide supports to understand modalities for 0-5
3. **If there is capacity and opportunity, pilot improvement referrals from pilot primary care sites to external behavioral health providers (Fall 2020-Spring 2021)**
   - Ensure that these pilots include tools and workflows for improved communication & coordination providers

Activities Since December 2019 Stakeholder Meeting
Pathways for Children with Social-Emotional Delays Intervention

Pre-COVID-19 Response

January-Mid March

- Update asset map of behavioral health providers following the October 2019 meeting.
  - Meetings with organizations who wanted to enhance services for young children to learn more about the modalities and billing.
  - Documented changes and enhancements to availability of services overall and by region
- Coordination with meetings with Dawn Creach & AIC
  - Preparation to support small group at April AIC meeting (subsequently cancelled)
- Training of integrated behavioral health staff in COPA and MOSAIC
  - Developed brand new materials and guides.
  - Shared asset map
  - Feedback survey given new content
- Developed "Booster" trainings for COPA and Mosaic for April (subsequently cancelled)

During COVID-19 Response

Mid March-Mid-May

- Identifying other strategies to provide booster training (recording, one-one-one sessions)
- Updating asset map of behavioral health provider based on any changes or enhancements, inquired about telehealth options
- Documenting impact of COVID-19 response on this pathway

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

- COPA and Mosaic primary care providers were 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** focused on:
  - **Child development** as it relates to social-emotional health and self-regulation, overview of clinical constructs meant to assess delays.
  - **Additional assessments** related to child's social-emotional health, parental attachment, other factors
  - **Brief Interventions**
  - Overview of **external behavioral health providers in region**
- **Clinical expertise and review provided by** Andrew Riley, Ph.D., Pediatric Clinical Psychologist who specializes in integrated behavioral health care

Behavioral Health Provider Asset Map

- Conducting three rounds of updates to the asset map by end of this reporting period
- Example of enhancements:
  - Updated staff who speak a language other than English (e.g. Best Care)
  - Updates in staff that provide additional modalities (Rimrock)
  - Staff availability in Jefferson and Crook (Brightways, Best Care)
  - **Telehealth capability (new update currently making)**
- Tracking enhancement, changes and evolutions over time.
- Important to understand the impacts of COVID-19 response on staffing and viability of new locations

Appendix 4: Central Oregon's Asset Map of Specialty Mental Health Providers who can serve kids 0-5

Draft Version 12 May, 15 2020	Current Assessment of Specialty Mental Health Providers Who See Children 0-5 in Central Oregon															
	County in Which the Services are Available															
	Deschutes								Deschutes & Crook	Crook		Jefferson		Home Visits Across All Counties			
Company	Deschutes County	Brightways Counseling	Cherie Skillings	Forever Family Therapy	Life Source Therapy	Starfish Counseling	The Child Center	Treehouse Therapies	Rimrock Trails	Crook County BestCare	Prineville Counseling Center	Jefferson County BestCare	Brightways Counseling	Amy Bordelon, LMFT	Now and Zen	Blossom Therapeutic Collective	Youth Villages
Office Location	Redmond (7) Bend (6) LaPine (3)	Redmond	Bend	Bend	Redmond	Bend	Bend, La Pine, Redmond	Bend, Redmond	Bend , Redmond & Prineville	Prineville	Prineville	Madras	Madras	Bend	Redmond & Sisters	Bend	Redmond
# of Providers	16	3	1	4	1	1	10	2	3	2	2	3	2	1	1	2	6
Case Load (per week)	114	85	24	40	30	25	134	51	75	*	40	*	50	12 families + 9 groups	30	30	24
Capacity for New referrals	25 families	28 families	12 families	16 families	Limited	At Capacity	At Capacity	17 families	40 families	6 families	4 families	20 families	15 families	Limited	3-5 families	1-2 families	2 families
Provider Race, Ethnicity	14 White, 1 White/ Hispanic,	White	White	3 White, 1 African American	White	White	White	White	White	White	White	White	White	White	White	1 White	1 Japanese-American, 5 White
Provider Language Spoken	14 English, 1 Spanish/ English	English	English	English	English	English	8 English, 2 Spanish/ English	English	3 English, 1 Spanish	English	English	English	English	English	English	English	English
Payor	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP	OHP	OHP/ Private	OHP/ Private	OHP/ Private	Private/ Sliding scale	OHP/ Private	Patient submits claims	OHP/ Private

Need follow up Interviews with: IHS Warm Springs

Do Not see Children 0-5: Lutheran Community Services, Bend; Cascade Child and Family Center

*	Counts need to be verified
	Only takes referrals for children/families that are at risk for out of home placement. Won't count towards capacity.
	Only provides services to those currently enrolled in other medical therapies. Won't count towards total capacity.

