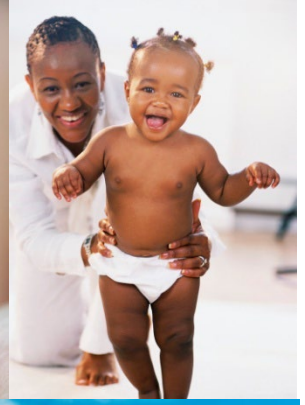
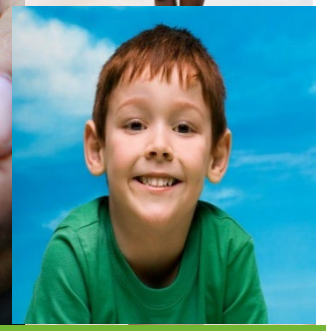





Welcome!

Thank you for coming to the

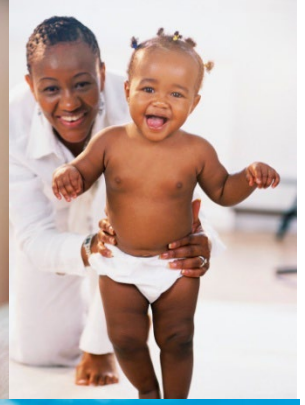
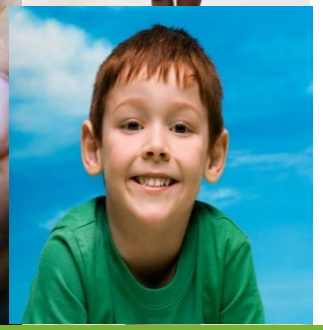
Galvanizing Action for Children with Health Complexity Community Meeting

You will be muted upon entry

We will be encouraging participation, using some of the functions on ZOOM

We know its lunch time, please grab a snack and a glass of water!

We will also be recording this Webinar for folks unable to attend.


Douglas County Community Level Meeting

Led by the Oregon Pediatric Improvement Partnership (OPIP), funded by The Ford Family Foundation and Supported by Local Community Partners Services on the Steering Committee

November 12, 2021, 11:30 AM – 1:00 PM

We will be recording this webinar for folks unable to attend.

Objectives for Meeting

- Provide an **update on the work** that has happened in partnership with local partners.
- **Share materials** developed to support the community in disseminating information about the Call to Action.
- Provide an overview of the **two priority population health strategies** confirmed by the local Steering Committee: *1) Enhancing use of the health complexity data, and 2) Addressing the capacity of and child and family centered pathways to behavioral health.*
- Provide an overview of the updated **2021 Child Health Complexity Data**.
- Describe how the work is **aligned with the new Coordinated Care Organization incentive metric** focused on Social-Emotional Health.
- Obtain input and guidance on **community-level members** that should be engaged and opportunities for shared learning.

Agenda

- Welcome, Introductions and Acknowledgements.
- Refresher: Where We Have Been Since March 2020!
- What Has Been Developed to Support Your Community in Sharing About the Douglas County Call to Action
- Where We Are Going and How You Can Be Involved
  - Enhancing Use of the Health Complexity Data
  - Addressing the Capacity of and Child and Family Centered Pathways to Behavioral Health
- Alignment of Efforts with New CCO Incentive Metric Focused on Social-Emotional Health for Young Children
- Overview of Next Steps

Oregon Pediatric Improvement Partnership

The **Oregon Pediatric Improvement Partnership (**OPIP) supports a meaningful, **long-term collaboration of stakeholders** invested in child health care quality, with the common purpose of improving the health of the children and youth of Oregon.

OPIP is primarily contract and grant funded.

Statewide organization based out of Pediatrics Department Oregon Health & Sciences University.

What do we do?

OPIP uses a **population based approach—starting with child/family**. Our staff and projects focus on:

1. Collaborating in **quality measurement and improvement** activities;
2. Supporting **evidence-guided quality activities**;
3. Incorporating the **patient and family voice** into quality efforts; and
4. Informing **policies that support optimal health** and development

oregon-pip.org

Steering Committee of Local Colleagues: Thank you!

- Alison Hinson, Douglas Education Service District
- Amanda Rigsby, Umpqua Health Alliance
- Amy Thuren, Health Care Coalition of Southern Oregon
- Brian Mahoney, Douglas Public Health Network
- Gillian Wesenberg, South Central Early Learning Hub
- Jessica Hunter, Dept of Human Services Child Welfare
- Jill Fummerton, FEEAT Family Network
- Kat Cooper, Umpqua Health Alliance
- Lee Ann Grogan, Creating Community Resilience
- Lisa Platt, Mercy Foundation
- Rob McAdam, Umpqua Health Alliance
- Robin Hill-Dunbar, The Ford Family Foundation
- Sondra Williams, Early Intervention/Early Childhood Special Education
- Tracy Livingston, Dept of Human Services Child Welfare
- Kim Tyree (New Member!), Evergreen Family Medicine
- Ruth Galster, Douglas County Communities Network of Care (Retired from Committee Fall 2021)

Acknowledgement of The Ford Family Foundation Support

Grant Award to OPIP: Galvanizing Action for Health Complex Children

Goal: Support local communities to engage partners, galvanize action and support improvement efforts.

Funder: The Ford Family Foundation

Within Douglas County this supports:

- Facilitation of Community-Level Meetings
- Development of Materials
- Implementation support for the **two priority population health strategies** confirmed by the local Steering Committee:

  1) Enhancing use of the health complexity data, and

  2) Addressing the capacity of and child and family centered pathways to behavioral health.

Agenda

- Welcome
- Refresher: Where We Have Been Since March 2020!
- What Has Been Developed to Support Your Community in Sharing About the Douglas County Call to Action
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Refresher: Where We Have Been

Before March 2020 Meeting:

- Fall 2019 Meeting of Local Stakeholders about Interest in Community-Level Meeting
- Development of a Steering Committee of Local Partners to Inform the Work

March 2020 Meeting

- Over 70 people attended, including parents of children with health complexity
- Agenda focused on whether there should be a call to action, parameters to consider, and input on priority areas

POST March Meeting – Today!

- **COVID & COVID-19 RESPONSE**
- Quarterly Meetings of Steering Committee to Confirm Themes of the Call to Action
- Review and provide input on materials to disseminate information about Call to Action, Development of Materials
- Review and approve of the Two Population Health Strategies that OPIP would support given skills, priorities, and FFF funding

March 3, 2020

Douglas County Stakeholder Meeting

March 2020 Agenda

- **10:20 – 11:00**: **What is the Health Complexity Data Telling Us?** Douglas County's Child Health Complexity Data: Overview of medical, social and health indicators for children in the region
- **11:00 – 12:00: Hearing from Parents of Children with Various Levels of Health Complexity in Douglas County**
- **12:00-12:30 Break to Get Lunch**
- **12:30-1:45: Douglas County's Call to Action for Children with Health Complexity**
  - Setting the stage for the small group discussion.
  - Facilitated **small group discussion**
  - Small group report out of discussion
- **1:45-2:00 Looking Forward**
  - Second Meeting to Review Specific Action Plans

Meeting attended by 70 people that represented various sectors and parents of children with health complexity

Call to Action Need Clearly Identified

Community leaders from education, health care, early learning hubs, community action organizations, tribal representatives, and more came to consensus on the need for a ***call to action*** and began to immediately to explore ***priority areas*** on which to focus.

Small groups and post meeting surveys revealed a number of great ideas and insight from these cross-sector stakeholders:

- 100% agreed that the **data provided meaningful indicators** about the need for action to support children and families better
- 100% **expressed a commitment** to supporting next steps
- 95% agreed that there was **consensus on the need for action** in addressing children with health complexity.

Content of the Call To Action

- Focus of the Small Break Out Group at March Meeting
- Additional feedback requested from the After Meeting Survey
- OPIP then also conducted individual interviews with specific agencies

Community-Owned Themes Identified by OPIP based Meeting Small Group, Post Meeting Survey, and Reviewed by Local Steering Committee

1. Increase *Community-level Awareness* About the Health Complexity Data & Leverage Data to Identify Needs
2. *Community Resource Mapping and Assets*, Assessment of Capacity and Priority Needs to Fill Gaps
3. Address Barriers to Access of *Existing Services*
4. *Train Providers* to Better Care for Children with Health Complexity and Their Families
5. Address Capacity of, and *Child- and Family-Centered Pathways* to, Behavioral Health
6. Address *Preventive* Health & Social Service Needs of Children with Social Complexity
7. Improve Housing for Children with Health Complexity

