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

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Meet Today’s Speakers

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Agenda:

- High-level overview of the System-Level Social Emotional Health Incentive Metric for **Coordinated Care Organizations** in Oregon
- Overview of the development process & intent of the **Social-Emotional Reach data**
  - **Component 1** of the System-Level Social Emotional Health Metric Incentive Metric that could be used by states with administrative claims data
- Definition and **scope of social-emotional services intentionally included in the Social-Emotional Reach data** 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

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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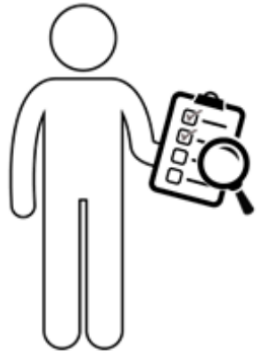
Broadly and Across Sectors: Services that Support **Social-Emotional Health** that within the Scope of Health Systems in Oregon

Promotion Activities

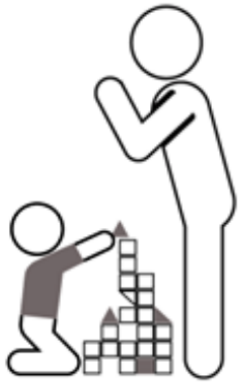
Screening

Assessment



Brief Intervention

Treatment Service



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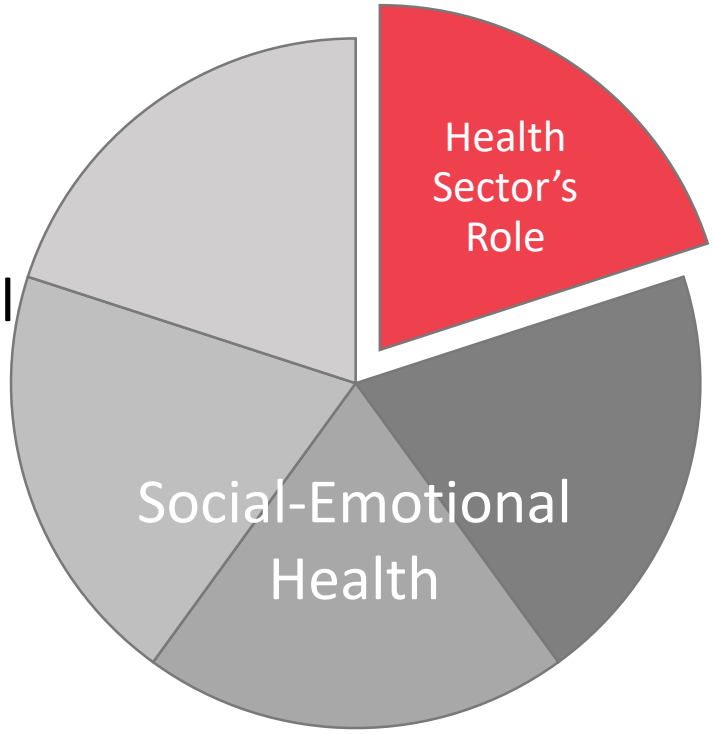
Defining the Scope of the System-Level Social-Emotional Health Metric and Key Terms

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

- Focused on the scope of services that are **within the Coordinated Care Organization (CCO) contract** and **opportunities to impact**.
  - In Oregon, 93% of Medicaid/CHIP children are enrolled within CCOs that accept risk to provide physical, behavioral and dental/oral health care within a global budget.
  - CCOs are within specific geographic regions.
- 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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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 health systems in Oregon (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 **incentive metric set** that incentivize care for Coordinate Care Organizations.

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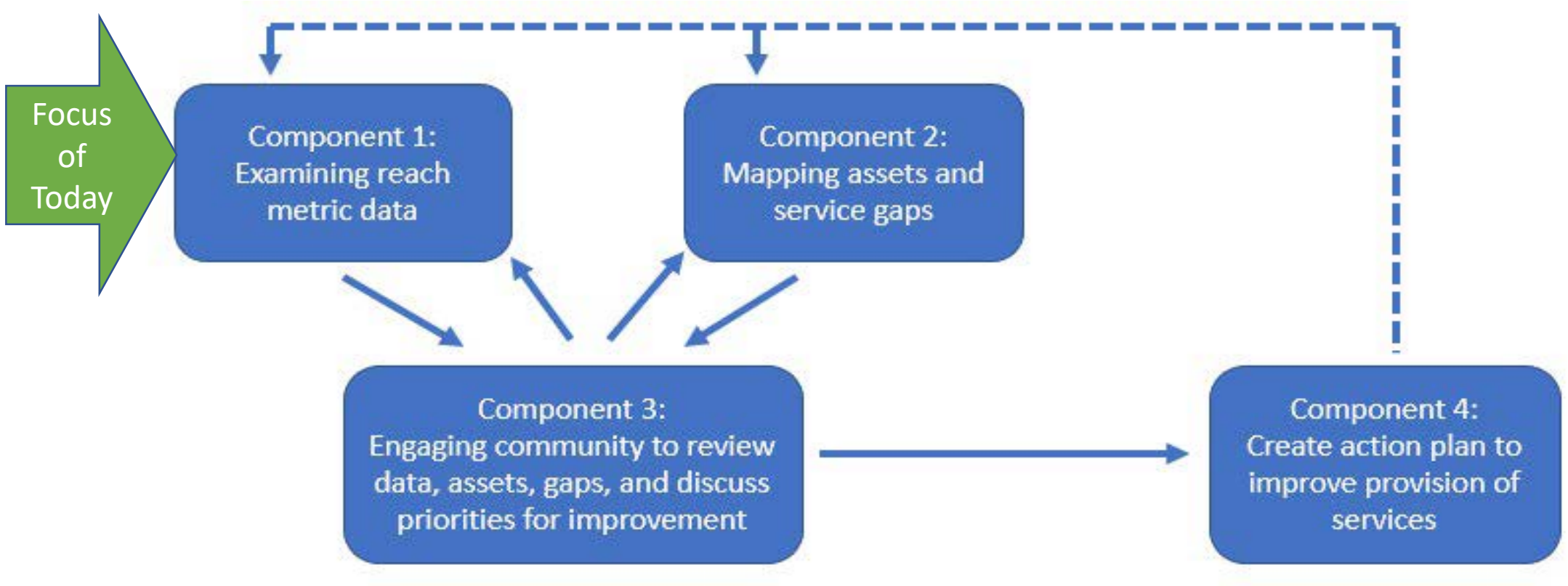
System Level **Social-Emotional Metric**