Behavioral Health Provider Asset Map

Example of updates provided in May 2020 on services in light of COVID-19 Response:

- Many organizations have indicated they have been adopting telehealth models for behavioral health services
  - Going forward, OPIP is going to inquire about telehealth strategies of all behavioral health providers during and after COVID-19.

Behavioral Health Provider Telehealth Access

- Previous work noted barriers to people accessing telehealth due to
  - Location (required travel)
  - Stigma (required parking in a place that people could see them)
  - Conflicts with work, etc
- Telehealth coverage of behavioral health
  - **Are there any regional conversations about maintaining coverage beyond COVID-19 response for people with these known barriers?**

Demand & Supply

Differential Barriers of COVID-19 Response & Young Children Social Emotional Health

- Important acknowledge & recognize the impact of COVID-19 response on **young children with social-emotional health delays and impact on progress on this transformative work**
- Important to acknowledge & recognize that vulnerable children's social-emotional health is **likely being further impacted due to COVID-19 response** and lack of access to protective factors and setting
- Opportunity to leverage parent and caregiver experience with children's social emotional health while at home during a traumatic time of a pandemic, value of supports to address behaviors

Demand & Supply

Differential Barriers of COVID-19 Response in Creating Barriers to Follow-Up Services Addressing Social Emotional Health

DEMAND

Children with needs for supports to address social-emotional are identified & referred

COVID-19 Response =**Lowering Demand**

Even Though Need is Still There

- Well-child visits at which delays or factors are identified modified or not occurring.
- Primary care behavioral health visits addressing delays and factors modified. Providers trained in January, limited time to implement

Other settings that children are identified

1. Childcare
2. Preschool
3. Home Visiting

Other barriers: Parent fear of accessing services, barriers to engaging in services at home and with other children present, Dyadic therapies via telehealth for example

SUPPLY

Trained Providers Who Can See Children 0-5 and Able to Provide Services

COVID-19 Response =**Impacted**

How Services Provided, Building Workforce & Capacity

- Ensuring coverage of services via telehealth
- Barriers to provision of in-person care
- Barriers to operationalizing services via telehealth
- Barrier to patients being able to access telehealth, willing to access telehealth
- Barriers to interviewing and hiring new staff.
- Logistic barriers with opening new spaces during the time of a pandemic

Hearing from Stakeholder Group

- Behavioral health providers
  - Does what we presented resonate?
  - What elements of the impact and opportunity of COVID-19 response did we miss?
- What **questions** do you have about what we presented?

