System-Level Social-Emotional Health Metric

Overview of Oregon's Novel Social-Emotional Reach Data for Children Birth to Five:

How the reach metric is meant to guide & inform system-level improvement efforts

August 17th, 2022

Colleen Reuland, Oregon Pediatric Improvement Partnership
Lydia Chiang, Oregon Pediatric Improvement Partnership
Katie Unger, Oregon Pediatric Improvement Partnership

Webinar is made possible with funding support from the David and Lucile Packard Foundation.

Agenda:

- Overview of the development process & intent of the **Social-Emotional Reach data**
- Definition and **scope of social-emotional services intentionally included in the CCO Incentive Metric** aligned with priority areas informed by feedback from parents of young children, front-line providers, early learning providers, and system-level leaders
- **Alignment of the Social-Emotional Reach data with clinical recommendations** and **community-level priorities** and specific codes and claims included and why
- How the metric is meant to guide and inform improvement
- **Frequently Asked Questions**: Provide answers to the most common questions asked about the metric not addressed in earlier content
  - This 8/17 webinar is didactic providing background and information, addressing common questions we have received.
  - 9/21 webinar is for people who have attended or listened to this webinar and will be more interactive and answering questions.

Broadly: What is Social-Emotional Health?

Social-emotional health is the developing capacity of the child from birth to 5 years old to:

- Form **close and secure relationships with their primary caregivers** and other adults and peers;
- **Experience, manage, and express a full range of emotions**; and,
- **Explore the environment and learn**, all in the context of family, community, and culture.

Babies, toddlers, and young children can and do suffer from mental health conditions caused by trauma, neglect, biological factors, and environmental situations that disrupt their social-emotional development.

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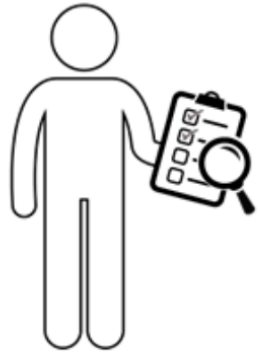
Broadly and Across Sectors: Services that Support Social-Emotional Health

Promotion Activities

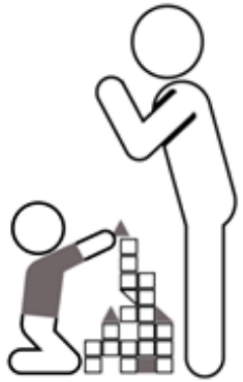
Screening

Assessment



Brief Intervention

Treatment Service



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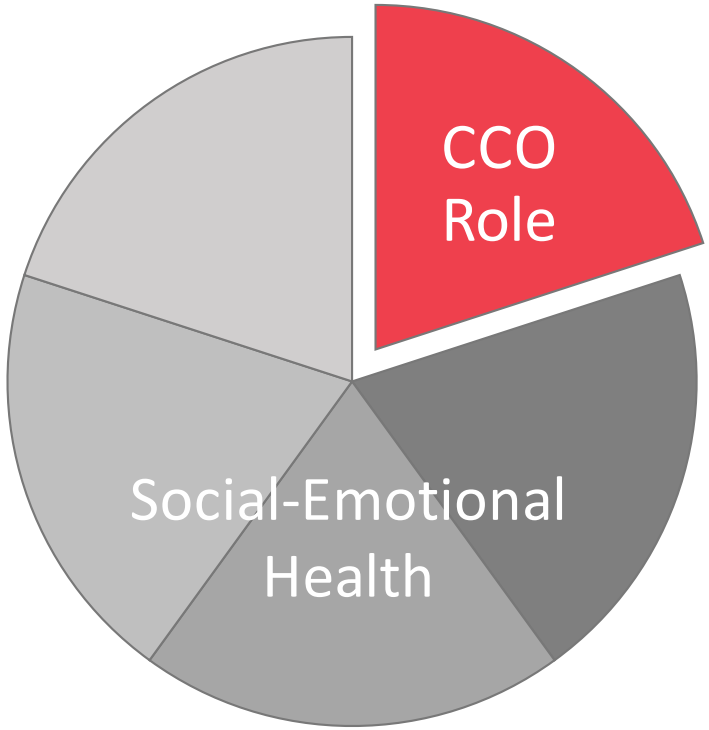
Defining the CCO Incentive Metric Scope and Key Terms

Scope of CCO System-Level Social-Emotional Metric: Red Piece of the Pie

- Focused on the scope of services that are **within the CCO contract** and **opportunities to impact**.
- Aligned with barriers and gaps in social-emotional health services within the health system and CCO contracts.
- Recognizes the flexibilities and opportunities that the CCO global budget may offer.



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CCO System-Level Social-Emotional Metric: Vision and Purpose

Vision:

Children from birth to age 5, and their families, have equitable access to services that support their social-emotional health and are the best match for their needs.

Purpose:

- Drive **CCOs** to address complex system-level factors that impact the services kids and families receive and how they receive them, and for which there may be payment or policy barriers.
- Address gaps in **CCO incentive metric set**.

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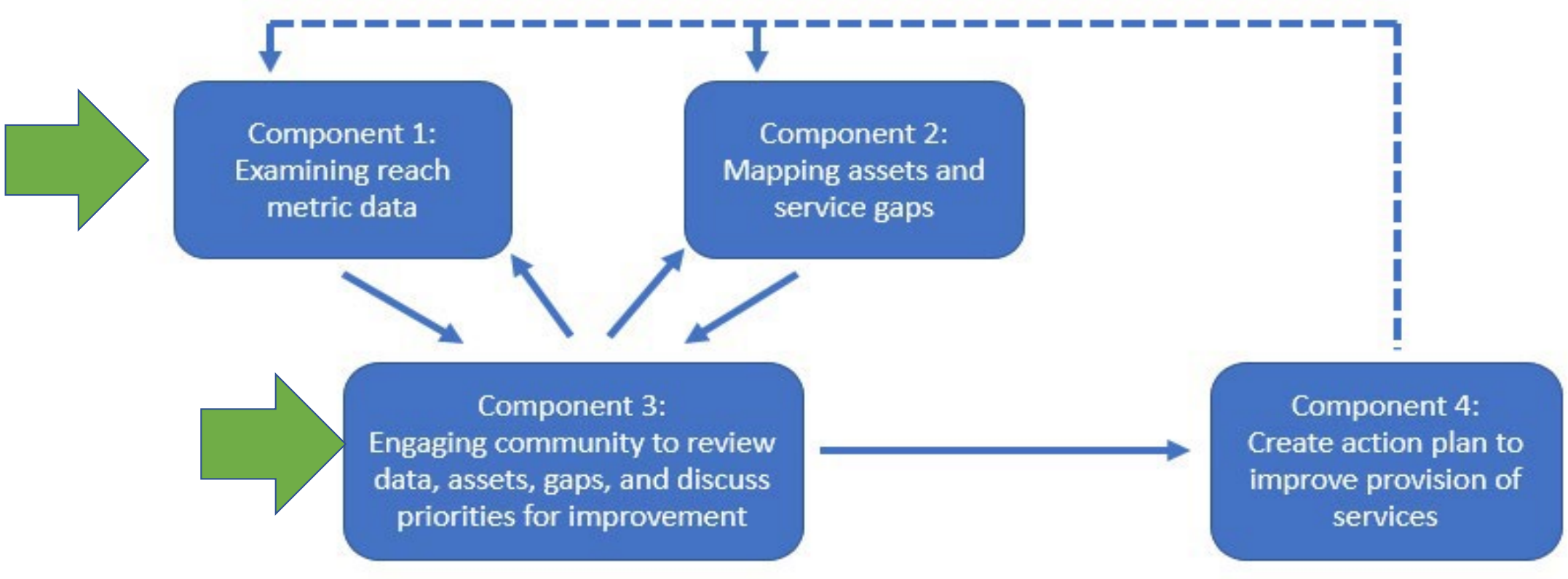
System Level **Social-Emotional Metric**

Metric Type: The metric is an attestation metric in which the CCO will attest to conducted specific activities and engaging specific community partners relative for four component areas.



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Glidepath from System-Level Metric to a Child-Level Metric

- **Years 1-3** CCOs meet the metric (*and are therefore are eligible for incentive funds*) based on completing required activities.
  - The attestation activities are anchored to and informed by improvement pilots and extensive multi-year stakeholder feedback.
  - Standardized reporting via an attestation survey administered and scored by OHA.
- **Year 4** proposed transition to a child-level metric with CCO accountability for improving provision of social-emotional health services. Specifications for child-level metric will be informed by learnings from years 1-3.
  - Therefore, the proposed child-level metric in Year 4 may be a subset of the SE Reach Metric included in Component 1.
  - Aiming to ensure that the child-level metric addresses the largest pain points and needs identified and creates a focus on **services** for children that address factors that impact their kindergarten readiness.