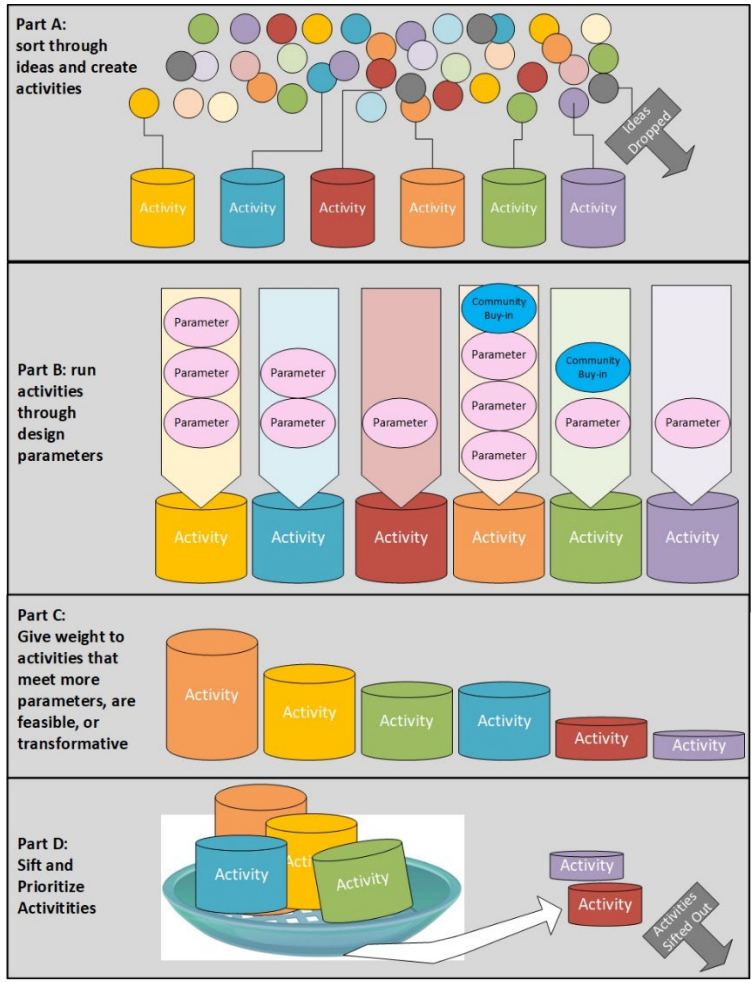
Design Parameters Confirmed At Meeting

- Be able to be **started in the next year**.
- Be **Family-centered & family-informed**, ensuring representation and diversity.
- Be **Provider-informed**, ensuring a diverse front-line provider perspective.
- Be **Trauma-informed** and ensure a focus on **cultural competence**.
- Be focused on **building strengths and resilience** in health complex children and their families.
- Ensure a focus for all children & will **include an intentional focus on health complex children under five.**
- **Align with and leverage priorities** and momentum within:
  - Coordinated Care Organization Priorities
  - Raise Up Oregon for Early Learning
  - Title V Priorities
  - Student Success Act
  - Other local community initiatives such as community health improvement plans, Network of Care, Systems of Care, the Blue Zones project, perinatal task force.

Parameters Used to Identify Two Population Improvement Priorities that OPIP Would Lead

OPIP proposed to the Steering Committee **the two priorities areas** and **specific activities**

- Project priorities were explored with Covid-19 in mind
- All themes were filtered through a priority lens to find items ready for action
- Ensured overarching priorities incorporated
- Ensured **children with health complexity under five** explicitly addressed in work plan
- Consensus was obtained that the steering committee would pursue planning



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Communication Materials and Data to Support Cross-Sector Call to Action for Children With Health Complexity

Developed in Collaboration with the **Children's Institute** & Support and Review from **Local Steering Committee**

- Two-Page Overview of Call to Action (Document)
- Video Vignette of the Need for the Call to Action, Select Representatives from the Steering Committee and Parents
- Developed by **Oregon Health Authority**, with consultation and technical assistance from OPIP
- 2021 Health Complexity Data
  - County-Level Aggregate Report
  - CCO Aggregate Report
  - CCO Child-Level Data File

Call to Action

In the late fall of 2019, the Oregon Pediatric Improvement Partnership (OPIP), in partnership with The Ford Family Foundation, convened key stakeholders in Douglas County to develop a call to action for creating solutions for children with medical and social needs. That meeting was the beginning of a year-long process, guided by a steering committee of local leaders, that set the foundation for cross-sector collaboration focused on the social and medical needs of children birth to age 21.

The community wide effort established the foundation for transformative partnerships connected to a common goal: support local communities to engage partners, galvanize action, and support improvement efforts focused on children with medical and social needs.

This work builds on previous OPIP efforts to engage health systems and communities in Oregon using data to inform population-based improvement efforts for children with complex health needs.

ADDRESSING

Child Health Complexity

In Douglas County

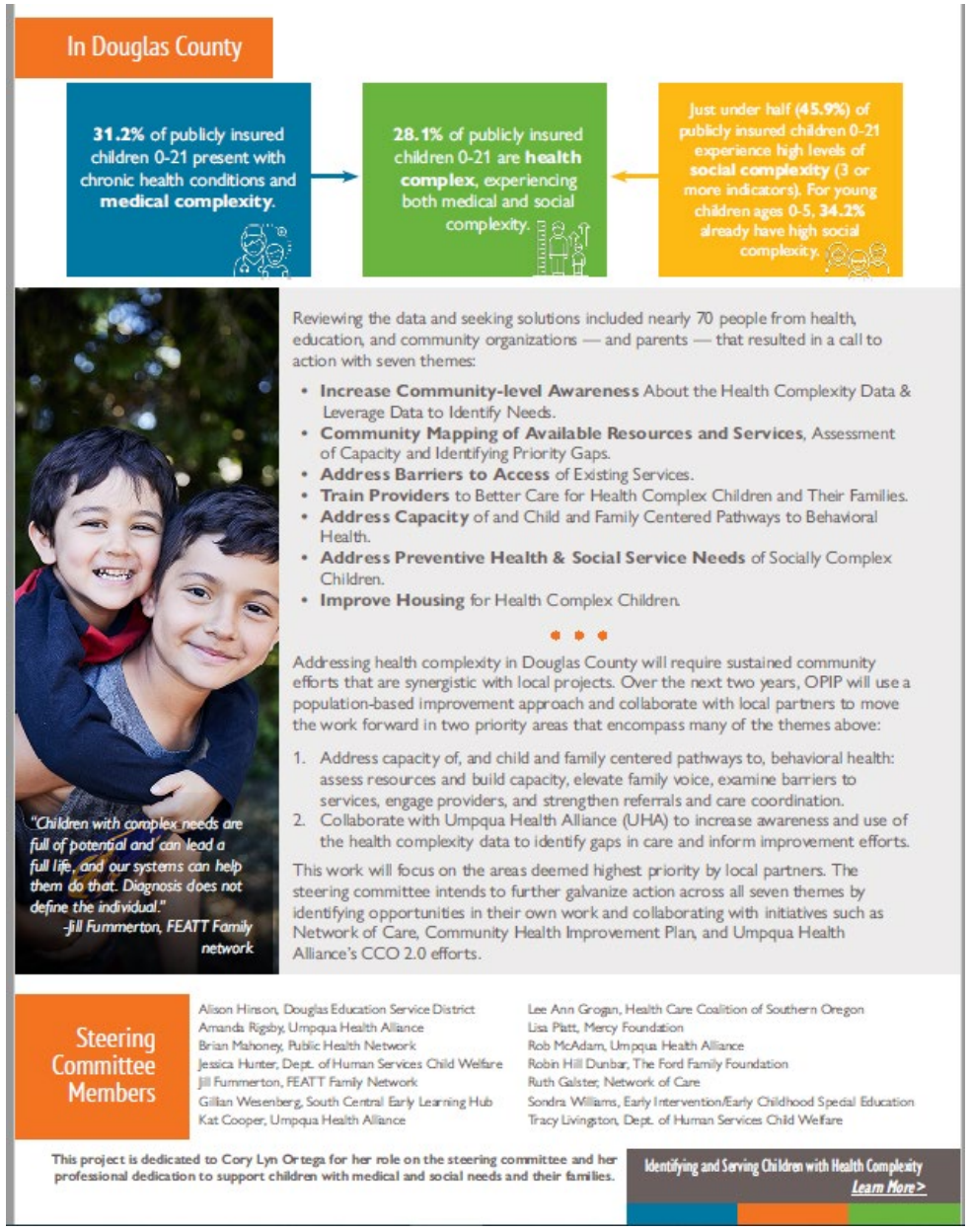
Why focus on child health complexity?

- Lifelong health and well-being start in early childhood.
- Child health and development are particularly impacted by the social determinants of health and equity.
- Thoughtful and innovative approaches are needed to address children's health complexity and health disparities.
- Provides a targeted approach to addressing Oregon's priorities focused on families.

Medical Complexity
Includes utilization of services, diagnoses, and number of body systems impacted.

Health Complexity
Combining the medical and social complexity factors create a health complexity score.

Social Complexity
Includes individual, family, or community characteristics that impact health outcomes.



In Douglas County

31.2% of publicly insured children 0-21 present with chronic health conditions and **medical complexity.**

28.1% of publicly insured children 0-21 are **health complex**, experiencing both medical and social complexity.

Just under half **(45.9%)** of publicly insured children 0-21 experience high levels of **social complexity** (3 or more indicators). For young children ages 0-5, **34.2%** already have high social complexity.

Reviewing the data and seeking solutions included nearly 70 people from health, education, and community organizations — and parents — that resulted in a call to action with seven themes:

- **Increase Community-level Awareness** About the Health Complexity Data & Leverage Data to Identify Needs.
- **Community Mapping of Available Resources and Services**, Assessment of Capacity and Identifying Priority Gaps.
- **Address Barriers to Access** of Existing Services.
- **Train Providers** to Better Care for Health Complex Children and Their Families.
- **Address Capacity** of and Child and Family Centered Pathways to Behavioral Health.
- **Address Preventive Health & Social Service Needs** of Socially Complex Children.
- **Improve Housing** for Health Complex Children.