Project Activities

Detailed Updates on Project Activities

1. Primary Care Pilot Sites
2. Early Intervention – Improving Closed Loop Communication
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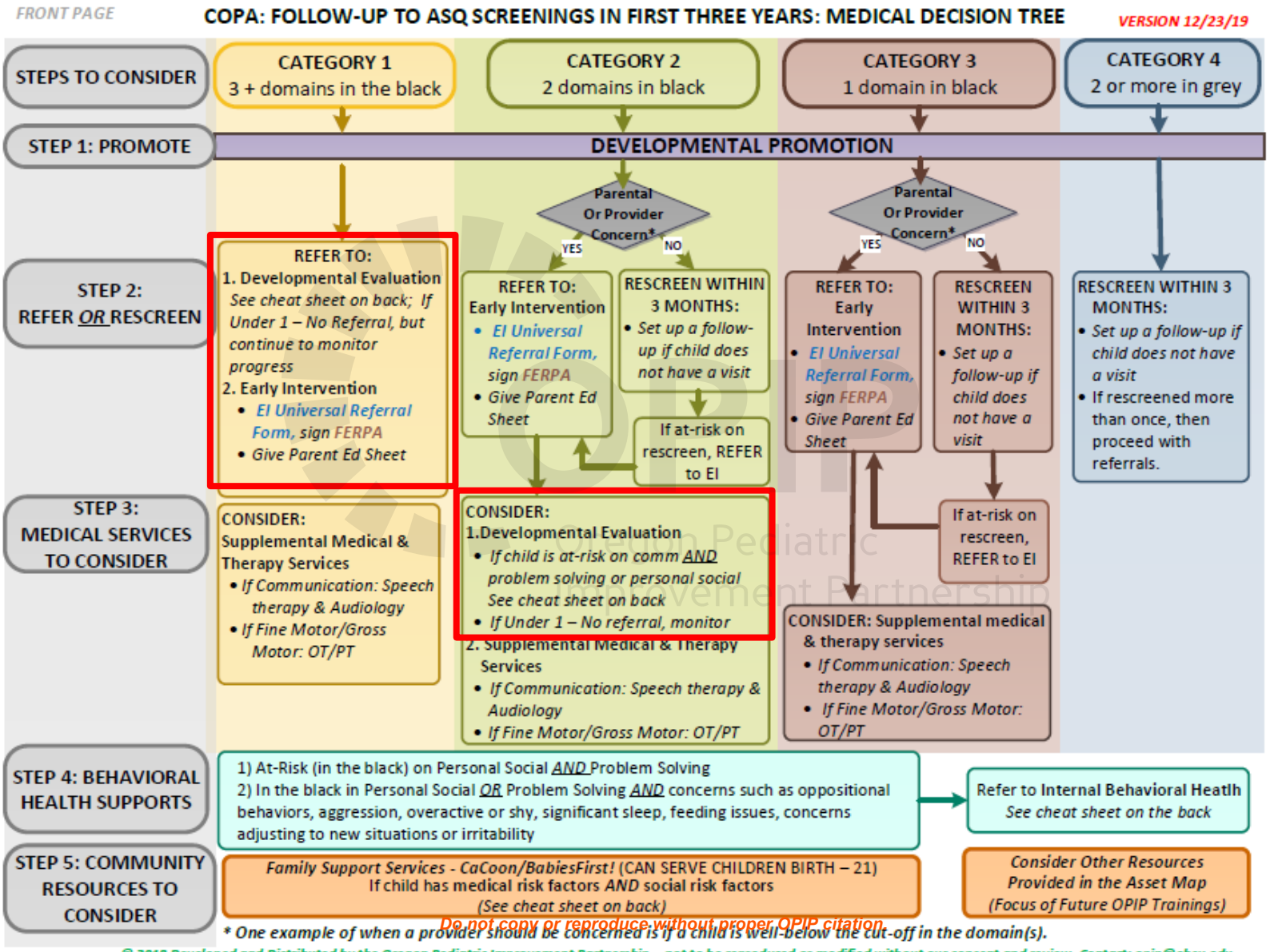
Pathways from Primary Care to Medical and Therapy Services

1. **Provide Supports for the Pathways to a Developmental & Behavioral Evaluation**
   - Support on referrals to PEDAL to improve process for practices and parents
2. **Asset Map of OT/PT and Speech Therapy Services**
   - Update Asset Map in 2020
   - Apply an Equity Lens
3. **Share updated asset map with the medical and therapy providers, provide information about gaps of services and coverage of services (Currently slated for Fall 2020)**
   - Identify gaps in services.
   - Ensure provider knowledge of Updates to OHP coverage

Pathway to Developmental Evaluation

Appendix 2: Central Oregon Pediatric Associate's (COPA) Medical Decision Tree



Referring to PEDAL: Enhancements Made

Our goal in updating and supporting enhancements to the referral pathway to PEDAL for kids 0-5:

- **Streamlining workflow for providers to share information and context**
- **Reduce family's barriers to evaluation** by providing documentation that may be in the EHR
- **Facilitate the appropriate team based evaluation** at PEDAL by providing relevant clinical information
- Ensuring a way that provider **context and concern is invaluable** in this referral process and will help supplement parental concern and insight
- Supporting **enhanced closed loop communication**

PEDAL's COVID Response and Implications to Work

For referrals for the 0-5 clinic, ***PEDAL has adapted the 1st appointment to be provided using telehealth***

- Based on initial feedback, **families are liking the telehealth** appointments as it reduces travel burden
- PEDAL has been able to **see more families for the initial appointment** – though they are still waiting to conduct child level assessments for in person

Implications to Work:

- Pilot primary care provider training on enhanced processes will be done in late June (instead of May)
- Meet and Greet of PEDAL and practices will be done after once acceptable

Capacity Mapping of Medical and Therapy Providers (OT/PT and Speech) in Central Oregon