Metric Type: The metric is an attestation metric in which the Health Systems (CCOs) will attest to conducting 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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Social-Emotional Services Reach Data of Health System-Covered Covered Services

Child-level metric:

- Meant to capture a **range of Health System 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 **Health System 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

Health System Covered Services that Support Social-Emotional Health

Screening

Assessment

Biggest Pain Points from Parent & Provider Input

Brief Intervention

Treatment Service

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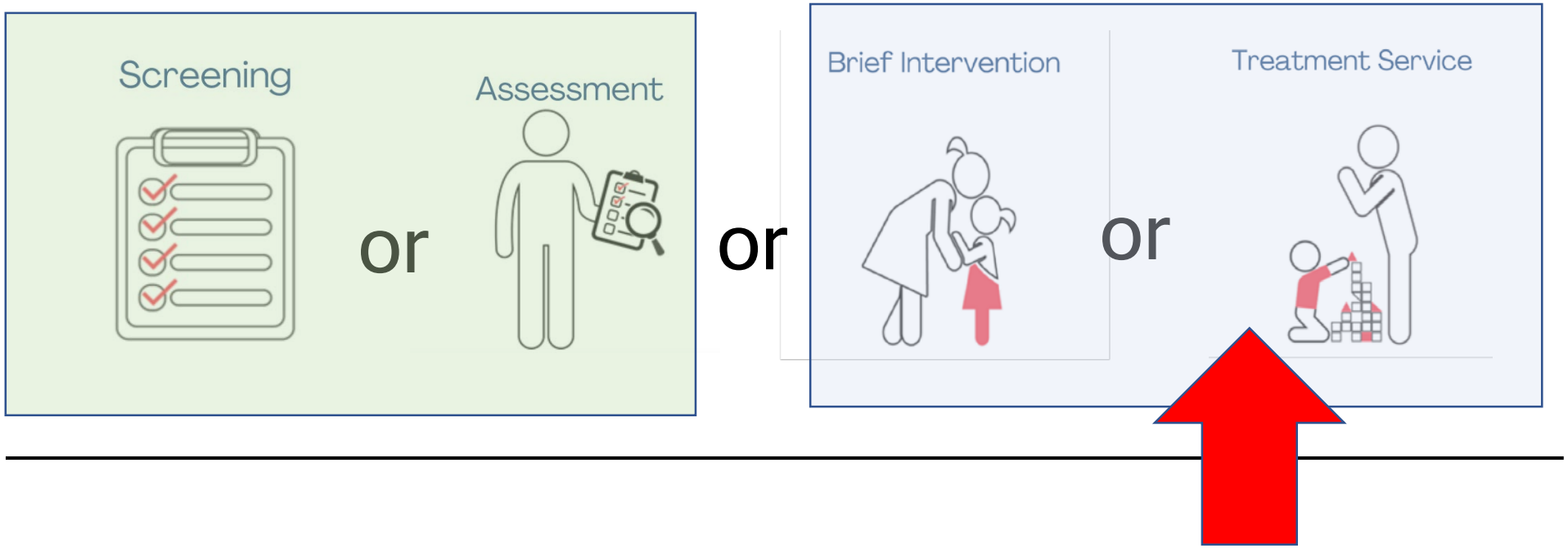
Social-Emotional Services Reach Metric: Development Process led by the Oregon Pediatric Improvement Partnership

- 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
- Cross-sector Health Aspects of Kindergarten Readiness (HAKR) Team Review (Medicaid, Child Behavioral Health, Early Learning Division, Oregon Health Authority 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/

Social-Emotional Reach Data Child-Level Metric

Numerator:



Denominator:

Children aged 1-5 within Health System

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

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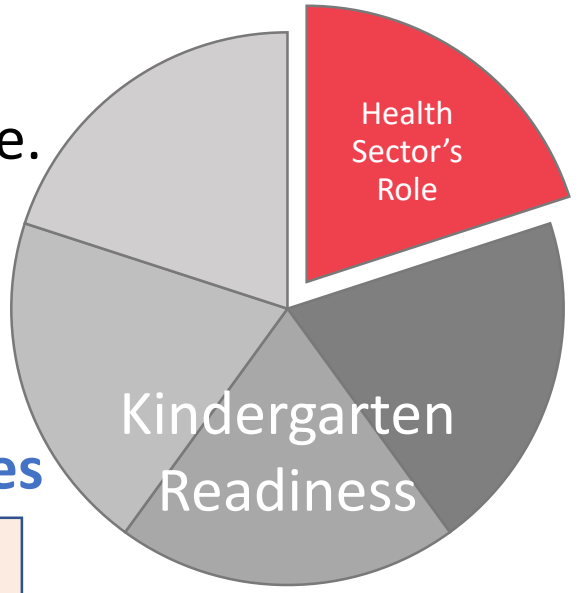
Social-Emotional **Reach Data**: Services Aligned with Clinical Recommendations of the Health Sector (Physical, Behavioral)

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: Therapy Services - Brief Interventions to 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

Screening/Assessments

- Bright Futures recommended **screening tools** to assess 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 considering 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*

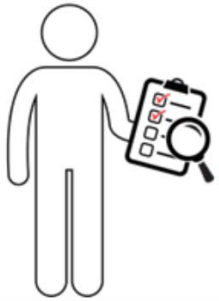
Summary: Services Included in Reach Data

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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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

Example of Claims:

- 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)

o See Page 2 of Therapies, Evidence Base, and Descriptive Information 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 therapy codes normally.
- **Note:** Within early learning, could be health or home visiting nurse

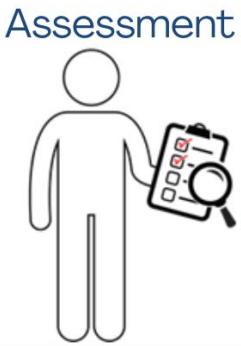
Claims:

- 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)

- 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. Ages and Stages Questionnaire, Maternal Depression screening, Autism screening)

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

Example Screening Tools: *Ages and Stages Questionnaire-Social Emotional (ASQ-SE), Pediatric Symptom Checklist (PSC), Survey of Well-Being of Young Children (SWYC), Behavior Assessment System for Children (BASC), Child Behavior Checklist (CBCL), Devereux Early Childhood Assessment (DECA), Eyberg Child Behavior Inventory (ECBI), Strengths and Difficulties Questionnaire (SDQ)*

Claim: Brief behavioral or emotional assessment 96127, Health and behavior assessment codes: 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: 96127 Brief Behavioral or Emotional Assessment

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Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9] →		★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	●	←	● [10] →		←	● →		←	● →		
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20] →																													
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★																
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	★	←			● →		
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←		● →		★	★	★
Hepatitis B Virus Infection[31]		★ →																														→
Hepatitis C Virus Infection[32]																													●	→		
Sudden Cardiac Arrest/Death[33]																						★ →										
Cervical Dysplasia[34]																																●
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★	★	★															
Fluoride Varnish[37]							←				●				→																	
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

Zoom In on Developmental/Social/Behavioral Domain

	INFANCY									
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH										
Maternal Depression Screening[11]				●	●	●	●			
Developmental Screening[12]								●		
Autism Spectrum Disorder Screening[13]										
Developmental Surveillance		●	●	●	●	●	●		●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

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Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health

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COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, COUNCIL ON EARLY CHILDHOOD

By focusing on the safe, stable, and nurturing relationships (SSNRs) that buffer adversity and build resilience, pediatric care is on the cusp of a paradigm shift that could reprioritize clinical activities, rewrite research agendas, and realign our collective advocacy. Driving this transformation are advances in developmental sciences as they inform a deeper understanding of how early life experiences, both nurturing and adverse, are biologically embedded and influence outcomes in health, education, and economic stability across the life span. This revised policy statement on childhood toxic stress acknowledges a spectrum of potential adversities and reaffirms the benefits of an ecobiodevelopmental model for understanding the childhood origins of adult-manifested disease and wellness. It also endorses a paradigm shift toward relational health because SSNRs not only buffer childhood adversity when it occurs but also promote the capacities needed to be resilient in the future. To translate this relational health framework into clinical practice, generative research, and public policy, the entire pediatric community needs to adopt a public health approach that builds relational health by partnering with families and communities. This public health approach to relational health needs to be integrated both vertically (by including primary, secondary, and tertiary preventions) and horizontally (by including public service sectors beyond health care). The American Academy of Pediatrics asserts that SSNRs are biological necessities for all children because they mitigate childhood toxic stress responses and proactively build resilience by fostering the adaptive skills needed to cope with future adversity in a healthy manner.

abstract

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Dr Garner collaborated in conceptualizing and drafting this document, took the lead in reconciling the numerous edits, comments, and suggestions made by many expert reviewers, and made significant contributions to the manuscript; Dr Yogman collaborated in conceptualizing and drafting this document and made significant contributions to the manuscript; and all authors approved the final manuscript as submitted.