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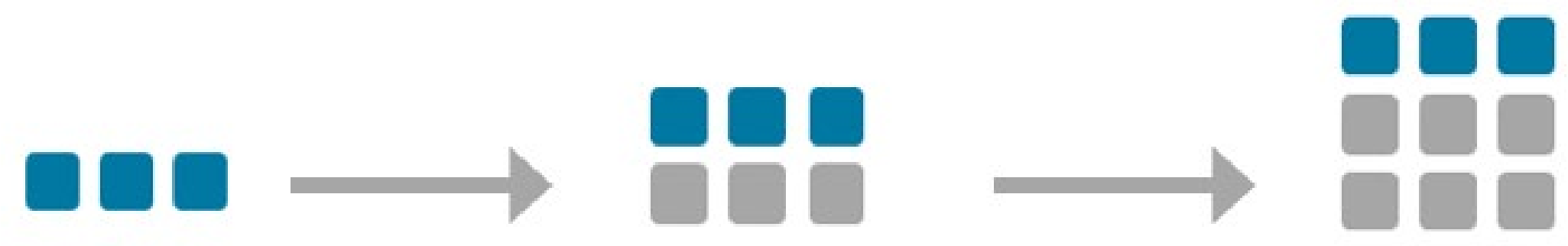
Have you seen your region's Social Emotional Reach metric data?

- Yes – and I understand the data well
- Yes – and I have some questions
- The data is probably buried somewhere in my email
- What is the **social** emotional reach metric data?

Core Components of the Social-Emotional Metric and Glidepath Related to Social Emotional Reach Data



Year 1 | Years 2-3 | Year 4

Part 1.1 Social-Emotional Health Reach Metric Data: Review Data Provided by OHA, Analyze, & Interpret Implications.

Part 1.2 Attestation of Activities and Processes to Support Review of Data, Identifying Services and Gaps, and Prioritizing System-Level Activities to Increase Provision of Services.

CCOs address barriers identified in earlier years by attesting to specific interventions in areas such as:

- ✓ Community engagement
- ✓ Workforce
- ✓ Access
- ✓ Care Coordination
- ✓ Payment

Track progress with Reach Metric.

Child-level metric focused on improving equitable receipt of social-emotional health services.

- Learnings from Years 2-3 will inform what version of child-level reach data will be proposed. Option examples:

#1) What part of reach data

- Services only
- Services & Assessments/Screen

2) For what population:

- Full
- Populations with historical and contemporary inequity

Social-Emotional Services Reach Data of CCO Covered Services

Child-level metric:

- Meant to capture a **range of CCO Covered services** provided across the spectrum of providers and to allow for innovative billing by early learning providers.
- Based on community feedback and pain points, clinical recommendations aligned with claims, and claims data validity, anchored to **CCO Covered services that span from screening to services.**

- **Two components:**
  - **Component A: Assessments/Screening**
  - **Component B: Services (Includes Brief Interventions to Dyadic Therapies)**
    - ❖Services can be provided in an array of settings – integrated behavioral health, home visiting, and in specialty mental health
    - ❖Includes applicable codes that are valid, even though they may not be currently used given feedback through engagement and attestation focus on payment and internal policies

CCO-Covered Services that Support Social-Emotional Health

Screening

Assessment

Biggest Pain Points from Parent & Provider Input

Brief Intervention

Treatment Service

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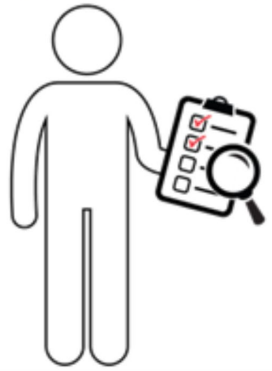
Social-Emotional Services Reach Metric: Development Process led by the Oregon Pediatric Improvement Partnership

- Stakeholder calls with national experts
- Built from review of other metrics (NCQA Mental Health Utilization Metric, Washington DSHS Mental Health Utilization Metric)
- Aligned with covered services and diagnoses in Oregon
  - ✓Oregon's 0-5 diagnostic crosswalk
  - ✓Integrated behavioral health in primary care: guidance used in improvement projects aligned with Primary Care Payment Reform Collaborative
  - ✓Considered HERC prioritized list
- Cross-sector HAKR Team Review (Medicaid, Child Behavioral Health, Early Learning Division, OHA Health Analytics)
- Review by Center for Health Care Strategies, and contracted experts, supporting the Aligning Early Childhood and Medicaid Effort
  - ✓https://www.chcs.org/project/aligning-early-childhood-and-medicaid/

CCO-Covered Services that Support Social-Emotional Health

Screening

Assessment



Brief Intervention

Treatment Service

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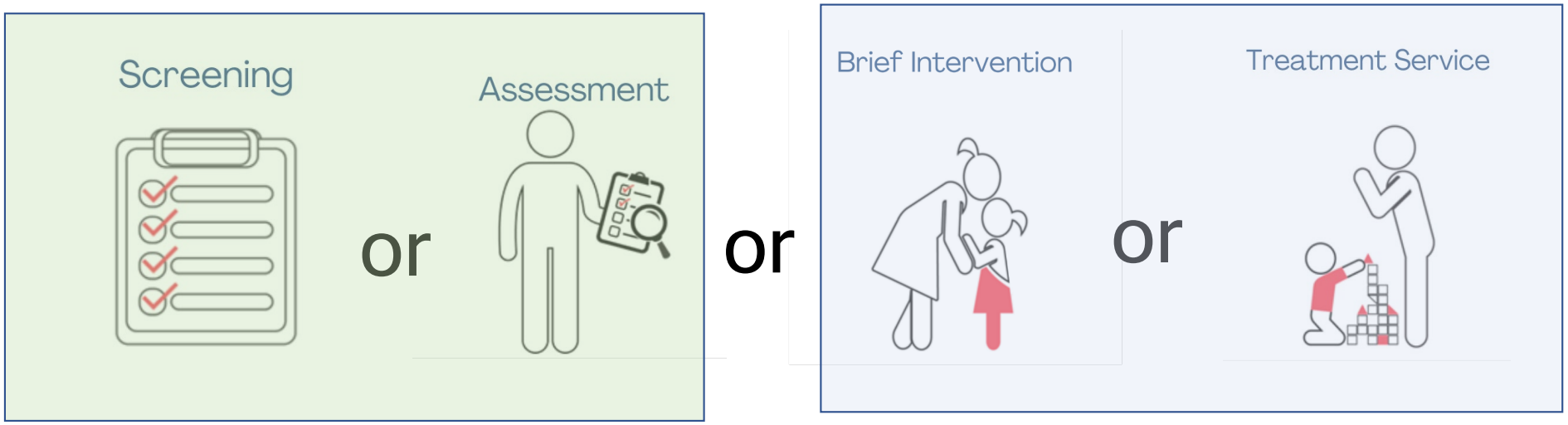
Social-Emotional Reach Data

Numerator:



Denominator:

Largest Pain Point in CCO Systems that Cross Sector Providers Wanted Improvements

Children aged 1-5 within the CCO

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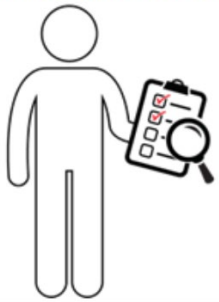
Summary: Services Included in Reach Data

Screening

Bright Futures recommended screenings to assess for social-emotional health that primary care providers may use

(Example: Pediatric Symptom Checklist)

Assessment



Assessments that integrated behavioral health may do for children referred to them based on ASQ or MCHAT results or clinical judgment (Example: ASQ-SE or brief evaluation tools)

Brief Intervention

Brief interventions that could be provided by eligible billing providers such as integrated behavioral health or home visiting nurse
(Example: Preventive counseling, Health and Behavior interventions)

Treatment Service

Services provided by specialty behavioral health that can include, but are not limited to, dyadic therapies, group therapies, and other services
(Note: This is NOT specific to one type of modality or one set of services)

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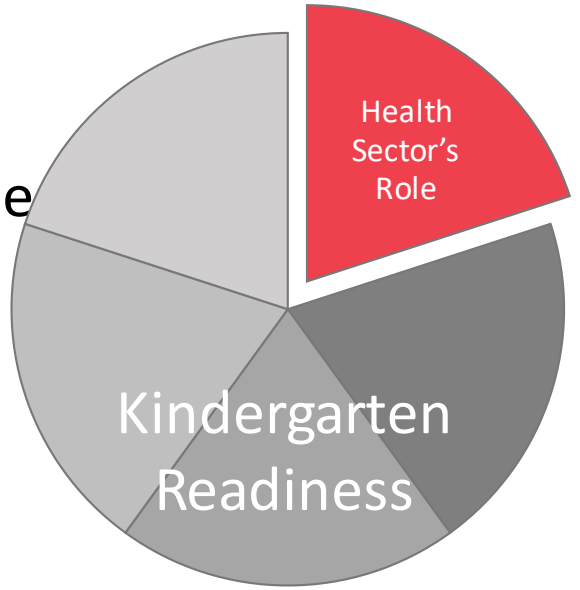
Social-Emotional **Reach Data**: Services Aligned with Clinical Recommendations of the Health Sector (Physical, Behavioral)

Component A: Early Identification & Screening: Screening & Assessments

- Bright Futures recommends screening for all young children as part of routine well-child care. EPSDT anchored to Bright Futures periodicity table https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
- Assessments for children identified through other screens and/or clinical judgement (e.g. ASQ, maternal depression screening, MCHAT)



Component B: Interventions/Therapies: Brief Interventions- Intensive Therapies

- Services can be provided in an array of settings – integrated behavioral health, home visiting, and in specialty mental health.
- Includes applicable codes that are valid, even though they may not be currently used given feedback through engagement and attestation focus on payment and policies.