Addressing health complexity in Douglas County will require sustained community efforts that are synergistic with local projects. Over the next two years, OPIP will use a population-based improvement approach and collaborate with local partners to move the work forward in two priority areas that encompass many of the themes above:

1. Address capacity of, and child and family centered pathways to, behavioral health: assess resources and build capacity, elevate family voice, examine barriers to services, engage providers, and strengthen referrals and care coordination.
2. Collaborate with Umpqua Health Alliance (UHA) to increase awareness and use of the health complexity data to identify gaps in care and inform improvement efforts.

This work will focus on the areas deemed highest priority by local partners. The steering committee intends to further galvanize action across all seven themes by identifying opportunities in their own work and collaborating with initiatives such as Network of Care, Community Health Improvement Plan, and Umpqua Health Alliance's CCO 2.0 efforts.

Steering Committee Members

Alison Hinson, Douglas Education Service District
Amanda Rigsby, Umpqua Health Alliance
Brian Mahoney, Public Health Network
Jessica Hunter, Dept. of Human Services Child Welfare
Jill Fummerton, FEATT Family Network
Gillian Wesenberg, South Central Early Learning Hub
Kat Cooper, Umpqua Health Alliance
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Rob McAdam, Umpqua Health Alliance
Robin Hill Dunbar, The Ford Family Foundation
Ruth Galster, Network of Care
Sondra Williams, Early Intervention/Early Childhood Special Education
Tracy Livingston, Dept. of Human Services Child Welfare

This project is dedicated to Cory Lyn Ortega for her role on the steering committee and her professional dedication to support children with medical and social needs and their families.

Identifying and Serving Children with Health Complexity
Learn More >

Child Health Complexity Data

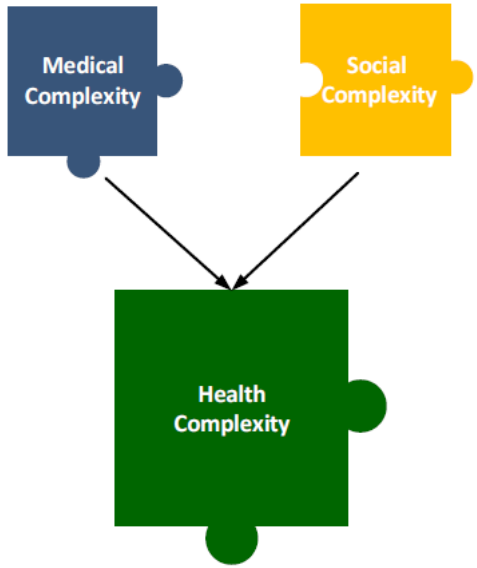
Health Complexity in Children – Douglas County

October 2021

Introduction

The goal of this report is to provide a summary of system-level data about children with health complexity in the Oregon Health Plan (OHP, Medicaid) and Children's Health Insurance Program (CHIP). This report has data specific to this county's population. It contains data for children who were residing in this county as of August 2021. The cohort of this dataset includes all children, ages 0 - 20 years old, who were enrolled in Medicaid/CHIP as of May 31, 2021. For measuring medical complexity using the Pediatric Medical Complexity Algorithm (PMCA), the data set has a look back at claims data from the All Payer All Claims (APAC) database for these children from January 1, 2018 through December 31, 2020. For measuring social complexity, the look back period for these indicators is the lifetime of the child plus one year prior to birth when available.

Health complexity is a concept that takes into account both the child's medical and social complexity. The Oregon Pediatric Improvement Partnership (OPIP), Office of Health Analytics at the Oregon Health Authority (OHA), Oregon Enterprise Data Analytics (OEDA) and Integrated Client Services (ICS) at the Oregon Department of Human Services (ODHS) are partnering to identify children with health complexity and share this data with CCOs, community partners and other stakeholder groups. Additional support for OPIP's role in providing technical consultation and facilitation of public and private stakeholders was provided by the Lucile Packard Foundation for Children's Health.



OPIP

DHS Oregon Department of Human Services

Oregon Health Authority

Health Complexity in Children – Umpqua Health Alliance

October 2021

Introduction

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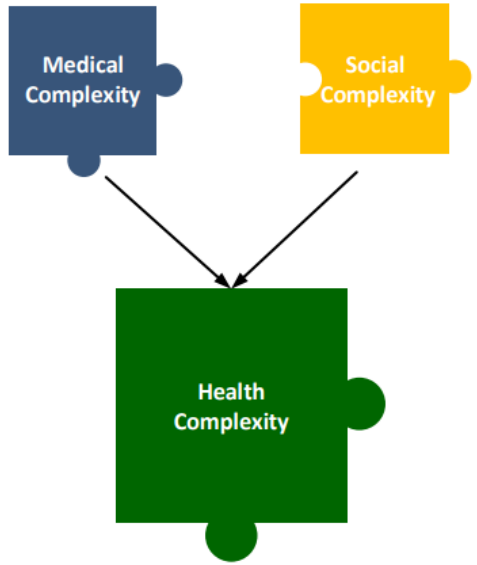


OPIP

DHS Oregon Department of Human Services

Oregon Health Authority

Douglas County Health Complexity Findings

Highlight of Data Included in the 2021 Reports

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

Note: There is also a version for Umpqua Health Alliance here:
https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Umpqua-Health-Alliance-2021-October.pdf

Measuring Children's Health Complexity

Medical Complexity

Defined using the Pediatric Medical Complexity Algorithm (PMCA)

- Leverages system-level data over a three year period
- Takes into account: 1) Utilization of services, 2) Diagnoses, 3) Number of Body Systems Impacted
- Assigns child into one of three categories: a) Complex with chronic conditions; b) Non-Complex, with chronic conditions; or c) Healthy

Social Complexity

Defined by The Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN) as:

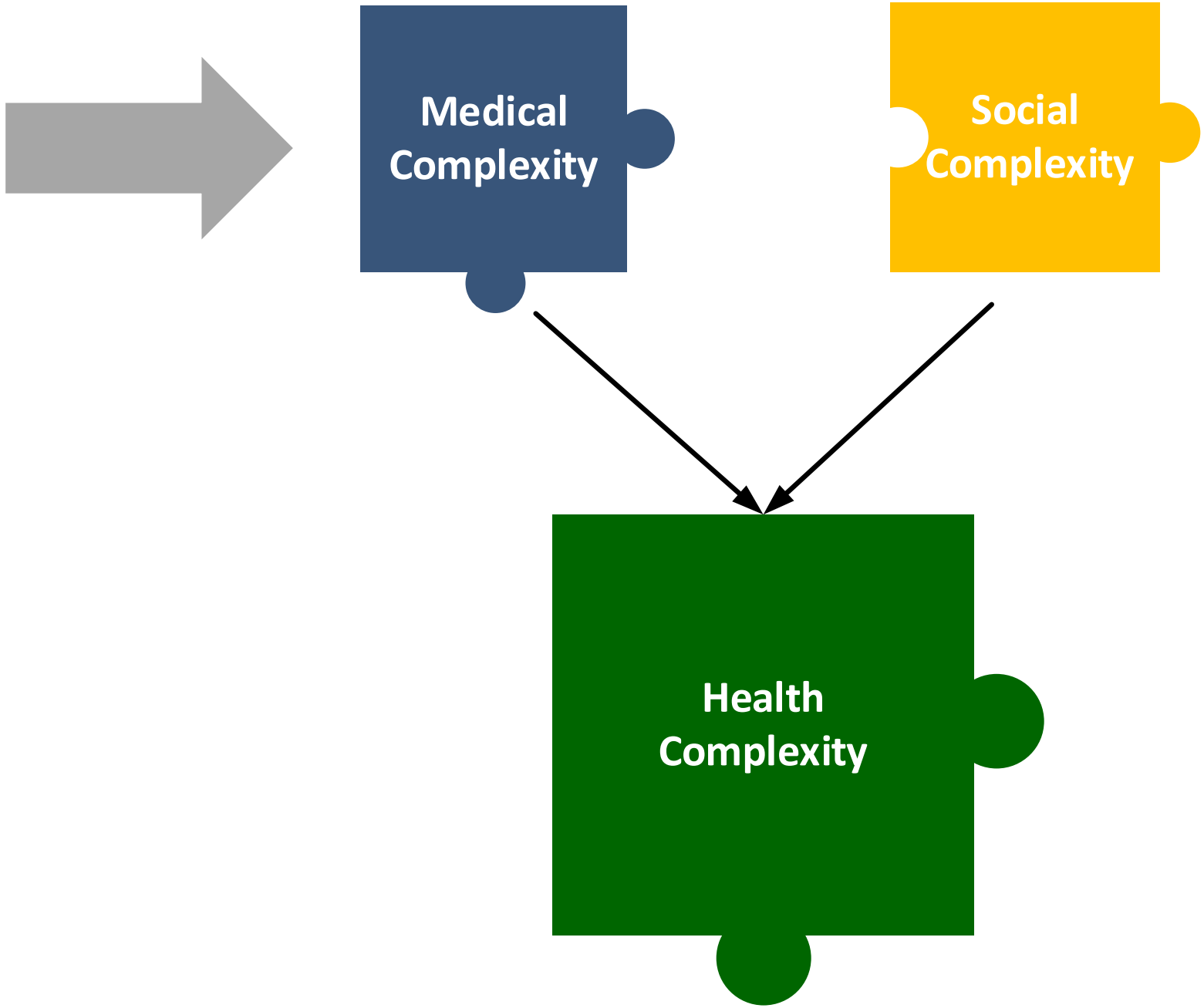
> *"A set of co-occurring individual, family or community characteristics that can have a direct impact on health outcomes or an indirect impact by affecting a child's access to care and/or a family's ability to engage in recommended medical and mental health treatments"*

Our work incorporates factors identified by COE4CCN as predictive of a high-cost health care event (e.g. emergency room use).