- Nine providers identified

  Five Multidisciplinary Sites (OT, PT, Speech)

  1. Treehouse Therapies,
  2. Blossom Therapies,
  3. SONOS Neurotherapies
  4. St. Charles Rehabilitation

  Speech ONLY sites

  5. Redmond Speech and Language,
  6. Skidmore Speech & Language,
  7. Connections Speech and Language Pathology
  8. Bend Speech Express
  9. Bend Speech and Language

Capacity Mapping of Medical and Therapy Providers in Central Oregon

- Five Multidisciplinary Sites (OT, PT, Speech)
  - **3 of 4 Interviewed**: Treehouse Therapies, Blossom Therapies, SONOS Neurotherapies
  - **1 Interview Needed**: St. Charles Rehabilitation
- Speech ONLY sites
  - **4 of 5 Interviewed:** Redmond Speech and Language, Skidmore Speech & Language, Connections Speech and Language Pathology, Bend Speech and Language
  - **Declined Interview As They Are At Capacity:** Bend Speech Express,
- **Many sites operating near capacity** for providers' available hours
- COVID-19 has led to decrease in number on wait lists and reduced ability to take on new referrals for specialized needs or challenging diagnoses

Capacity Mapping of OT/PT and Speech Providers That See Young Children in Central Oregon

Version 1.1 May 15, 2020	Current Assessment of Medical Therapies Providers Who See Children 0-3 in Central Oregon												
	Physical Therapy				Occupational Therapy				Speech				
	Multidisciplinary Providers								Speech Only Providers				
Company	Treehouse Therapies		St. Charles Rehabilitation*		Blossom Therapeutics		Sonos*		Redmond Speech & Language	Bend Speech Express*	Bend Speech and Language*	Skidmore Speech and Language	Connections Speech & Language Pathology
Number of Providers	14 (+1 on leave)				6		5		10 (+2 on leave)		1	3	1
	7	7			5	1	1	4					
Current Case Load (clinical hours per week)	119	157			122	30	20-35	65-75	10-40^		14	46	20^
Staff typically "at capacity" (Can't take new referrals)	No	Yes			Yes	Yes	*	*	No	Yes	No	Yes	No
Location	Deschutes *(Bend, Redmond)*		Deschutes *(Bend)*		Deschutes *(Bend)*		Deschutes *(Bend)*		Deschutes *(Bend)*	Deschutes *(Bend)*	Deschutes *(Bend)*	Deschutes *(Bend)*	Deschutes *(Bend)*
Race of Provider	White	White			White	White	White	White, Hispanic	White		White	White	White
Language	English	English, Spanish			English	English	English	English, Spanish	English, Spanish (with interpreter)		English	English & Spanish	English
Payor(s) Accepted	OHP, Private				Private		OHP, Private		Private, OHP		OHP, most private	OHP, most Private	OHP, Private

^Site describes capacity as FTE or appointment slots; clinical hours estimated

*Interview not completed or information not yet fully verified by OPIP

= Physical Therapy = Occupational Therapy = Speech Therapy

Hearing from Stakeholder Group

- Are there any **missing service providers** we should outreach to?
- What **questions** do you have about what we presented?

Project Activities

Detailed Updates on Project Activities

1. Primary Care Pilot Sites
2. Early Intervention – Improving Closed Loop Communication
3. Pathways for Children with Social-Emotional Delays (Behavioral Health for Young Children)
4. Pathways for Children Needing Medical and Therapy Surveys
5. Building Health and Resilience for Children with High Social Complexity – Identify Community-Level Priorities

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

- This track was **targeted for Year 2** of the project (June 2020-May 2021)
- That said, given the transformative nature of the work and learnings about the novel nature of these pathways, we started conversations late December 2019 and early 2020
  - We also enhanced and are increasing the pace of the conversations given the Integrated Care for Kids Grant (more on that soon)

Key Activities During this Period Following Input obtained at December Stakeholder Meeting:

- **Engage key community level partners in coordination with CCO leaders** to **identify specific populations of children** with high social complexity who would be focus of this effort.
- **Interviews with identified stakeholders to identify potential pathways** and **proactive developmental and behavioral health** supports that may be valuable.