Examples of Broad Services Included in the Reach Metric Data: Not a Complete List, but Examples of Breadth of What is Included

Screening/Assessments

- Bright Futures recommended **screening tools** to asses for social-emotional health that primary care providers may use: Example: Pediatric Symptom Checklist

OR

- **Assessments** integrated behavioral health may do for children referred to them based on ASQ or MCHAT results or clinical judgment, such as ASQ-SE or brief evaluation tools

OR

Intervention/Therapies

- **Brief interventions** that could be provided by eligible billing providers such as Integrated Behavioral Health, Home Visiting Nurse or eligible providers (which is something that can be addressed in 1.3* of the metric – how to consider contracting models)

OR

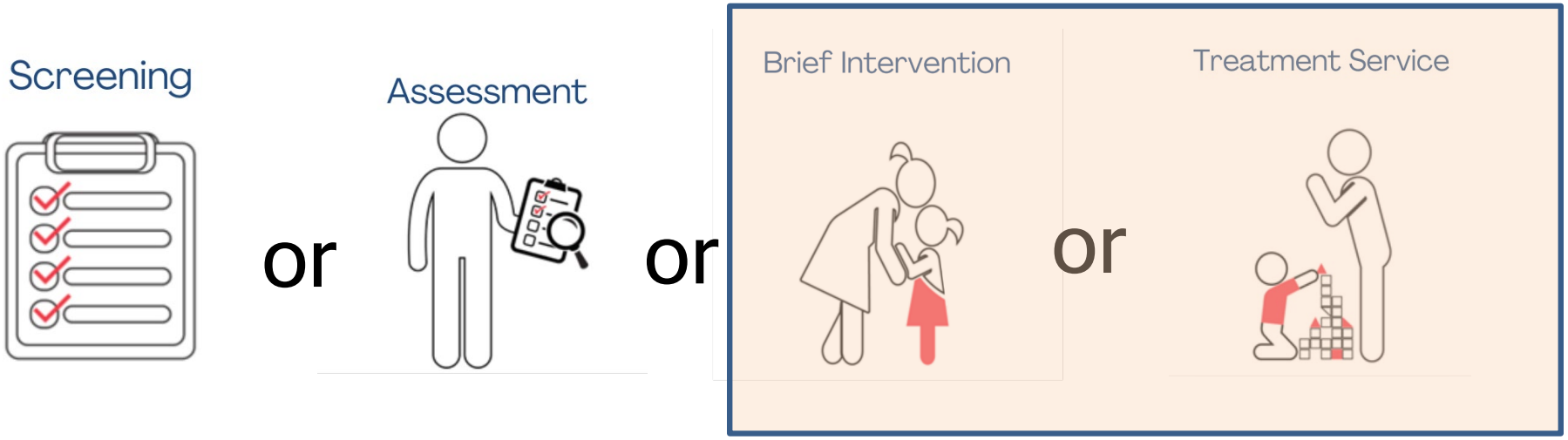
- **Treatment services (**individual, family or group psychotherapy) provided by Specialty Behavioral Health that can include, but are not limited, to dyadic therapies, group therapies, and other services provided by Specialty Behavioral Health

(Note: This is NOT specific to one type of modality or one set of services)

** A policy consideration could be exploring how to expand reach of providers who could bill for services that are being provided*

Social-Emotional Reach Metric

Numerator:



Denominator:

Children aged 1-5 within the CCO

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Numerator: All members age 1-5 receiving a behavioral health assessment or service within the 12-month measurement year

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Denominator: All attributed Children ages 1-5 within the 12-month measurement year who meet a cont. enrollment requirement

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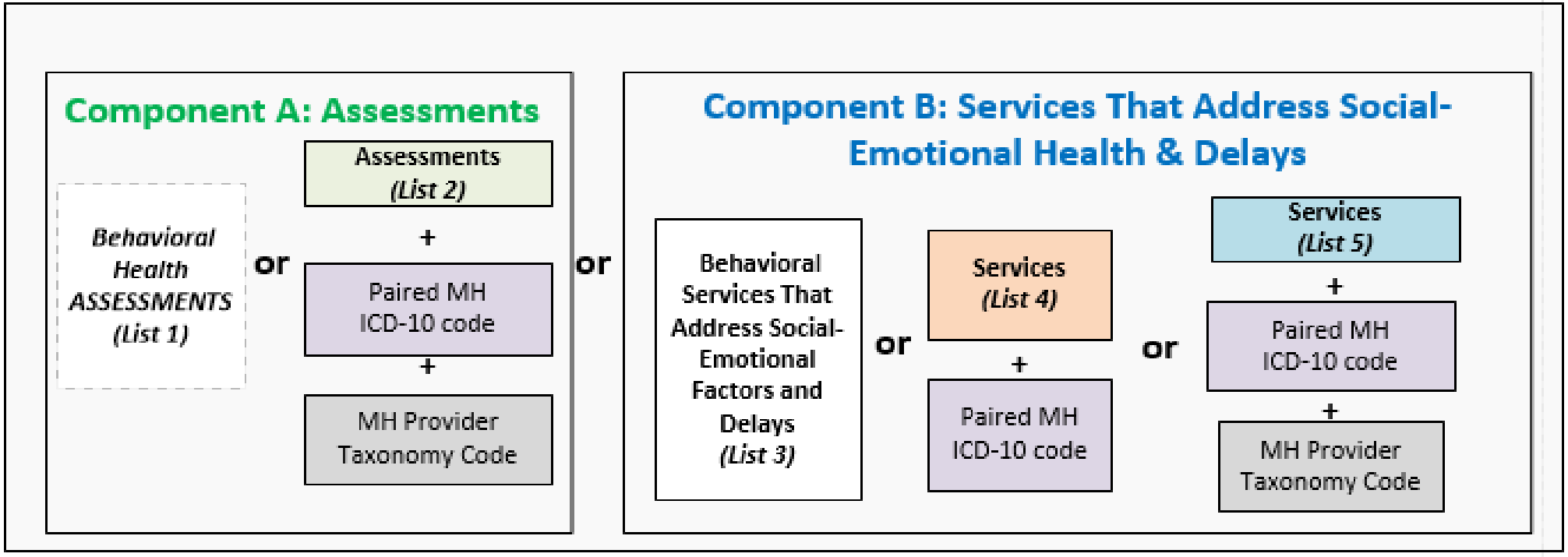
REACH Percentage:
Proportion of attributed children age 1-5 who received an assessment (A) or services (B) in the last 12 months.



Version: 4-18-2021

Developed by Oregon Pediatric Improvement Partnership as part of the HAKR SE Metric Development in Partnership with Children's Institute and Oregon Health Authority.

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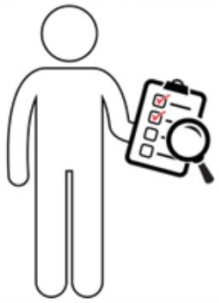
Social-Emotional Reach Metric

Numerator:

Screening

or

Assessment



or

Brief Intervention

or

Treatment Service

Denominator:

Children aged 1-5 within the CCO

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Treatment Therapies: Common Services, Claims and Providers

Treatment Service

What: Treatment services

Where/By Whom: Provided by Specialty Behavioral Health, Eligible providers that may be in primary care home (more limited right now)

Examples of Service: Include, but not limited to, dyadic therapies, group therapies, and other services provided by Specialty Behavioral Health

Note: This is NOT specific to one type of modality or one set of services

Note 2: Some Primary Care HAVE hired staff within the clinic that can bill for psychotherapy codes

Claims: List 3 Codes

- 90832 -90838 - Individual psychotherapy
- 90847 -Family psychotherapy with patient present
- 90853 - Group psychotherapy (Not many currently offer, but a great way to enhance access and address culturally relevant care)

- See Asset Map and List of Modalities for "Aim of Services"
- See Page 2 of Therapies, Evidence Base, and Descriptives https://secureservercdn.net/198.71.233.179/kxw.e5f.myftpupload.com/wp-content/uploads/2020/07/5.15.20-CO-Behv-Health-Summary.pdf

Brief Interventions: Common Services, Claims & Providers

What: Brief intervention(s)

Where/By Whom: Eligible billing providers such as integrated behavioral.

- Specialty behavioral often doesn't use these, they use Tx codes normally.
- **Note:** Within early learning, could be health or home visiting nurse. 1.3 of the metric: how to consider contracting models for providers that do this, that can be in contracting model, but are not.