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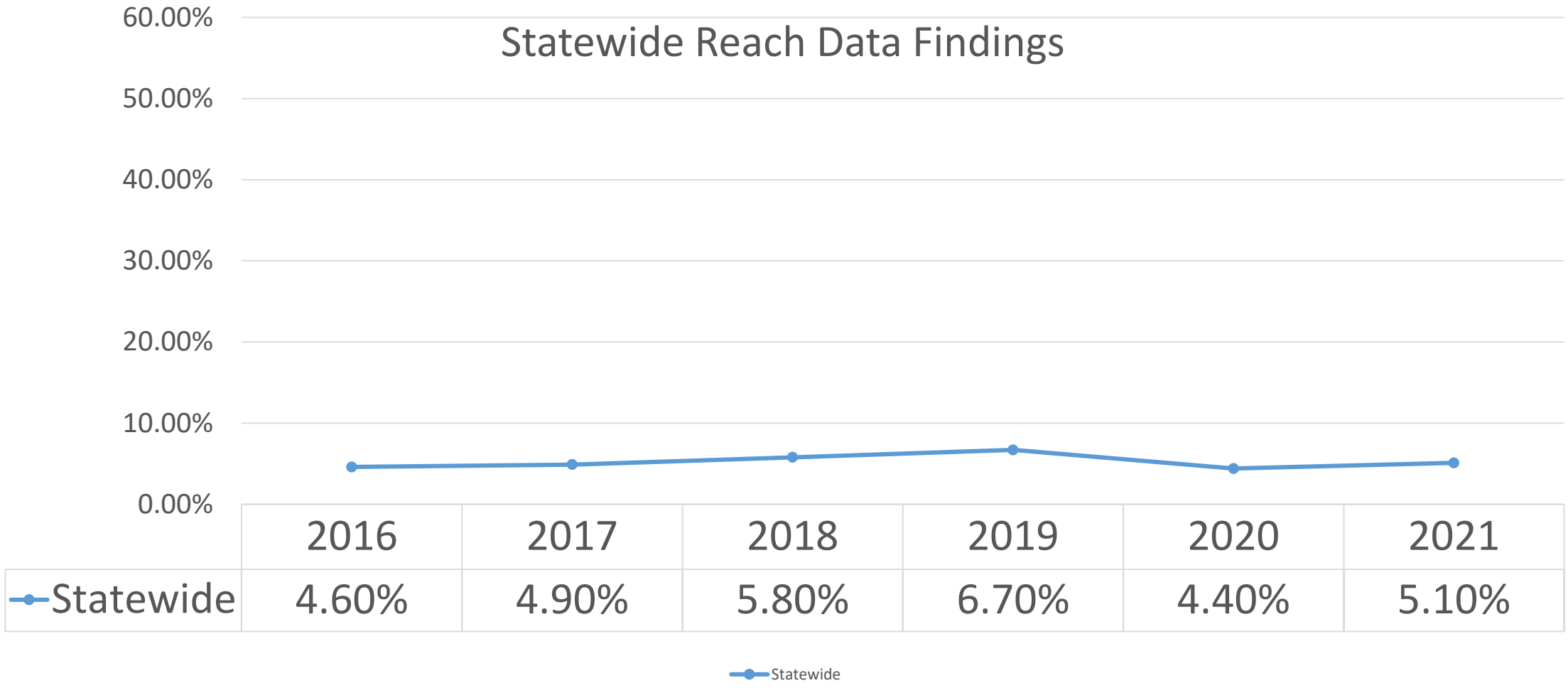
Citation: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