Health Complexity

Combines the factors of **Medical** + **Social** = **Health Complexity**

OPIP


Medical Complexity
Social Complexity
Health Complexity

Pediatric Medical Complexity Algorithm Findings for Children Enrolled in Medicaid/CHIP

Page 3 of the report: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Douglas-2021-October.pdf

Douglas County Publicly Insured as of August 2021: 16,071

1. Complex Chronic Disease: 9.9%
   N=1,587
2. Non-Complex Chronic Disease: 19.3%
   N=3,101

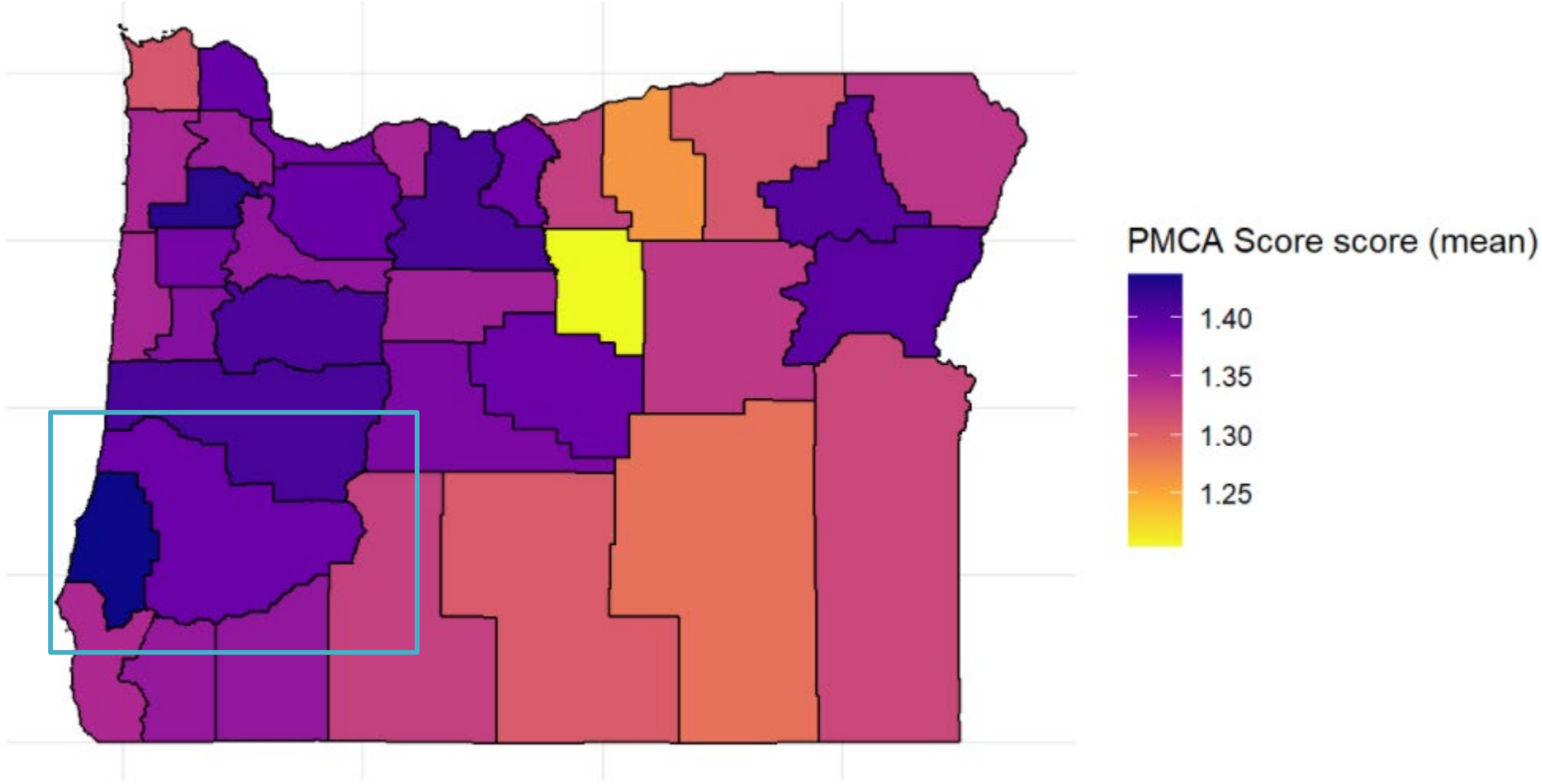
29.2%

3. Healthy: 70.8%

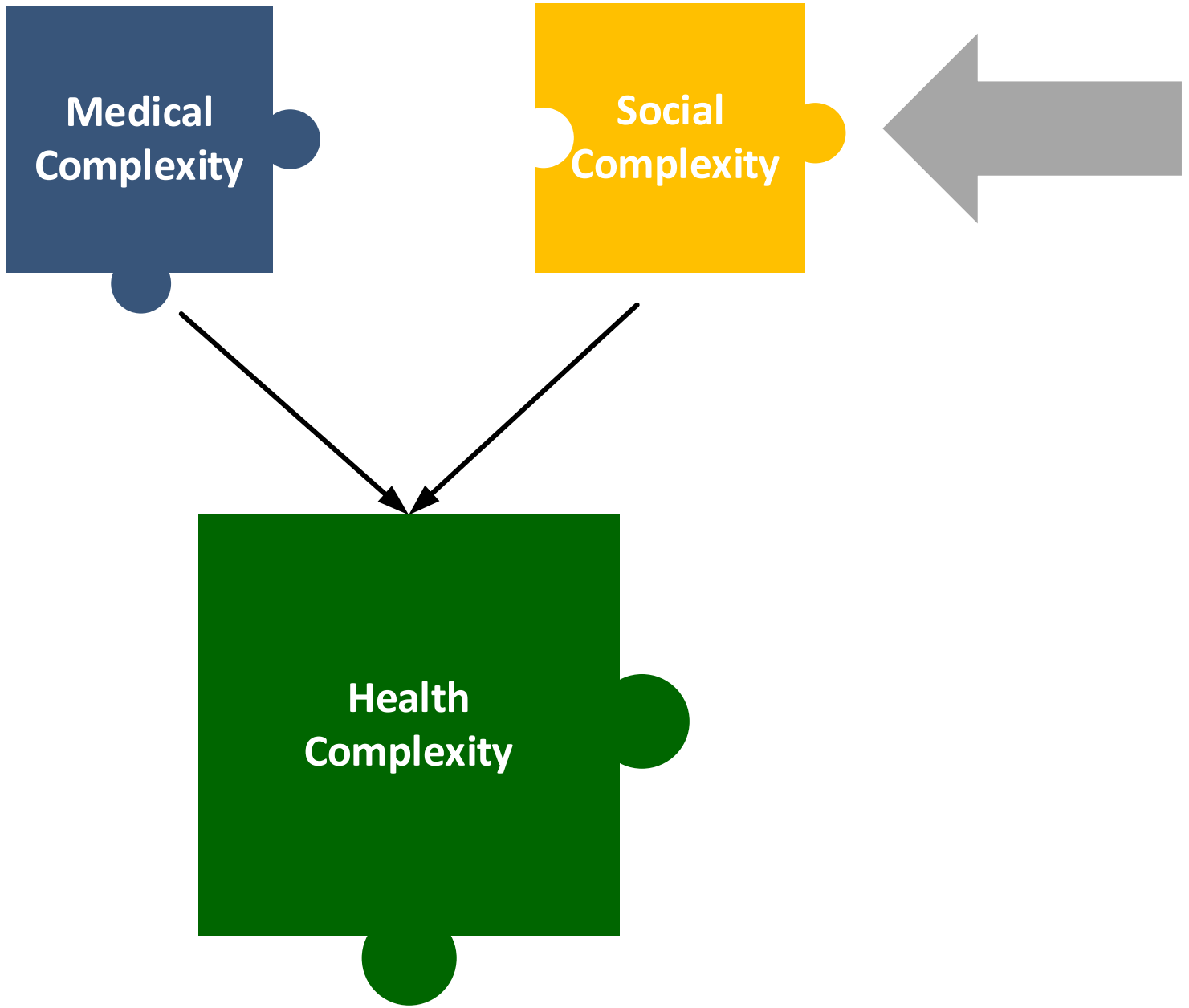
*There is a **statistically significant** difference in the distribution of the three PMCA Categories **across counties** in Oregon.*

Data Source: Medicaid/CHIP data sourced from All Payer All Claims. Claims data was pulled from January 1, 2018 to December 31, 2020 for a three-year total lookback period.

Average PMCA Medical Complexity Score by County



Data Source: Medicaid/CHIP data sourced from All Payer All Claims. Children publically insured as of August 2021. Claims data was pulled from January 1, 2018 to December 31, 2020 for a three-year total lookback period.