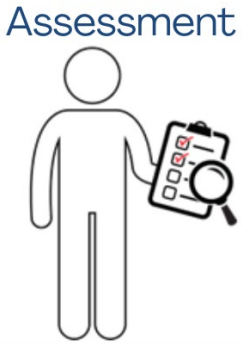
Claims: Lists 3 and 4 (all above line, covered with specific Dx pairing):

- **List 3**: Health and Behavior Intervention Codes

96158-96159	Health behavior intervention, individual, face-to-face (new in 2020)
96164-96165	Health behavior intervention, group (2 or more patients), face-to-face
96167-96168	Health behavior intervention, family(with the patient present), face-to-face (new in 2020)
96170-96171	Health behavior intervention, family(without the patient present), face-to-face (new in 2020)

- **List 4**: Preventive medicine counseling and/or risk factor reduction intervention(s): 99401 – 99404

Assessments: Common Services, Claims & Providers



What: Assessment of Social and Behavioral Needs, Follow-up strategy to clinical judgment or information from other screens done (e.g. ASQ, Maternal Depression screening, MCHAT)

Where/By Whom: Primary Care Providers , Integrated Behavioral Health, Contracted Early Learning Providers.

Example Screening Tools: *ASQ-SE, PSC, SWYC, BASC, CBCL, DECA, ECBI, SDQ*

Claim: List 1 – Brief behavioral or emotional assessment 96127, Health and behavior assessment 96156, 97151, 97152

- OPIP has developed a summary and training for IBH on this and factors to consider based on what the referring provider noted.
- High-Level Summary of A Community Based Approach We Used: https://secureservercdn.net/198.71.233.179/kxw.e5f.myftpupload.com/wp-content/uploads/2020/07/Strategic-Summary-for-Promotion-of-SE-Health-in-CO_4-8-20.pdf

Screening: Common Services, Claims & Providers

What: Screenings aligned with Bright Futures recommendations https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf;

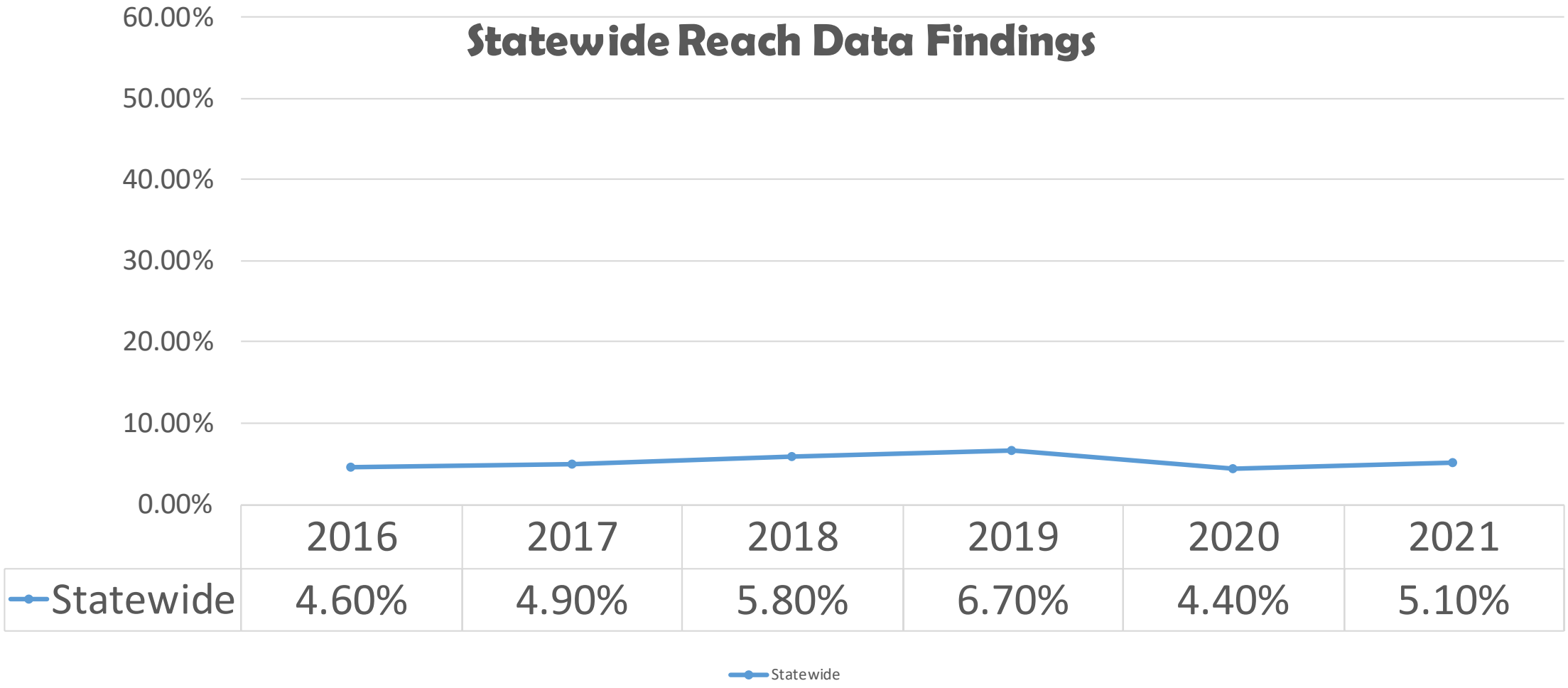
- Periodicity table is backbone of EPSDT
- Recommendations updated in July 2022 clearly stating screening as a component of recommendation
- https://publications.aap.org/pediatrics/article/135/2/384/33387/Promoting-Optimal-Development-Screening-for
- Claim used for screening is "Brief Behavioral Assessment" claim

Where/By Whom: Primary Care Providers in Context of Well Visits

Example Screening Tools: Pediatric Symptom Checklist, Strength and Difficulties Questionnaire

Claim: List 1 – 96127 Brief Behavioral or Emotional Assessment

State SE Reach Metric Data Over Time



Data Source: January 2022 SE Reach Metric Report Provided by OHA

Poll about Rates

The measure is a roll-up of whether children received screening/assessments and/or intervention services

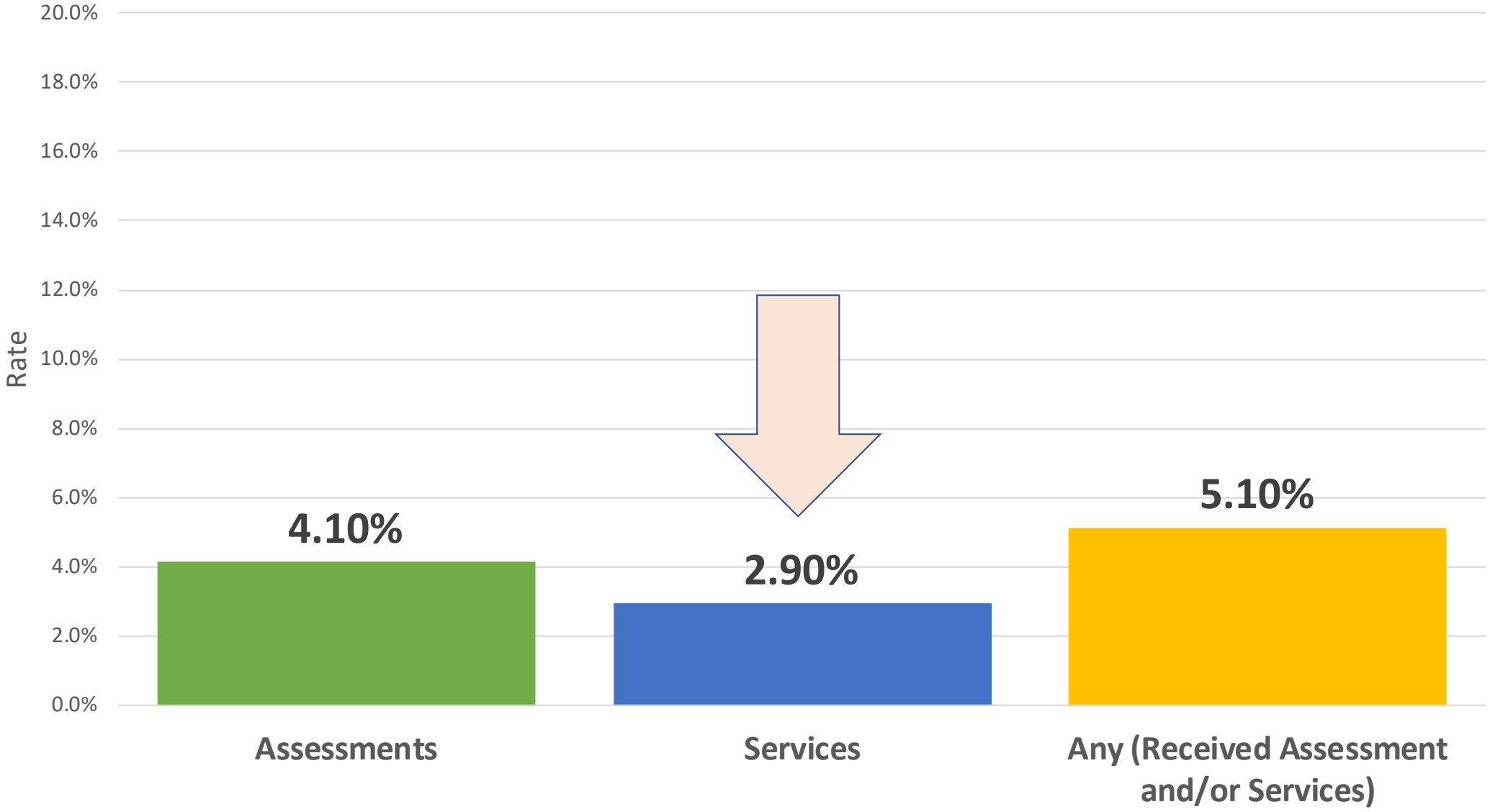
Which rate do you think is higher?