State Social Emotional Reach Metric Data Over Time

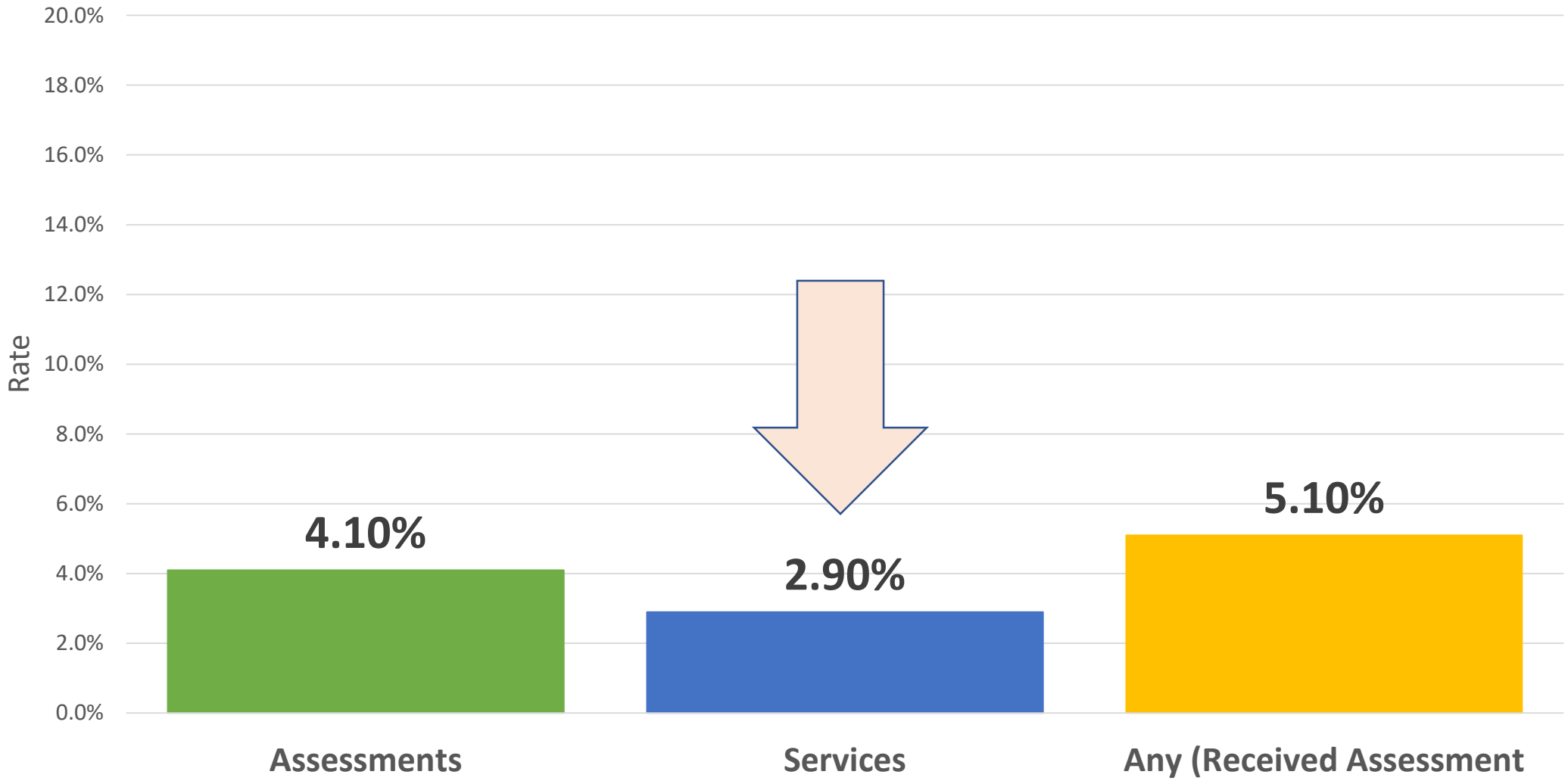


Data Source: January 2022 SE Reach Metric Report Provided by OHA

Statewide CY 2021 Data:

Social Emotional Health Reach Metric Data

Assessments vs. Services → Either



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

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 prioritize services to address delays or preventive behavioral health interventions to promote healthy SE development
  - Alignment of Adverse Childhood Experiences (ACEs) with Social Complexity Data
  - ACE 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.

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

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

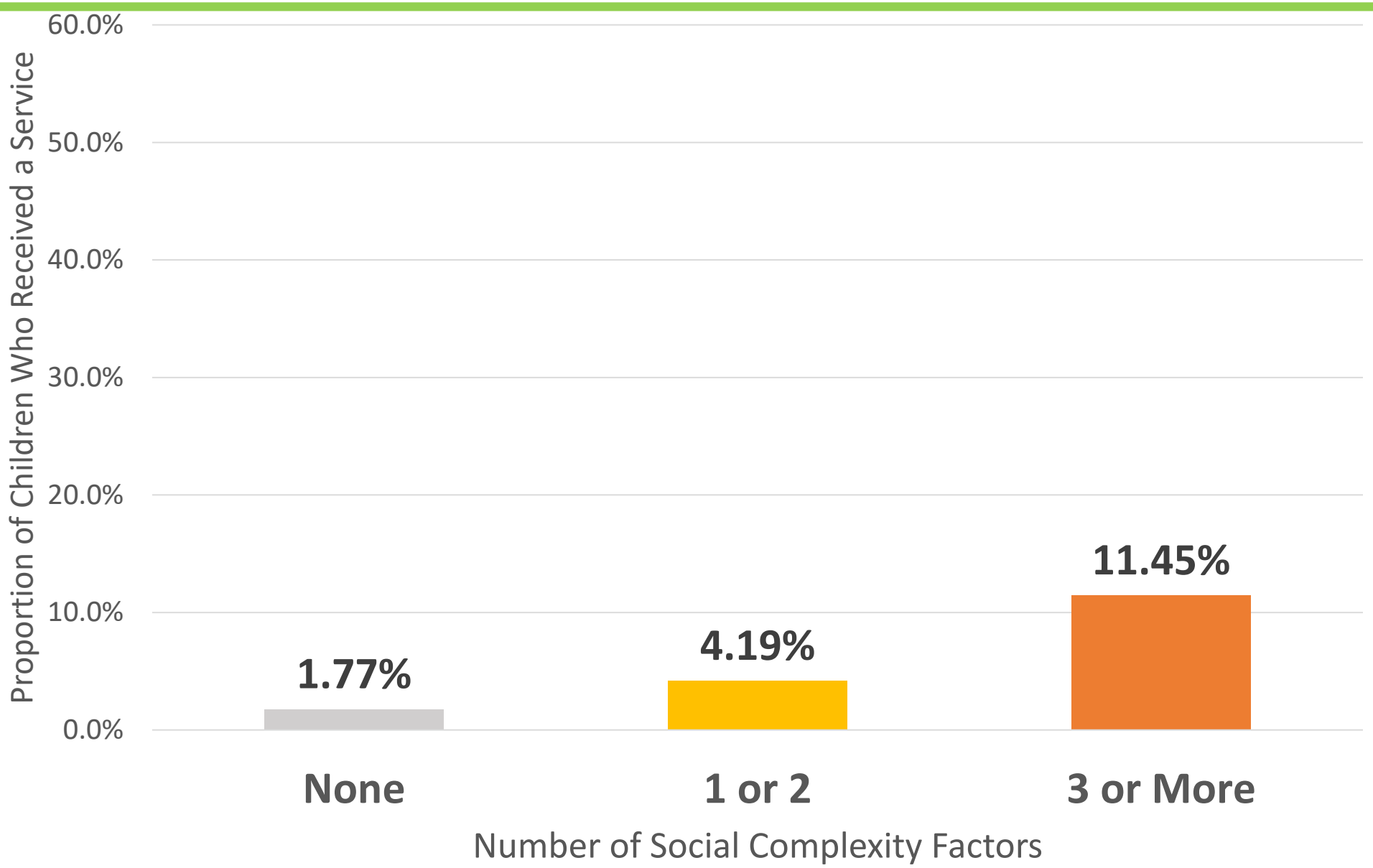
Source: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Statewide-Report-2021-October.pdf