Medical Complexity
Social Complexity
Health Complexity

Douglas County: Findings on Prevalence of Each Social Complexity Indicator

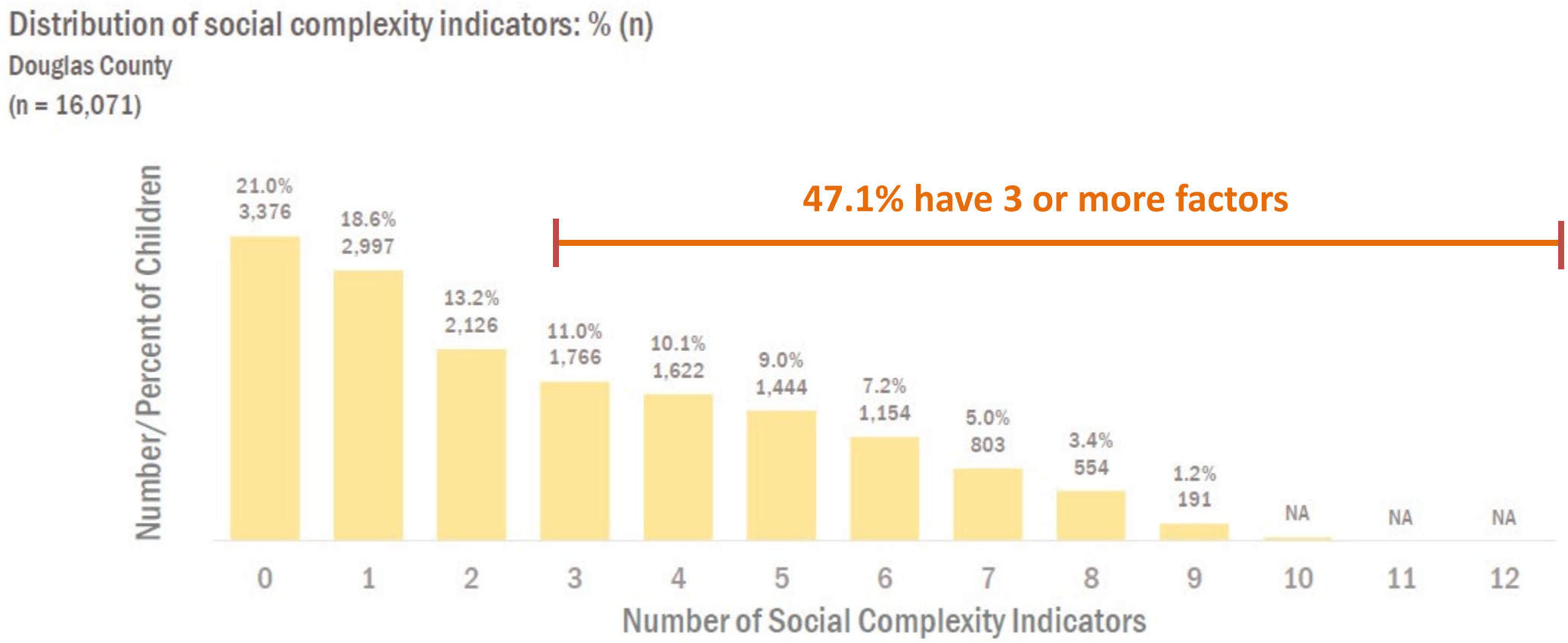
INDICATOR	CHILD FACTOR	FAMILY FACTOR
Poverty – TANF (for Child and by Parent)	**45.6%** (n=7,325)	**44.1%** (n=7,090)
Foster Care – Child receiving foster care services DHS ORKids	**16.9%** (n=2,718)	
Parent Death – Death of parent/primary caregiver in OR		**2.9%** (n=466)
Parental Incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon		**24.5%** (n=3,937)
Mental Health: Child – Received mental health services through DHS/OHA	**38.2%** (n=6,140)	
Mental Health: Parent – Received mental health services through DHS/OHA		**52.0%** (n=8,357)
Substance Abuse: Child – Substance abuse treatment through DHS/OHA	**3.8%** (n=604)	
Substance Abuse: Parent – Substance abuse treatment through DHS/OHA		**33.3%** (n=5,347)
Child Abuse/Neglect: ICD-9, ICD-10 dx codes related used by provider	**11.2%** (n=1,805)	
Potential Language Barrier: Language other than English listed as primary language		**3.2%** (n=511)
Parent Disability: Parent is eligible for Medicaid due to a recognized disability		**6.4%** (n=1,032)

Page 6 of the report: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Douglas-2021-October.pdf

Data Source: ICS Data Warehouse and Medicaid/CHIP data sourced from All Payer All Claims (APAC). Children publically insured as of August 2021. Lookback period is lifetime of the child plus one year prior to birth (prenatal period).

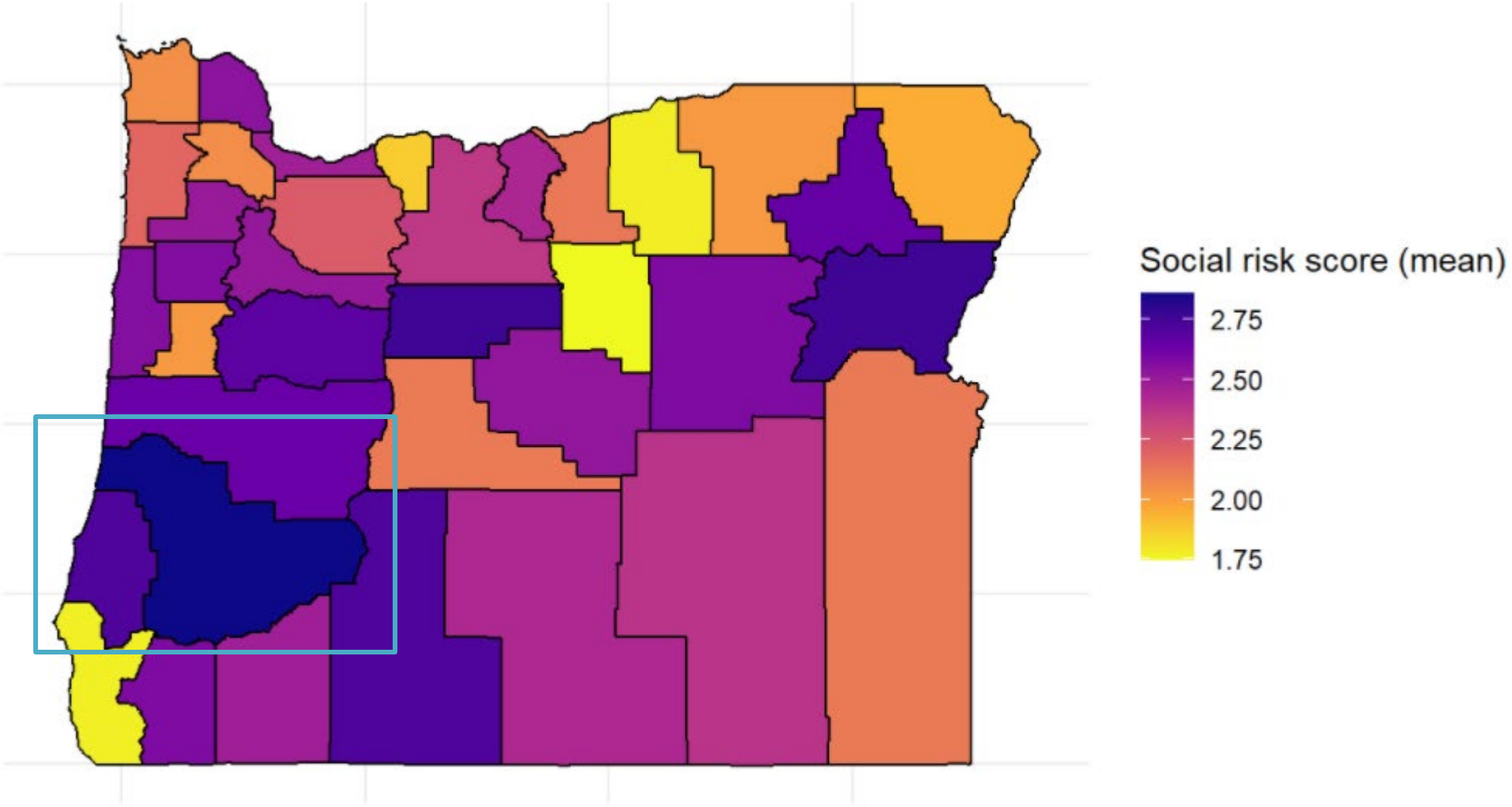
Douglas County: Distribution of Social Complexity Factors

Page 7 of the report: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Douglas-2021-October.pdf



Data Source: ICS Data Warehouse and Medicaid/CHIP data sourced from All Payer All Claims (APAC). Children publically insured as of August 2021. Lookback period is lifetime of the child plus one year prior to birth (prenatal period).