1) Screening/assessment rates
2) Intervention/therapy service rates
3) They will be the same

Statewide CY 2021 Data:

Social Emotional Health Reach Metric Data

Assessments vs. Services → Either



Purpose for Inclusion of Social Complexity Data in Reach Data Report

- Overall need for **all children** to have their social-emotional health assessed
- For children with **identified social complexity** need to services to address delays or preventive behavioral health interventions to promote healthy SE development
  - Alignment of ACES with Social Complexity Data
  - Adverse Childhood Experiences data and other evidence suggest that children who experience one or more of the social complexity factors would benefit from at least an assessment.
  - Lifelong and potential two-generational impact of ACES
- Examination of data for children who have specific social complexity factors can inform community-level outreach, partner engagement, and potential strategies to target efforts for children with historically inequitable outcomes.
  - Use to consider where to start given Social Reach data findings showing low rates and asset maps showing limited services.

Need for Social-Emotional Supports (including Behavioral Health and Attachment Focused Services) for Children Birth to Five: Statewide Child Health Complexity Data

- Literature on **social emotional health established** in first five years.
- Importance of **attachment and relationships in brain development**.
- **Adverse Childhood Experiences** have lifelong impacts.
- **Positive impact behavioral health services** that focus on attachment and building resilience can have.

SOCIAL INDICATORS FOR WHICH BEHAVIORAL HEALTH MAY BE VALUABLE: BIRTH TO FIVE Medicaid/CHIP Enrolled (N=145,005)	CHILD FACTOR	FAMILY FACTOR
Foster Care – Child receiving foster care services DHS ORKids	**6.9%** (9,966)	
Parent Death – Death of parent/primary caregiver in OR		**.8%** (1148)
Parental Incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon		**17.3%** (25,112)
Mental Health: Parent – Received mental health services through DHS/OHA		**40.1%** (58,210)
Substance Use Disorder: Parent – Substance use disorder treatment through DHS/OHA		**19.9%** (28,920)
Child Abuse/Neglect: ICD-9, ICD-10 dx codes related used by provider	**6.4%** (9,249)	

28.9% (41,883) had three or more social complexity indicators

Source: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Statewide-Report-2021-October.pdf

Purpose for Inclusion of Social Complexity Data in Reach Data Report

Data Specification and SE Reach Report Details to Note:

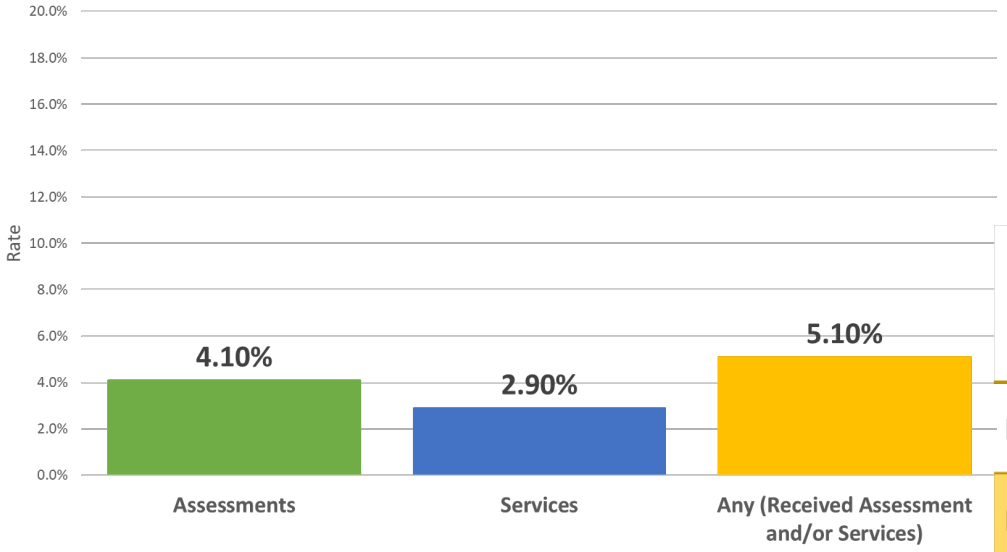
- Linked to population that was used for 2021 Health Complexity Data Reports
  - https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Statewide-Report-2021-October.pdf
- Data is run annually, looking back at experiences during the child's lifetime and prenatal period.
- Social complexity indicators based on various data sources of services received and linked to one or both parents through birth record data
  - Across all ages: Unable to link for about 26% of the population (so underrepresents social complexity experience)
- Data use agreements suppress data if there are small Ns to avoid child-level identification
  - SE reach metric report data suppressed if NUMERATOR was too small.
  - Child Health Complexity shows how many children have that experience-DENOMINATOR
- Child-level SE reach metric data could be linked to 2021 Health Complexity Data to allow for further analysis

State SE Reach Metric Data Over Time

State Wide CY 2021 Data:

Social Emotional Health Reach Metric Data

Assessments vs. Services → Either



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Data Source: January 2022 SE Reach Metric Report Provided by OHA

Social Emotional Reach for Children Experiencing Social Complexity

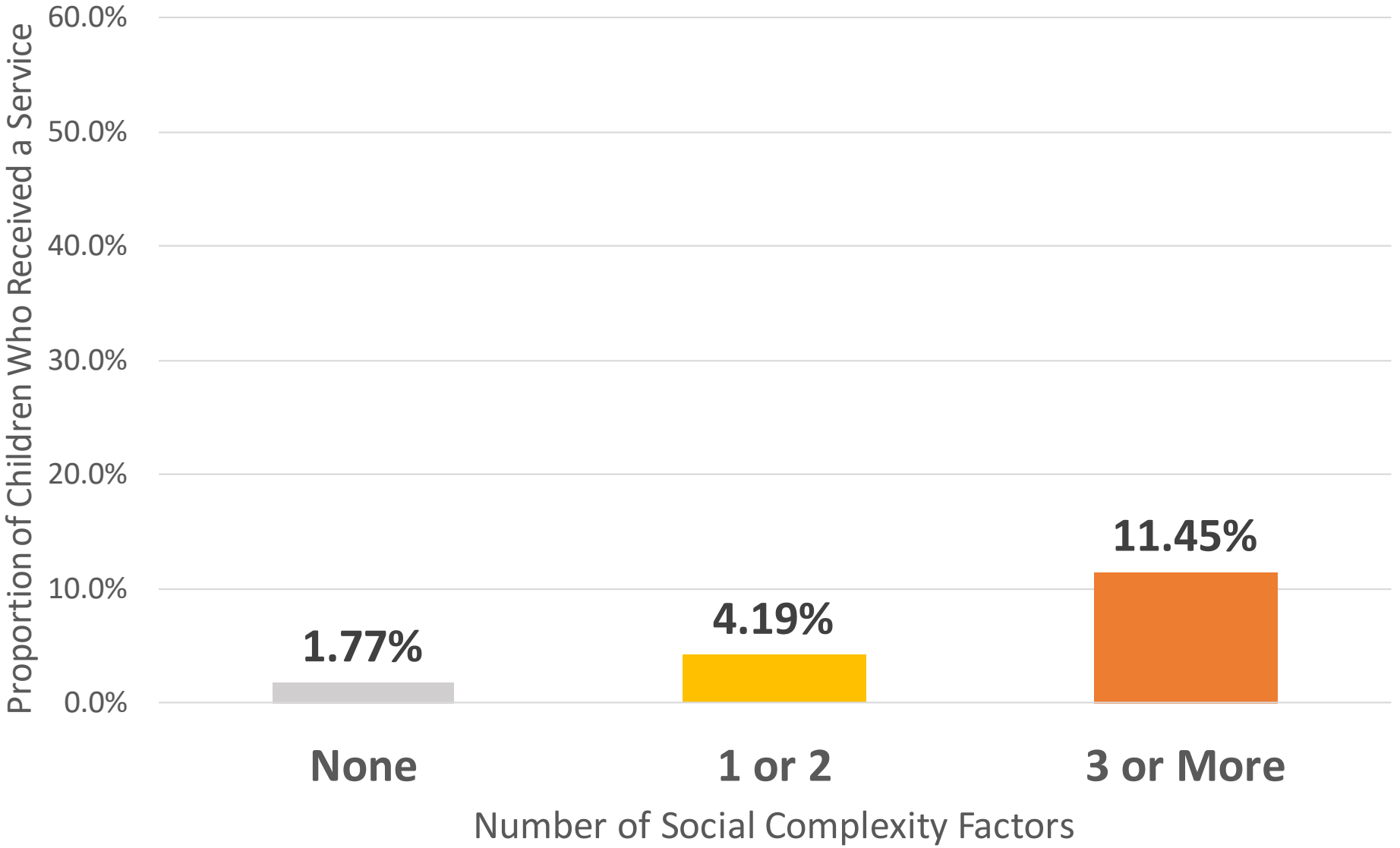
Statewide Reach Metric By Specific Child-Level Social Complexity Factors	% of Children with Social Factor that had Social Emotional Assessments or Intervention Service
Poverty –TANF (For Child and For Either/Both Parent), Below 37% of Poverty Level	**8.09%** (3883)
Foster care – Child received foster care services since 2012	**23.27%** (1959)
Parent death – Death of parent/primary caregiver in OR	**13.54%** (67)
Parental incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon	**9.22%** (1948)
Mental Health: Child – Received mental health services through DHS/OHA	**22.61%** (4504)
Mental Health: Parent – Received mental health services through DHS/OHA	**8.26%** (4019)
Substance Abuse: Child – Substance abuse treatment through DHS/OHA	**N/A***
Substance Abuse: Parent – Substance abuse treatment through DHS/OHA	**10.01%** (2192)
Child abuse/neglect: ICD-9, ICD-10 dx codes related used by provider	**30.10%** (2202)
Potential Language Barrier: Language other than English listed in the primary language	**7.06%** (1063)
Parent Disability: Parent is eligible for Medicaid due to recognized disability	**12.13%** (496)