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
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: Parent – Received mental health services through DHS/OHA	**8.26%** (4019)
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)

***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**

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



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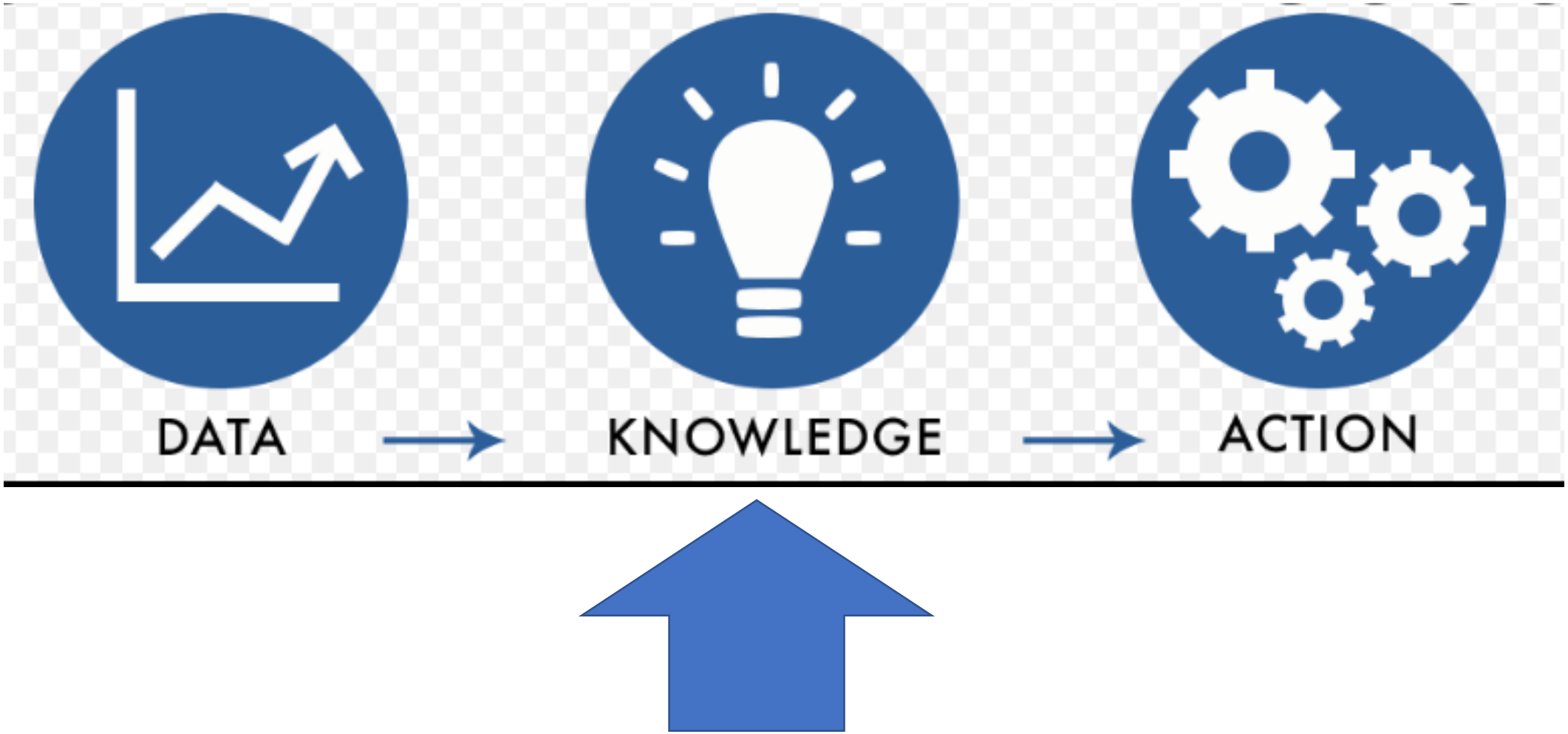


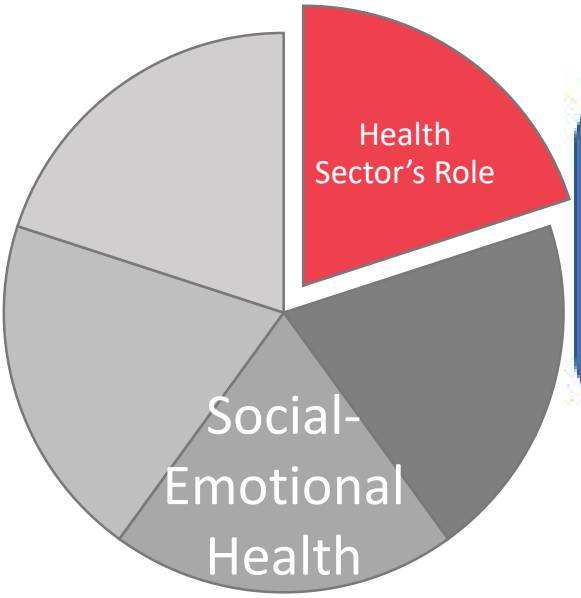
- Review and informed by Health System contracted partners (clinical, behavioral), community partners, and parents with lived experienced.
- Emphasis and requirement on listening to children with historical and contemporary inequitable outcome and access.