Average Social Complexity Count by County



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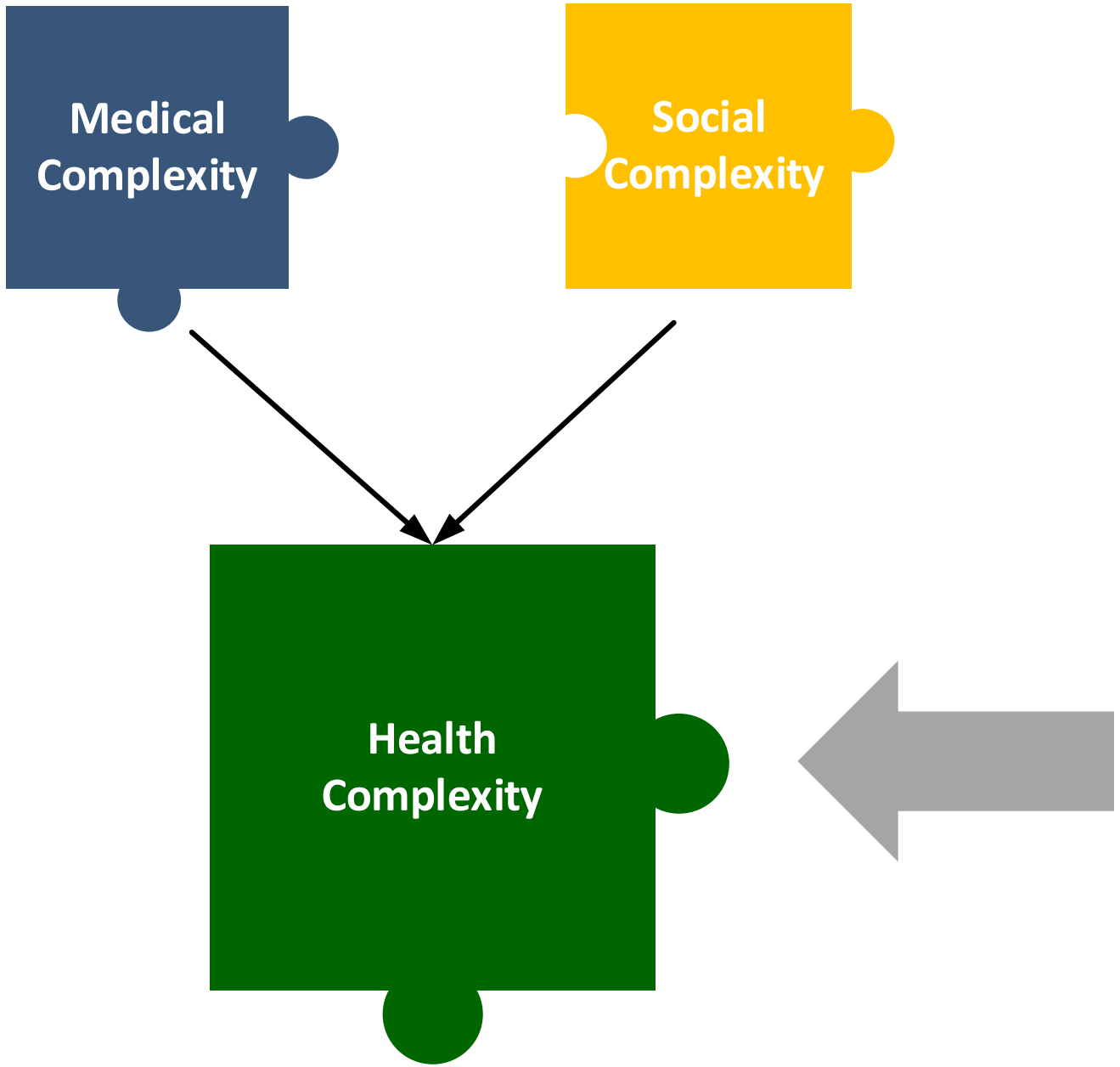
Medical Complexity
Social Complexity
Health Complexity

Douglas County Health Complexity Categorical: Source Variables Related to Medical and Social Complexity

Page 8 of the report: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Douglas-2021-October.pdf

MEDICAL COMPLEXITY (3 Categories)	SOCIAL COMPLEXITY (Total Factors Possible in Preliminary Data Shown Here N=12)		
	3 or More Indicators	1-2 Indicators	None in System-Level Data
HIGH Medical Complexity (Chronic, Complex PMCA=1)	6.0% (967)	3.1% (498)	0.8% (122)
MODERATE Medical Complexity (Non-Complex, Chronic PMCA=2)	11.0% (1,775)	6.4% (1,022)	1.9% (304)
NO MEDICAL COMPLEXITY (PMCA=3)	30.1% (4,830)	22.4% (3,603)	18.4% (2,950) Neither Medically or Socially Complex

Data Source: ICS Data Warehouse and Medicaid/CHIP data sourced from All Payer All Claims (APAC). Children publically insured as of August 2021. Lookback period is lifetime of the child plus one year prior to birth (prenatal period).

Appendix A of the report shows the medical, social and health complexity findings by AGE of the child:

- **Birth to Five**
- **6-11 years old**
- **12-17 years old**
- **18-20 years old**

Agenda

- Welcome
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  1. Enhancing **Use of the Health Complexity Data**
  2. Addressing the Capacity of and Child and Family Centered Pathways to **Behavioral Health**
- Alignment of Efforts with New CCO Incentive Metric Focused on Social-Emotional Health for Young Children
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Two Priority Population Health Strategies OPIP will Facilitate & Support

1) Enhancing **use** of the health complexity data, and

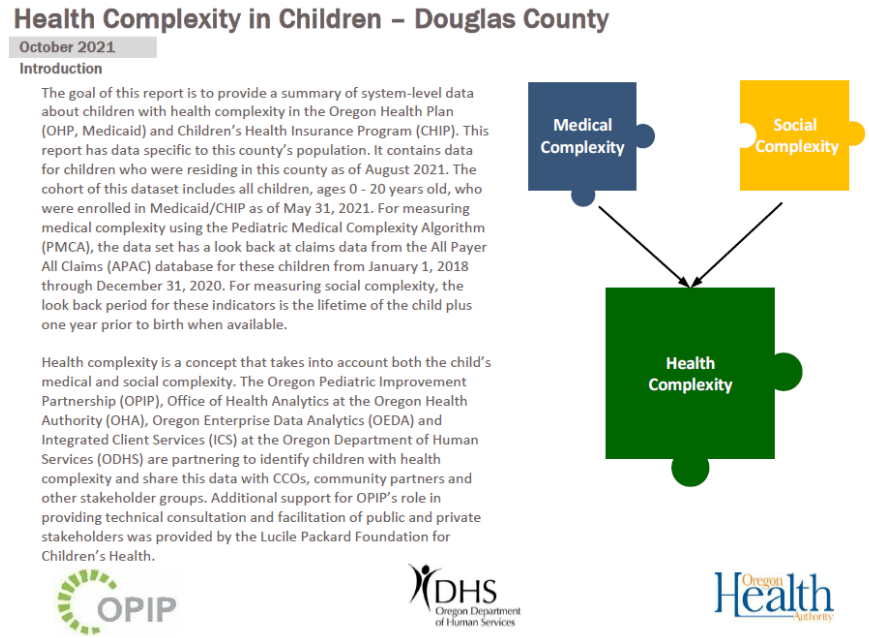
2) Addressing the capacity of and child and family centered pathways to **behavioral health**.

Track #1: Enhancing Use of Health Complexity Data

Health Complexity Data That Can be Leveraged for Use:

Aggregate Reports:

- Douglas County: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Douglas-2021-October.pdf
- Umpqua Health Alliance:https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Umpqua-Health-Alliance-2021-October.pdf



Health Complexity in Children – Douglas County

October 2021

Introduction

The goal of this report is to provide a summary of system-level data about children with health complexity in the Oregon Health Plan (OHP, Medicaid) and Children's Health Insurance Program (CHIP). This report has data specific to this county's population. It contains data for children who were residing in this county as of August 2021. The cohort of this dataset includes all children, ages 0 - 20 years old, who were enrolled in Medicaid/CHIP as of May 31, 2021. For measuring medical complexity using the Pediatric Medical Complexity Algorithm (PMCA), the data set has a look back at claims data from the All Payer All Claims (APAC) database for these children from January 1, 2018 through December 31, 2020. For measuring social complexity, the look back period for these indicators is the lifetime of the child plus one year prior to birth when available.

Health complexity is a concept that takes into account both the child's medical and social complexity. The Oregon Pediatric Improvement Partnership (OPIP), Office of Health Analytics at the Oregon Health Authority (OHA), Oregon Enterprise Data Analytics (OEDA) and Integrated Client Services (ICS) at the Oregon Department of Human Services (ODHS) are partnering to identify children with health complexity and share this data with CCOs, community partners and other stakeholder groups. Additional support for OPIP's role in providing technical consultation and facilitation of public and private stakeholders was provided by the Lucile Packard Foundation for Children's Health.

Child-Level Data:

- Provided to UHA for members enrolled in the CCO
- UHA requested 3 variables from OHA based on 2020 data, Opportunity to submit a data request

Track #1: Enhancing Use of Health Complexity Data

Overall Goal: Increase community-level awareness and use of health complexity data

- Component A: Support **Community Use** with Publicly Available Data or Data Provided by UHA

- Component B: Support **Umpqua Health Alliance Maximal** Use of Aggregate and Child-Level Data

Track #1: Enhancing Use of Health Complexity Data

Component A: Support Community Use with Publicly Available Data or Data Provided by UHA

- Disseminate **public facing communication materials** (i.e. two page call to action, video, reports) so that it can be maximally used by the community
- **Ongoing communication** and potential data spotlights (**Input needed in feedback survey**)
- Work with UHA to maximize use of child-level data and develop of new reports based on community-level priorities identified, share at the community-level
  - ✓ Display data by zipcode/School District
  - ✓ Display data by REAL-D information UHA has internally
- Hearing from and **learning from families about their lived experience** and adding to that to the story
- Ensuring those people who are using the data and who may receive the data **are trauma informed** and **use a trauma informed lens** in all applications

Track #1: Enhancing Use of Health Complexity Data

Component B: Support UHA Maximal Use of Aggregate and Child-Level Data

- OPIP will provide consultation to UHA and technical assistance support.
- Developing a steering committee within UHA to inform maximal use across various priority areas within UHA
- Priorities Already Identified:
  - Create specific reports for this population to be reviewed monthly for utilization trend and supports needed.
  - Analyze applicable quality metrics by **health complexity** to inform root cause drivers of gaps in care and inform better targeting to improve metrics
  - Analyze the **health complexity** **data by PCPCH** in order to consider trauma-informed trainings or follow-up steps to ACEs for practices that serve patients with high health complexity rates.