***Data Source**: ICS and Medicaid /CHIP data sourced from All Payer All Claims database*

Population: Children Medicaid/CHIP insured in Oregon as of July 2020, **Used for 2021 CCO PIlot.**

*Numbers too small to report

2020 Reach Metric Findings by Children With System-Level Complexity Factors



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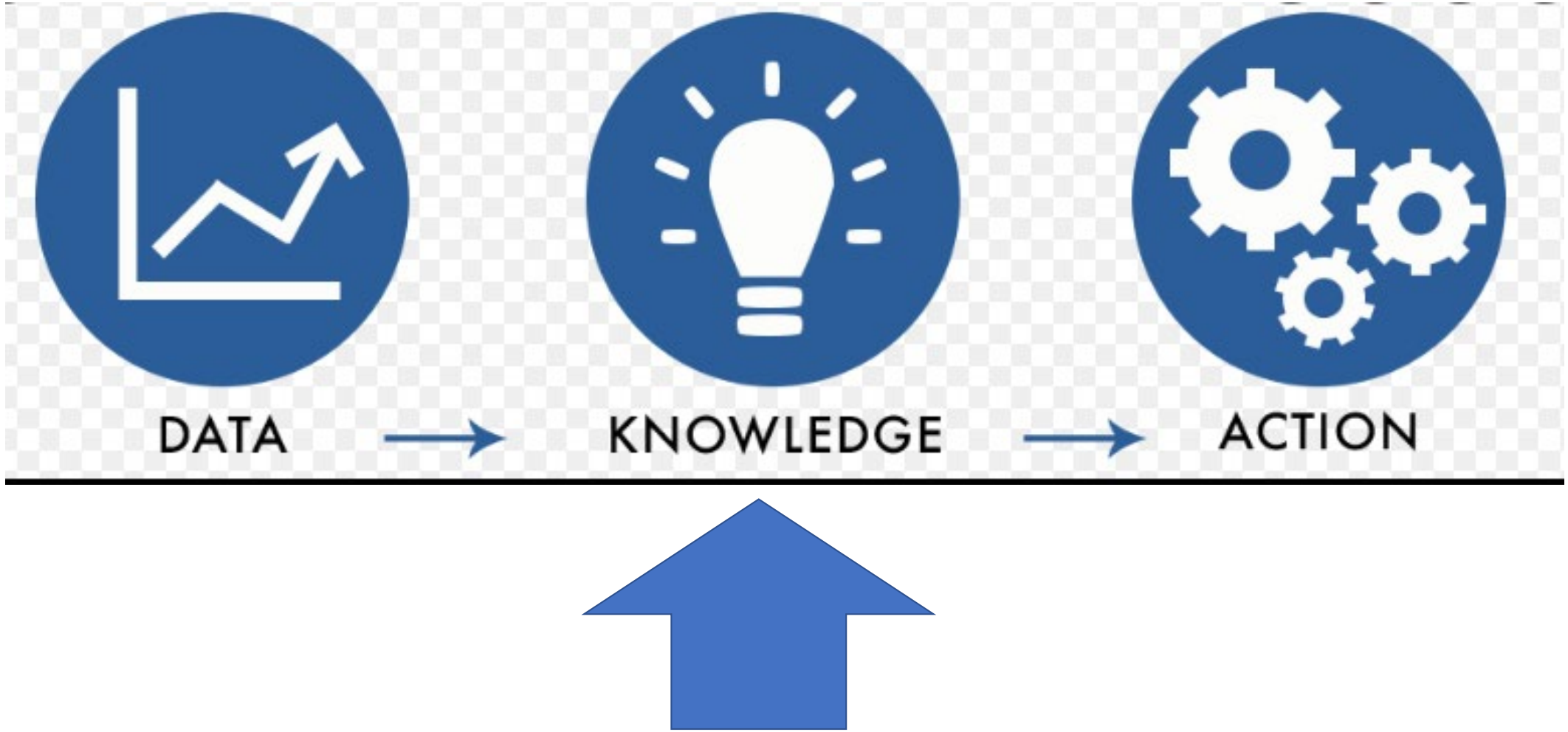


- Review and informed by CCO contracted partners (clinical, behavioral), community partners, and parents with lived experienced.
- Emphasis and requirement on listening to children with historical and contemporary inequitable outcome and access.

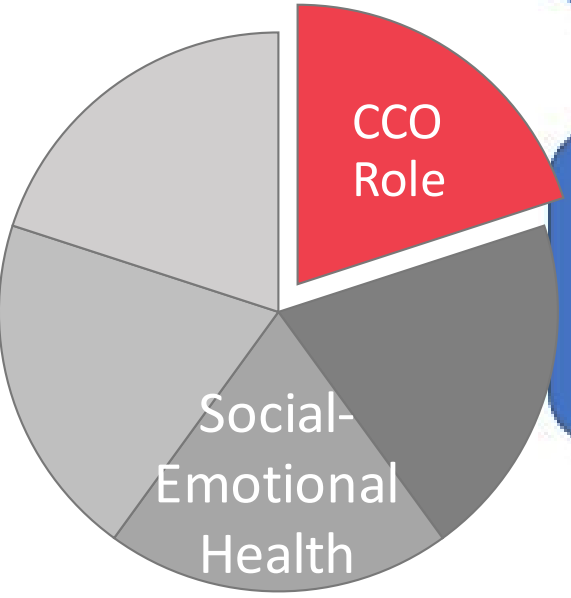
What are children getting now?

Year 1: What CCO Covered Providers Exist for the "Services" Component

Years 2-3 enhance expand access mapping

Component 1: Examining reach metric data

Component 2: Mapping assets and service gaps



Component 3: Engaging community to review data, assets, gaps, and discuss priorities for improvement

Component 4: Create action plan to improve provision of services

Given what children are getting, what exists in the system, where should we start?

Frequently Asked Questions Not Already Addressed

- Below are the ones we will cover today based on what we have already heard.
- 9/21 webinar will be interactive discussion and participants can submit their questions beforehand.

1) What should the Reach Metric data rate be? How do we set benchmarks?
2) Is it surprising that the rate is so low?
3) Why is the list so large and inclusive? Are claims included that are not covered on the prioritized list?
4) Why don't you include anticipatory guidance?
5) Why don't you include maternal depression screening?
6) Shouldn't we just focus on screening first to increase the rates?

What SHOULD be the SE Reach metric rate be? What are we aiming for with benchmarks?