Reach Data: What are children getting now?

Year 1: What Health System Contracted Covered Providers Exist for the "Services" Component

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

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 isn’t anticipatory guidance included?
4) Is Developmental Screening (96110) included in the reach metric rate?
5) Why isn’t maternal depression screening included?
6) Shouldn’t we just focus on screening first to increase the rates?

What SHOULD the Social-Emotional Reach metric rate be? How do we set 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 can be addressed in considering 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 social complexity indicators

Screening/Assessments

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

OR

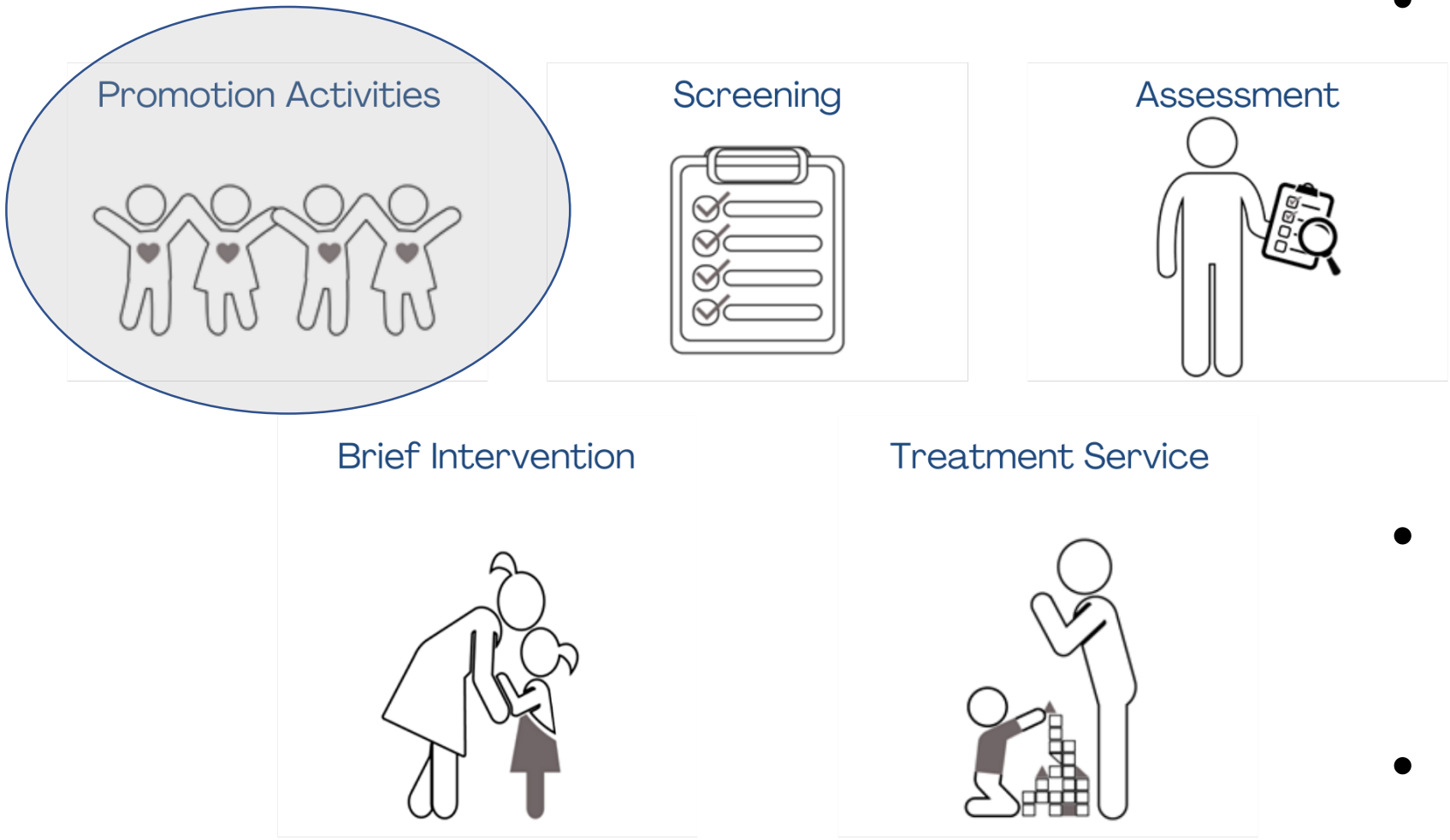
- **Assessment** integrated behavioral health may do for children referred to them based on clinical judgment or ASQ or MCHAT results such as ASQ-SE or brief evaluation tools

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

Is it surprising that 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 when services not adequately available
  - Training on SE health for young children
  - Behavioral health capacity and workforce shortage, especially with focus on "big kids and adults" with "big" 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.

Why isn’t anticipatory guidance included?



- 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

Is Developmental Screening Included in the Reach Metric Data?