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)

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)

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

- Met with Pacific Source leadership, COHC and ELHCO discuss health complexity data at large and specific opportunities for populations that may be of focus.
- 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**.
- Meeting with Best Care regarding pathways from **Adult Substance Use and Mental Health services** for behavioral health services for their children
- Meeting with other organizations that provide supports for adults who are receiving services within the social complexity on pathways to support young children
  - Changing Patterns (Frank)
  - Project COPY (Bob)

Some ideas that have been generated so far (Just the beginning!)

a) **Data Flags** to Guide Assessments and Outreach for Specific Children

- ✓ 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 (Aligned with InCK)
- ✓ Flag of whether the child has one of the three

b) **Starting point conversations** on pilot specific of pathways in Best Care for **adult services to child services and dyadic bundles of care** that consider the adult + child service package.

c) **Spring 2021 meeting of the "helpe**rs" for the adult services that target persons with specific risk factors to describe provide an overview of services available for children of those adults

Agenda

- **Welcome**
- **50,000 Foot View** – Background & Context on the Pathways Project Goals & Activities
- **Brief Updates on Project-Level Activities Conducted Since the Last Meeting**
- **Overview of Integrated Care for Kids (InCK) Cooperative Agreement**
- **Q & A and Next Steps: Next Stakeholder meeting**

Acknowledgement of Funding:

- This project is supported by Funding Opportunity Number CMS2B2-20-001 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.
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Oregon's Integrated Care for Kids Model

- The **Oregon Health Authority** (awardee) and the **Oregon Pediatric Improvement Partnership** (OPIP; sub-awardee and "Lead Organization") jointly applied for InCK Model funding to be implemented in partnership with regional "child core service" partners & CCOs in Oregon.
- The InCK Model cooperative funding from CMS/CMMI consists of ***up to* $16 million** distributed over seven years:
  - ***Pre-implementation period*** (years 1-2, 2020-21) and
  - ***Performance period*** (years 3-7; 2022-2026)
    - A subset of funding ($500K) in years 5-7 of the performance period is contingent on performance against a set of measures.
- Oregon's InCK target population: All Medicaid/CHIP enrolled children in **Crook, Deschutes, Jefferson, Marion and Polk counties**.

Oregon's Integrated Care for Kids Model

Some general principals as we wrote the application:

- Build on **CCO 2.0 key goals**, **regional partnerships,** and **existing infrastructure.**
- Leverage Oregon's innovative **Child Health Complexity** data model and data sharing.
- Leverage and build off OPIPs work child- and family-centered **complex care coordination improvement models**, models developed in Oregon.
- Build off **partnerships with OHA & DHS.**
- Build off strengths and opportunities in **Crook, Deschutes, Jefferson, Marion and Polk counties.**

Oregon's Integrated Care for Kids Model

1. ***Early identification of children*** with multiple physical, behavioral, or other health-related needs and risk factors through population level assessments and risk stratification.
   - Leverage **children's health complexity** system-level data to identify priority populations who have higher needs for care coordination.
2. ***Integrated care coordination and case management*** across physical health, behavioral health, and other local service providers.
   - Oregon's InCK Model will provide training and dissemination of best practices in care coordination and community-based services with a focus on culturally and linguistically responsive care.
3. ***Health information exchange*** & **community provider information exchange** enhancements and regional service integration coordinators to support care coordination for children with health complexity.
4. ***Development and Implementation of Alternative Payment Models (APM)*** to align payment with care quality and accountability for improved child health outcomes.

VERSION 1.0: 3/26/20

Oregon's Integrated Care for Kids (InCK) Model: Overview

Seven Year Cooperative Grant from the Centers from the Centers for Medicare and Medicaid Innovation to the Oregon Health Authority, with the Oregon Pediatric Improvement Partnership. Pre-implementation and planning period: 2020-2021 • Implementation : 2022-2026*

Goals

1. **Improve health outcomes** of children/youth age 0-21
2. **Reduce out of home placements** such as foster care and residential behavioral health
3. **Reduce costs** associated with unnecessary ER visits and inpatient stays

Population of Children to Receive InCK Model

All **Medicaid/CHIP** enrolled children ages 0-21 residing in **Crook, Deschutes, Jefferson, Marion and Polk** counties. Efforts will target prevention and needs screening for children in order to provide enhanced access and service connection. The implementation of a stratification plan will identify subsets of at-risk children to receive targeted best-matched supports and care coordination.