Interventions/Therapies

- **Brief interventions** that could be provided by eligible billing providers such as Integrated Behavioral Health, Home Visiting Nurse or eligible providers (which is something that ban be addressed in 1.3* of the metric – how to consider contracting models)

  OR

- **Treatment services** (individual, family or group psychotherapy) provided by Specialty Behavioral Health that can include, but are not limited, to dyadic therapies, group therapies, and other services provided by Specialty Behavioral Health (Note: This is NOT specific to one type of modality or one set of services)

Children That Will Have Dx: 12-17%

High ACEs in Oregon: 28.9% (41,883) had 3 or more

Screening/Assessments

- Bright Futures recommended **screening tools** to assess for social-emotional health that primary care providers may use: Example: Pediatric Symptom Checklist

  OR

- **Assessment** integrated behavioral health may do for children referred to them based on clinical judgment or ASQ or MCHAT results such as ASQ-SE or brief evaluation tools

Recommendations Call for All Children to be Screened in First Five Years

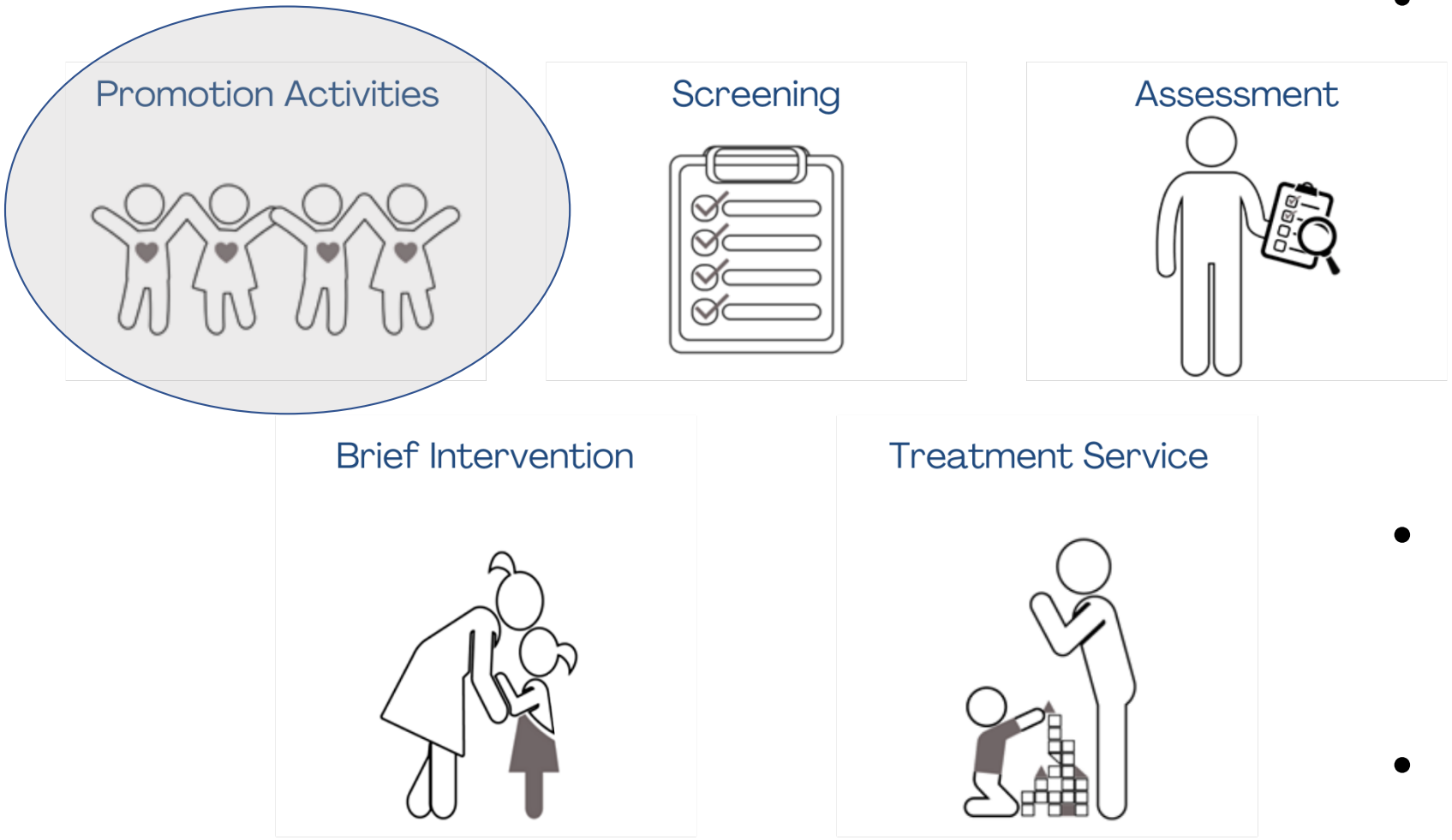
Is it surprising the rate is so low?

- OPIP was not surprised by low rates given community and practice-level work
- Complex set of factors across the full system (primary care, integrated behavioral health, specialty behavioral health) that lead to barriers within each, interdependency of each
  - Tug/Pull of screening for something that the are not services
  - Training on SE health for young children
  - Behavioral health capacity and workforce shortage, especially with focus on “big kids and big adults” with problems first
- Gap between clinical recommendation and implementation
  - Bright Futures standards clarified in July 2022
  - Remember the journey with Developmental Screening and where we started in 2013 when it had been a recommendation since the 1990s.

Social-Emotional Reach Metric Data: To be Inclusive or Narrow to Most Common and Important Systems and Processes

- **Key discussion points facilitated in CCO Pilot and in TAG engagement**
  - OPIP asked about **List 2 and List 5,** specifically the added value, but cons of inclusion
    - Consensus was to be as inclusive as possible
    - Allows CCOs to count all things
    - Allows CCO flexibility within 1.3 to consider payment and contracting policies aligned with clinically relevant and valid services
    - Before the decision to modify waiver language related to EPSDT
- **That said, anchored to population-based recommendations (Bright Futures) and the most common services aligned with the standards of care - priority codes would be:**
  - **List 1**: Bright Futures recommended **assessments** – 96127 (Diagnostic procedure list), Health and Behavior Assessment Codes (96156,97151, 97152)
  - **List 3&4**: **Brief interventions** used by integrated behavioral health - Preventive medicine counseling and/or risk factor reduction intervention(s): 99401 – 99404; Health and Behavior Intervention Codes (All above line, covered with specific Dx pairing)
  - **List 3**: **Dyadic Services** Aligned with Evidence Based, Clinical Recommendations to Address Delays: 90832-90838, 90847, 90853 (Above Line, Covered with specific Dx Pairing)

Why don’t you include anticipatory guidance?



- Anchored to pain points identified by community pilots, therefore focused on screening, assessments and services → with priority on services
- Lack of validity of claims data about anticipatory guidance
- Importance of individualized behavioral health support

Why don’t you include maternal depression screening?

- Maternal depression screening is its own clinical recommendation. Currently in CCO Incentive Set, metric on pre/post natal care. HAKR workgroup identified priority for metric on services **that the child receives**.
- Maternal depression is important correlate and factor that impacts child’s social emotional health.
- Intent of metric is to directly assess and address a child's social-emotional health, so using maternal depression as a flag to perform individual assessments and provide SE support is an important priority follow-up and IS included in the reach metric data
    - E.g. If you identify maternal depression and an ASQ score that is borderline or delayed, claims related to assessment anchored to the follow-up to assess for impact on SE health

Shouldn’t we just focus on screening first to increase the rates?