Track #1: Enhancing Use of Health Complexity Data

Component B: Cont. Support UHA Maximal Use of Aggregate & Child-Level Data

- 2020 Data Requests UHA Made to OHA
  - Data by Zip Code (To support community-level reports by school district/area)
  - New Indicator that is a COUNT of the following factors to inform efforts focused on adults:
    1. Parental access of TANF
    2. Substance abuse-parent
    3. Mental Health-parent
    4. Parental Incarceration,
    5. Child Substance abuse.
  - New indicator count for the following social complexity variables to support an focus on enhancing behavioral health access for these children:
    1. Foster care
    2. Parental Death
    3. Parental Incarceration
    4. Mental Health-parent
    5. Substance abuse-child
    6. Substance abuse-parent
    7. Child abuse and neglect

Agenda

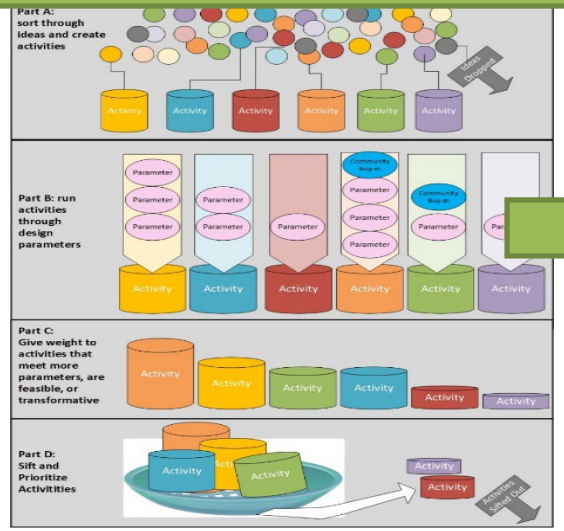
- Welcome
- Refresher: Where We Have Been Since March 2020!
- What Has Been Developed to Support Your Community in Sharing About the Douglas County Call to Action
- Where We Are Going and How **You** Can Be Involved
  - Enhancing Use of the Health Complexity Data
  - Addressing the Capacity of and Child and Family Centered Pathways to Behavioral Health
- Alignment of Efforts with New CCO Incentive Metric Focused on Social-Emotional Health for Young Children
- Overview of Next Steps

Track #2: Capacity of, and Child & Family Centered Pathways to, Behavioral Health

Community Identified Themes Related Behavioral Health

- **Community Resource Assets, Assessment of Capacity and Priority Needs to Fill Gaps**
- **Address Barriers to Access of Existing Services**
- **Train Providers to Better Care for Children with Health Complexity and Their Families**
- **Address Capacity of, and Child- and Family-Centered Pathways to, Behavioral Health**

Community Identified Parameters



- Be able to be **started in the next year**.
- Be **Family-centered & family-informed**.
- Be **Provider-informed**, ensuring a diverse front-line provider perspective.
- Be **Trauma-informed; cultural competence**.
- Be focused on **building strengths and resilience**.
- Ensure a focus for all children & will **include an intentional focus on health complex children under five.**
- **Align with and leverage priorities** and momentum with community-level efforts

OPIP Proposed Starting Point Activities for Track # 2 Reviewed by Steering Committee

A. **Assess Existing Behavioral Health Resources & Create Behavioral Health Asset Map**
B. **Facilitate Community Conversations on Behavioral Health Service Gaps and Building Capacity**
C. **Facilitate UHA on Opportunities to Enhance Behavioral Health Services**
D. **Improvement Proof Pilots: Work with Across-Sector Providers to Improve Behavioral Health Service Connection for Children**

Track #2: Capacity of, and Child & Family Centered Pathways to, Behavioral Health

Level Setting: When we say "behavioral health" for this work, what do we mean?

- Integrated Behavioral Health in Primary Care
- Community/Outpatient/Specialty Behavioral Health
- School-based Counseling
- Early Intervention Mental Health Consultation
- Home Visiting Services that can include Social-Emotional Services
- Parent-Child Attachment-Informed Services
- Substance Use Disorder Therapeutic Services
- Other Community-Based Supports

Track #2: Capacity of, and Child & Family Centered Pathways to, Behavioral Health

Initial Activities (Next Year) Identified in Alignment with Community Themes, Parameters, Priority Populations, and OPIP's Improvement Experiences:

- **a) Assess Existing Behavioral Health Resources & Create Behavioral Health Asset Map**
- **b) Facilitate Community Conversations on Behavioral Health Service Gaps and Building Capacity**
- **c) Facilitate UHA on Opportunities to Enhance Behavioral Health Services**
- **d) Improvement Proof Pilots: Work with Across-Sector Providers to Improve Behavioral Health Service Connection for Children**

A) Assess Existing Behavioral Health Resources & Create Behavioral Health Asset Map

- Develop an **across-sector asset map** of what behavioral services exist (specific to children **birth to 18**) and collect **descriptive information** that will illuminate gaps in **capacity, access, best match services**
  - Ensure this asset map specifically calls out services for children birth to five.

- **Share the asset map** with the community **as compared** to need identified within the **health complexity data**

- Consider **implications for the improvement work** that will focus on **training, closed loop referral pathways and communication.**

Services Included in Asset Map

- *Integrated Behavioral Health in Primary Care*
- *Community/Outpatient/ Specialty Behavioral Health*
- *School-based Counseling*
- *Early Intervention Mental Health Consultation*
- *Home Visiting Services that can include Social-Emotional Services*
- *Parent-Child Attachment-Informed Services*
- *Substance Use Disorder Therapeutic Services*
- *Other Community-Based Supports*


Community Advisors & Families Consult on Asset Map Components
Behavioral Health Providers Report on Service Components, Expertise, and Capacity
Information is Captured on Asset Map
Community Advisors and Families Assess Learnings and Ask Curious Questions
Learnings are Gleaned to Inform Improvement Efforts Priorities and Designs

What is included in an Behavioral Health Asset Map?

Service Details
Region
Zip code
Hours
Payer

Capacity
Case Load size
Average wait
New referrals

Delivery of Services
In person
Telehealth
Virtual
Community

Providers
Number Ethnicity
Race
Language

Population served
Age
Specialties
Diagnoses
Concerns

Treatment
Modalities
Individual
Group

Existing Lists We Heard About and Will Leverage

- Community Uplift
- DESD Resource Guide
- UCAN Website
- Network of Care
- UHA and Private Provider Contracts

Services Included in Asset Map

- *Integrated Behavioral Health in Primary Care*
- *Community/Outpatient/ Specialty Behavioral Health*
- *School-based Counseling*
- *Early Intervention Mental Health Consultation*
- *Home Visiting Services that can include Social-Emotional Services*
- *Parent-Child Attachment-Informed Services*
- *Substance Use Disorder Therapeutic Services*
- *Other Community-Based Supports*

Assess Existing Behavioral Health Resources & Create Behavioral Health Asset Map

Poll Question 1:
Where do folks currently go to find a behavioral health resource?

Poll Question 2:
What are the biggest barriers to determining the appropriate behavioral health resource to suggest to a family?

Contracted Behavioral Health Providers – Social Emotional Services for Birth to Five	Behavioral Health Organizations Contracted with CCO That Have Providers Who Serve Children Birth to Five				
	Organization # 1	Organization #2	Organization # 3	Organization # 4	Organization # 5
Location of Clinic Sites (City)					
County(ies) Served by the Clinic Site					
Number of Providers Who Currently Serve Birth to Five and Have Applicable Skill Sets					
Provider's Average Capacity for New Referrals Specific to Birth to Five (per week). Please note this will need to calculated for each provider within each organization in order to understand capacity. Measurement Options: Numerator: # of open (available for booking) appt slots in the next 2 months for new referrals 0-5 Denominator: # of total appt slots in the next 2 months					
Provider(s) Identified Race, Ethnicity					
Languages the Provider(s) are able to Use to Provide Services					
Therapy Modalities the Provider(s) Offer					

Early Learning, Family Support Services, and Other Community-Based Services with specific expertise and training on infant and early childhood mental health. (Potential Examples Below)	Community-Based Social Emotional Services							
	What social-emotional services are provided?	Are there eligibility requirements impacting access for publicly insured children?	Do they have openings for more children to be served by this program?	Counties in which these services are available?	Is there a focus on populations with historically inequitable outcomes?	Can this provider perform screenings and assessments of Social-Emotional health?	Could the provider submit a claim for these services?	Does the CCO provide supports or investments to the program?
Home visiting providers								
Early Head Start/Head Start								
Early Intervention/Early Childhood Special Education staff								
Evidence-based/ evidence informed parenting classes with a specific focus on attachment and Social-Emotional health								
Children's Relief Nurseries								
Other Services Identified								

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	Organization(s)	Number of Provider(s)
SERVICES TARGETED TO CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS					
Parent Child Interaction Therapy (PCIT)*	Dyadic	1-7	1		
** PCIT is also effective program for children with known trauma history (see categories below).*					
Generation-PMTO	Dyadic, Family, or Group	2-18	1		
Triple P Positive Parenting Program	Level 3 - Dyadic Level 4 - Group	0-12	2		
Theraplay	Dyadic	0-18	3		
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)					
Collaborative Problem Solving	Family, Individual	3-21	1		
Play Therapy	Family, Individual	3-12	3		
Helping the Non-compliant Child	Dyadic	3-8	3		
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY					
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, or Individual	0-21	NR		

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-January 2020.
Overall, there are 37 providers, some are able to provide different modalities.