InCK Model Components For All Children and for a Subset of Children

Level 1: All Children (ages 0-21) in the Model Area Covered by Medicaid/CHIP

Active Monitoring

Preventive care

- Ensure access to preventive care, mobile crisis response.
- Screening of children and their families for housing & food insecurity and connection to services.
- System-level data used to create indicators of a child's medical and social complexity in order to identify priority populations of children at-risk for at home placement and/or high-costs.
- Enhanced data tracking and data integration across sectors.

Level 2: Children Identified Through System-Level Data or Front-Line Screening as At-Risk for Out of Home Placement and High-Cost Events (Subset of Level 1)

Enhanced assessments and screenings

Best Match Care Coordination

- Strength and needs assessment conducted with child and family.
- Connection to services if need identified.
- Provision of care coordination.
- APM models developed and implemented to support enhanced assessments and coordination components.
- Enhanced data tracking and data integration across sectors.

Level 3: Children Identified in Level 2 Needing More Intensive Supports (Subset of Level 2)

Integrated Case Management & Child-Centered Care Planning

Home and Community-Based Supports

- Provision of more intensive supports addressing health and care needs.
- APM models developed and implemented to support enhanced complex care coordination.

Regional Activities & Supports Funded by Project

- Regional Partnership Councils.
- Parent & youth engagement.
- Partnerships with racial and ethnic communities most impacted by health inequities.
- Provision of system-level risk stratification data by OHA.
- Region-specific Service Integration Coordinators.
- Health information exchange enhancements.
- Infrastructure supports to operationalize screening.
- Training on best-match care coordination supports.
- Development and implementation of Alternative Payment Models (APM), in collaboration with PacificSource Community Solutions in Central Oregon & Marion and Polk to align payment with care quality and accountability for improved child health outcomes.

*https://www.oregon.gov/oha/ERD/Pages/Oregon-Health-Authority-awarded-16-million-improve-child-health.aspx.

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Oregon's Integrated Care for Kids Model

Time Frame

- *Pre-Implementation and Planning Period:* ***2020-2021***
- *Implementation Period:* ***2022-2026***

Goals

1. **Improve health outcomes** of children/youth age 0-21
2. **Reduce out of home placements** such as foster care and residential behavioral health
3. **Reduce costs** associated with unnecessary ER visits and inpatient stays

Population

- All **Medicaid/CHIP** enrolled children ages 0-21 residing in **Crook, Deschutes, Jefferson, Marion and Polk** counties.
- Efforts will target **prevention and needs screening for children** in order to provide enhanced access and service connection.
- The implementation of a **stratification plan will identify subsets of at-risk children** to receive targeted best-matched **supports and care coordination**.

Oregon's Integrated Care for Kids Model

InCK Model Components For All Children and for a Subset of Children

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Explicit and important focus on children 0-5.

Metrics focused on:

- *Well-child visits (0-15 months, 3-6)*
- *Immunizations*
- *Kindergarten Readiness*

Oregon's Integrated Care for Kids Model: Stratification Plan

- **Stratification plan is meant to identify <u>subsets of at-risk children</u>** to receive targeted best-matched **supports and care coordination**.
- Stratification Level #2 and Level #3 anchored to the "risk" for the InCK outcomes
  - ❖ **Out of home placements** such as foster care and residential behavioral health
  - ❖ **Costs** associated with unnecessary ER visits and inpatient stays
    - ➢ Prolonged admissions
    - ➢ Multiple, recurrent hospitalizations
- Anchored to and leverages **Child Health Complexity** data
  - o OPIP & OHA have been working to operationalize since 2016
  - o Operationalizes factors related to **medical** and **social complexity** = **health complexity**
- Termed **Service Integration Level "SIL"** in the InCK Model
- Implementation of stratification plan **begins** in Year 3

Oregon's Integrated Care for Kids Model

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Oregon's Integrated Care for Kids Model: **Stratification Model**

Level 2

	Point 1: Exhibited need for two core child services		Point 2: Functional symptom of impairment
	Child had 1+ core service…	*…and exhibited need for additional services*	
2A	Child had physical or behavioral health service	• Child in Foster Care or Ever Been in Foster Care • Child is at imminent risk for out of home placement	Medical Complexity • Complex Chronic, OR • Non-Complex Chronic
2B		Social Complexity that includes • Parent substance abuse, &/or • Parent mental health, &/or • Parental incarceration	Medical Complexity • Complex Chronic, OR • Non-Complex Chronic
2C		Social Complexity • 3 or more indicators (any)	Medical Complexity • Complex Chronic

Oregon's Integrated Care for Kids Model

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Oregon's Integrated Care for Kids Model & Alignment with COHC RHIP 2020-2023

Activities of InCK align with all six action areas with a specific focus on children 0-21 & Dyadic-based approaches to care.