Analogy of the Bike

Early Identification: Screening and then Assessments

Referral pathways and Parent Engagement

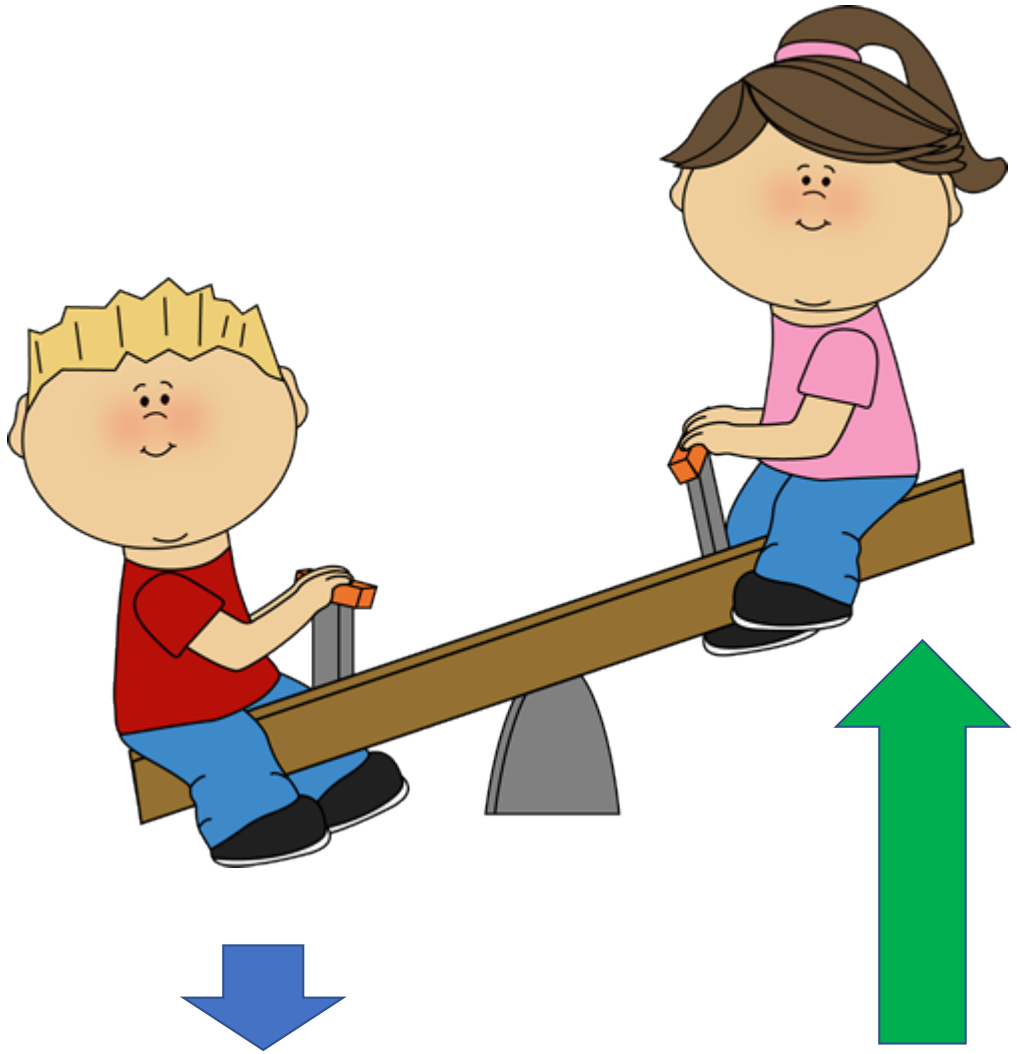
Intervention/Therapies

Shouldn’t we just focus on screening first to increase the rates?
Analogy of the Teeter Totter

Overall Supply of Behavioral Health What we Already Know in Exploring Services for Children and Heard from HAKR Survey:

- There are many cases of unmet need and the biggest pain point identified was in service delivery (supply of services are low)
- Component 2 will likely expose gaps in service or service capacity available for the children providers across sectors are already identifying and noting frustrations in CCO covered services.
- Why examining data in the context of the asset map is critical.
- Why hearing from community partners OUTSIDE CCO services that need CCO services for children they are identifying is critical in action plan development.

Shouldn’t we just focus on screening first to increase the rates?
Analogy of the Teeter Totter



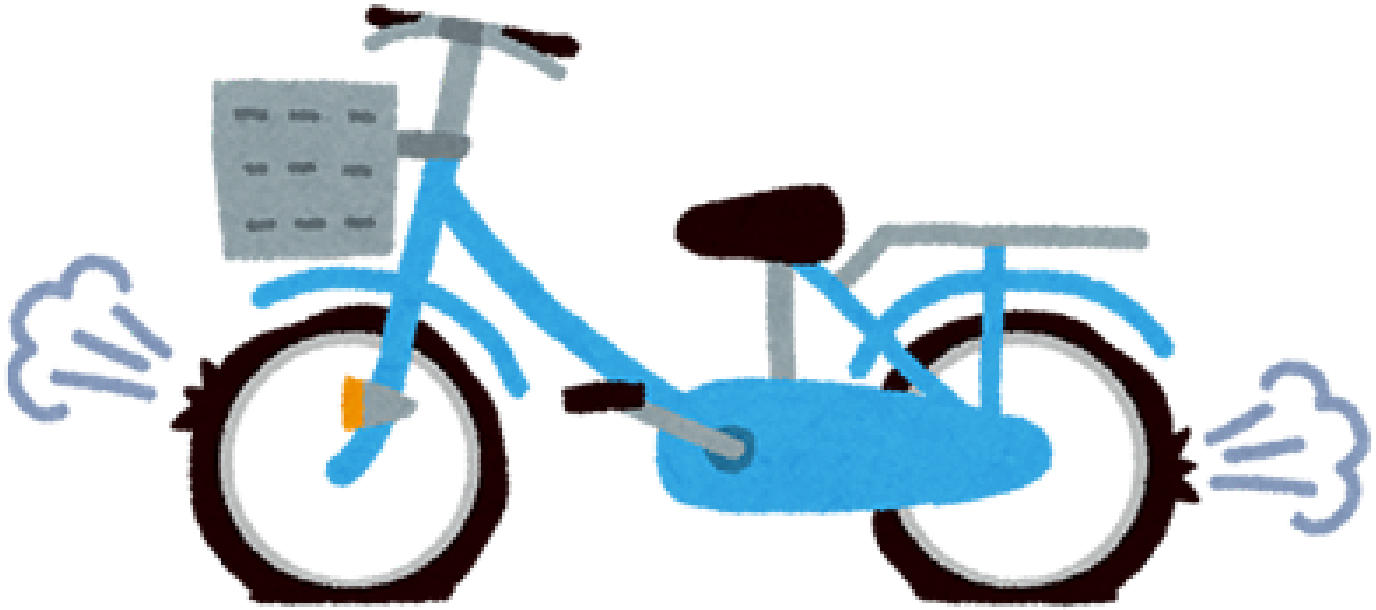
If we focus our efforts ONLY on **screening we are increasing the demand** for services, but the **supply of intervention & therapy services will remain low**

Need to consider family-centered approaches.

Shouldn't we just focus on screening first to increase the rates?

- Component 2 of the metric is anchored to asset mapping of the systems that can provide services for children identified.
  - Assessing availability and capacity of the system to provide the "**Intervention and Therapy Services**" claims in the Social-Emotional reach metric.
  - If Asset Mapping done in Component 2 shows capacity and availability, then a focus on screening may be a good follow-up.
- OPIP's experience in hearing from front-line primary care, community based and early learning providers is that there are not services for children they are identifying through their current efforts, current screens (ASQ, maternal depression, MCHAT).
  - Therefore, the priority was on enhancing the interventions and therapies available across the spectrum of places it could be provided (integrated behavioral health, specialty behavioral health).
  - Includes a focus on interventions that are right match and will increase engagement
  - Includes consideration of referral pathways

OPIP Perspective in Reviewing Data and Working with Some Partner



Early Identification: Screening and then Assessments

Referral pathways and Parent Engagement

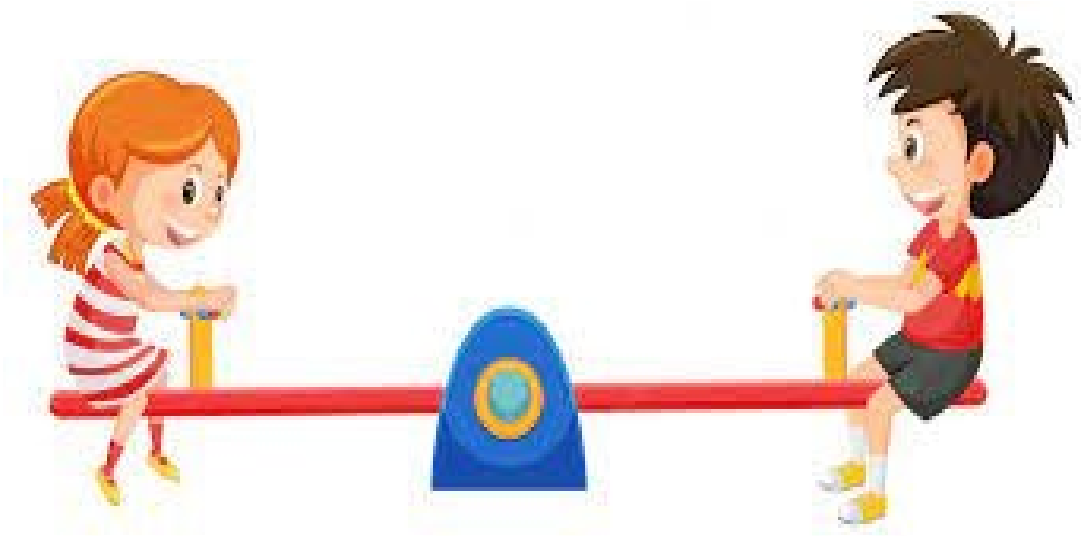
Intervention /Therapies

- LISTEN to Front Line
- Action plan needs to focus on putting “air” in tire for services.
  - ✓ Prioritize services needed for populations identified with historical inequitable outcomes.
- Then Focus on Air in Both Tires and the Pathways to Services, Considering Priority Focus on Populations

Shouldn't we just focus on screening first to increase the rates?
Analogy of the Teeter Totter

We need to balance the Teeter Totter

Why the incentive measure is not tied to improvements in the reach metric



Instead we recommend supporting a holistic approach aligned with the Action Plan Categories to:

- ✓ **Anchored to the listening of CCO contracted, community partners and parents about where to start**
- ✓ Build Capacity of Interventions and Therapies, Prioritize services needed for populations identified with historical inequitable outcomes.
- ✓ Develop Systems and Processes to Support Referral Pathways and Parental Engagement
- ✓ Understand Social Emotional Health for children birth-5 and indicators that may be present