Therapy	Organization (s)	# 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, Now and Zen Deschutes County, Starfish Counseling, Saul Behavioral LLC	13
Generation-PMTO		0
Triple P (Positive Parenting Program)		0
Theraplay	Rimrock Trails, Treehouse Therapies	3
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)		
Collaborative Problem Solving	Brightways, Forever Family Therapy, Rimrock Trails, Treehouse Therapies, Youth Villages	12
Play Therapy	Deschutes County, Starfish Counseling, Jefferson & Crook County BestCare, Brightways	22
Helping the Non-compliant Child		0
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY		
Child Parent Psychotherapy (CPP)	Cherie Skillings, Treehouse	2
Eye Movement Desensitization and Reprocessing (EMDR)	Brightways, Deschutes County, Starfish Counseling, Prineville Counseling Center	20
Attachment Regulation and Competency (ARC)	Deschutes County	1
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)		
Trauma Focused CBT	Jefferson BestCare, Treehouse Therapies, Rimrock Trails, Deschutes County, Brightways, Forever Family Therapy, Prineville Counseling Center, Youth Villages	34**
SERVICES TARGETED TO CHILDREN WITH AT-RISK PARENTS/ FAMILIES		
Family Check-Up		0
Attachment and Biobehavioral Catch-up (ABC)		0

Draft Version 15 September 10, 2020	Community-based Behavioral Health					
	Deschutes					
Company	Deschutes County	Cherie Skillings	Life Source Therapy	Starfish Counseling	The Child Center	Treehouse Therapies
Office Location	Redmond (7) Bend (6) LaPine (2)	Bend	Redmond	Bend	Bend, La Pine, Redmond	Bend, Redmond
# of Providers	15	1	1	1	10	3
Case Load (per week)	114	24	30	25	134	51
Capacity for New referrals	25 families	12 families	Limited	At Capacity	At Capacity	17 families
Provider Race, Ethnicity	14 White, 1 White/ Hispanic,	White	White	White	White	White
Provider Language Spoken	14 English, 1 Spanish/ English	English	English	English	8 English, 2 Spanish/ English	English
Payer	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private	OHP/ Private
Tele-services	Yes	Yes	*	*	*	Yes

- Sample Asset Map of Specialty/Community-based Behavioral Health Providers for Children birth – 5 in Central Oregon.
- Capturing relevant information once over a span of time gives relevant insight into long-term needs.
- These were identified rows and pieces of information for this community

Answer in the Chat:

If you had a magic wand, what row would you definitely want in a regional asset map for behavioral health services for birth to 18?

Track #2: Capacity of, and Child & Family Centered Pathways to, Behavioral Health

Initial Activities Identified in Alignment with Community Themes, Parameters, Priority Populations, and OPIP's Improvement Experiences:

a) Assess Existing Behavioral Health Resources & Create Behavioral Health Asset Map

b) Facilitate Community Conversations on Behavioral Health Service Gaps and Building Capacity

c) Facilitate UHA on Opportunities to Enhance Behavioral Health Services

d) Improvement Proof Pilots: Work with Across-Sector Providers to Improve Behavioral Health Service Connection for Children

B) Facilitate Community Conversations on Behavioral Health Service Gaps and Building Capacity

1. **Behavior Health Advisory Group**
   - Ensure across-sector involvement.
   - Oversee and provide guidance and direction on all components of work within this track.

2. **Parent, Youth & Young Adult** Advisors

3. **Frontline Provider** Perspectives

B) Facilitate Community Conversations on Behavioral Health Service Gaps and Building Capacity

Form **Behavior Health Advisory Group** and Work Groups

- Ensure across-sector involvement.
- Improvement efforts informed by those who will implement.
- Oversee and provide guidance and direction on all components of work within this track.

B) Facilitate Community Conversations on Behavioral Health Service Gaps and Building Capacity

- Facilitate conversations with **families** on barriers to using existing services and ways to build, and support existing, methods for accessing services.
  - Examples raised to date:
    - Transportation challenges for in-person services
    - Coverage and access to telehealth services, challenges & benefits
    - Insight on the asset map from lived experiences
- Form a **Parent, Youth & Young Adult** Advisory Council
  - Ensure representation and diversity (Community criteria)
    - Historically underserved
    - Lived experience with behavioral and mental health
    - Parents of children with special health needs
    - Involvement in complex systems of care
  - Engage community-level meetings & steering committee meetings
  - Share stories of experience with behavioral health systems to inform improvement efforts
  - Give context to health complexity data

B) Facilitate Community Conversations on Behavioral Health Service Gaps and Building Capacity

Ensure diverse **frontline provider** perspectives on understanding:

- Services and pathways that are working well
- Current barriers to accessing existing services
- Specific service area gaps
- Opportunities to build and support existing methods for accessing services

Track #2: Capacity of, and Child & Family Centered Pathways to, Behavioral Health

Initial Activities Identified in Alignment with Community Themes, Parameters, Priority Populations, and OPIP's Improvement Experiences:

a) Assess Existing Behavioral Health Resources & Create Behavioral Health Asset Map

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C) Facilitate UHA on Opportunities to Enhance Behavioral Health Services

Facilitate conversations with **Umpqua Health Alliance** on how health complexity data can be used to **inform, complement, and enhance** services for youth and families

- Representation on the Advisory Group for this work
- Review and use of the **asset map** and gaps and opportunities identified by community that could be addressed by UHA
- Support UHA in improving and enhancing required **intensive care coordination** for health complex children the behavioral health providers
- Synergy with effort to **support capacity and provider network** for children's behavioral health
- Learnings from **improvement pilots** as they related to close loop referral and communication pathways
- Alignment with **CCO Incentive Metric** on Social-Emotional Health and Mental Health Utilization Performance Improvement Project

UHA COVERS 16,003 CHILDREN IN DOUGLAS COUNTY

Track #2: Capacity of, and Child & Family Centered Pathways to, Behavioral Health

Initial Activities Identified in Alignment with Community Themes, Parameters, Priority Populations, and OPIP's Improvement Experiences:

- **a) Assess Existing Behavioral Health Resources & Create Behavioral Health Asset Map**
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- **c) Facilitate UHA on Opportunities to Enhance Behavioral Health Services**
- **d) Improvement Proof Pilots: Work with Across-Sector Providers to Improve Behavioral Health Service Connection for Children**

D) Improvement Proof Pilots: Work with Across-Sector Providers to Improve Behavioral Health Service Connection for Children

- **Informed by Activities A-C.**
- Leverage, and build off, training, facilitation and supports OPIP has **experience** with in facilitating across-sector proof pilots
- Include an explicit focus on **birth to five**
- **Working with <u>providers</u>** to improve best match referrals and closed loop communication for behavioral health services for children
    - Integrated primary care
    - Outpatient/Specialty behavioral health
    - Other health providers that provide a continuum of services that address behavioral health and emotional wellness
        - Examples: Early Head/ Start; Home Visiting; Schools; DHS Case workers

OPIP Led Support and Technical Assistance:

Examples from facilitation work throughout Oregon

1. Supporting Meet and Greets of Integrated Behavioral Health and Specialty BH
2. Training of Primary Care Providers on:
   - Who to Send to Internal Behavioral Health Services
   - How to Engage Family in Services
     - Talking point for providers, Developmental promotion materials to consider
   - Connection to Integrated Behavioral Health
     - Understanding the brief assessments and interventions
     - Identifying children to refer to Specialty Behavioral Health
   - What Specialty Behavioral Health Services Exists in their Area

Overview of Work with Specialty Behavioral Health Providers

Summarized Specialty Behavioral Health Providers that See Children birth-5

- Interview behavioral health providers in Central Oregon who serve children birth-5
- Developed an asset map, apply equity lens

Meeting with Specialty Behavioral Health Providers

- Understand services available
- Identify gaps
- Facilitate conversations to address gaps

Training of Internal Behavioral Health Providers in Primary Care Sites

- Assessments & brief interventions
- Overview of external specialty behavioral health supports

"Meet & Greet" between Internal Behavioral Health & Specialty Behavioral Health

- Organizations shared brief overview of their services for Internal Behavioral health

Training of Primary Care Providers

- Meet and Greets with Specialty Behavioral Health Providers
- Work on referral pathways

Next Steps

- Post-webinar survey
- Project-level implementation
  - Connecting with local resource partners
  - Interview with front-line providers
- Recruitment of parent, youth, and young adult Advisory Council
- Advisory Committee recruitment for child- & family-centered pathways to behavioral health

Closing Remarks

- Robin Hill-Dunbar (The Ford Family Foundation)
- UHA
- Steering Committee Members


THANK
YOU