1. Address Poverty & Enhance Self-Sufficiency
2. Behavioral Health: Increase Access & Coordination
3. Promote Enhanced Physical Health Across Communities
4. Stable Housing & Supports
5. Substance Abuse & Alcohol Misuse
6. Upstream Prevention

Oregon's Integrated Care for Kids Model: Regional Supports

1. Regional Partnership Councils.
2. Parent & youth engagement.
3. Partnerships with racial and ethnic communities most impacted by health inequities.
4. Provision of system-level risk stratification data by OHA.
5. Region-specific Service Integration Coordinators.
6. Health information exchange (HIE) and/or CIE enhancements.
7. Infrastructure supports to operationalize screening.
8. Training on best-match care coordination supports.
9. Development and implementation of Alternative Payment Models (APM), in collaboration with PacificSource Community Solutions Central Oregon.

Oregon's Integrated Care for Kids Model: **Critical Community-Level Partnerships**

- **Partnership Councils**
  - Convene quarterly in each of Oregon's InCK sub-regions (Central Oregon & Willamette Valley)
  - Must include, at a minimum, federally designated "Child Core Service"
  - Build on regional structures and partnerships already in place
  - Provide input on the formulation, priorities, and implementation of the InCK Model
- **Local Core Services Providers (Represented on Partnership Council)**
  - Key partners in the implementation and operationalization of the InCK Model

Oregon's Integrated Care for Kids Model: Regional Supports

OPIP will provide funds to local organizations to support:

1. Region-specific **Service Integration Coordinators**
2. **Health information exchange/Community-provider information exchange enhancements**

Oregon's Integrated Care for Kids Model: Regional Supports of SICs

Region-specific **Service Integration Coordinators** (SIC)

- SICs can NOT directly deliver any services to attributed children or their families (i.e., no direct service).
- Ensure one reliable main point of contact for the integrated care coordination and/or case management for:
  - Child core services providers (health care, education, housing, etc.)
  - Provide facilitation and support to **child core service providers** on the implementation of the model.
    - ➢ Build relationships between existing care coordinators & case managers.
    - ➢ Set up the processes and information infrastructure by which referrals are made, completed, and tracked across the different service types.
- OPIP provides funding to local organization for a full-time SIC position for duration of InCK Model funding (Through Year 7)

Oregon's Integrated Care for Kids Model: Regional Supports Information Exchange

- Funds allocated to support enhanced regional infrastructure and bodies.
- OPIP is responsible for facilitating decisions on the entities to receive the HIE funds and on local community implementation of the information technology.
  - Meant to be **synergistic with and build off regional infrastructure** and **regional bodies that determine local HIE/CIE decision making**.
- HIE/CIE infrastructure enhancements meant to:
  - Facilitate **coordinated provision or and tracking** of delivery of services
  - **Improve information sharing** among a range of providers to bring a complete picture of the child's health to their care team
  - Provide an **integrated experience of care** for the child and primary caregivers.
  - **Reduce families' burden** to navigate differing procedures and processes for the various organizations and programs that provide core services.
- This is an area where we are seeking enhanced clarity from the federal funder on data tracking & reporting requirements.

Hearing from Stakeholder Group

- What **questions** do you have about what we presented?
- What **are important factors related to young children that align with the grant goals that you want me to make sure I hear?**
- What regional efforts do we need to be synergistic with?
- Who do we need to partner with?

Looking Forward – Summary of Next Steps

Summary of Priority Next Steps

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

a) Improve follow-up in **Primary Care Pilot (PCP) Sites,** Conduct baseline trainings in St. Charles Prineville and MMG

b) Improve **closed loop communication and coordination** in **Early Intervention**

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) Continue with stakeholder engagement on **upstream** approaches that could build health and resilience (aimed to prevent delays): **Proactive Developmental Promotion & Preventive Behavioral Health for Socially Complex Children**

2) Next Stakeholder Meeting - August 10th

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

- Door is always open..with a mask! …
  or Zoom Call Always an Open
- Hub Lead
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  - 541-693-5784 (office)
- OPIP Contract Lead
  - Colleen Reuland:
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