- Developmental screening is a separate and important clinical recommendation.
  - CHIPRA Core Set Metric, OHA tracks
    - Note: OPIP Director is measure steward for this metric.
  - Developmental screening was an incentive metric from 2013-2019 in Oregon.
- Intent of SE Metric is to assess interventions and services that specifically address a child's social-emotional health and that specific domain of development.

Why isn’t maternal depression screening included?

- Maternal depression screening is its own clinical recommendation.
- Maternal depression is important correlate and factor that impacts child’s social emotional health.
- Intent of metric is to assess interventions and services that specifically 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 captured in the reach metric data
  - E.g. If you identify maternal depression and an ASQ score that is borderline or delayed for a child, an assessment done to follow-up and further evaluate child’s SE health can be billed and is included

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

Analogy of the Bike

Early Identification: Screening and then Assessments

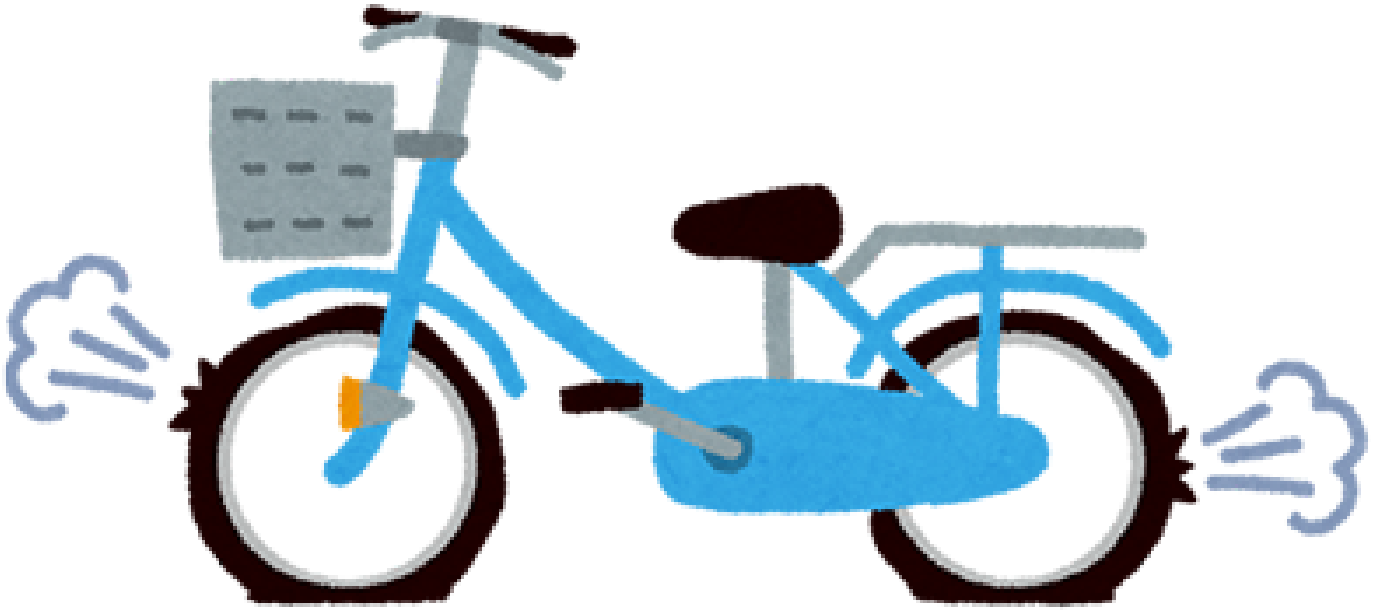
Referral pathways and Parent Engagement

Intervention/Therapies

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

- OPIP’s experience in hearing from front-line primary care, community based and early learning providers is that there are not enough services for children they are identifying through 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
- One component of the system-level metric is anchored to asset mapping of the systems that can provide services for children identified as needing support.
  - Asset map outlines availability and capacity of the system to provide the “**Intervention and Therapy Services**” claims in the Social-Emotional reach metric.
  - If Asset Mapping shows capacity and availability, then a focus on screening may be a good follow-up.

OPIP Perspective in Reviewing Data and Working with Some Partners



Early Identification: Screening and then Assessments

Referral pathways and Parent Engagement

Intervention/ Therapies

System-Level SE Health Metric is anchored to a holistic approach with Action Plans that:

- ✓ **Require listening to contracted partners, 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**

What is Happening and What is Next

System-Level Social-Emotional Metric

- CCOs are completing Year 1 of the Attestation Metric work if they are aiming to meet the metric.
  - Action plans are due to Oregon Health Authority in February 2023.
- Metric approved for inclusion in the 2023 CCO Incentive Metric Set

Input Needed on How to Share Claims-based Reach Metric for Other States

- Exploring options to share the reach metric specifications with Medicaid/CHIP and health systems so that they can be used by others if helpful.
- Barriers to publishing in peer-reviewed paper given data is being shared and used by CCOs and communities.

OPIP Work in Local Community to Support Implementation Improvement Efforts

- Working in a number of communities to support ground-level implementation efforts focused on enhancing social-emotional service provision for young children.
  - Efforts aligned with community Action Plans.
- Oregon's Transforming Pediatrics for Early Childhood Cooperative Agreement

For More Information

- Colleen Reuland – reulandc@ohsu.edu
- Lydia Chiang - chiangl@ohsu.edu
- OPIP website: **www.oregon-pip.org**
  - https://oregon-pip.org/health-aspects-of-kindergarten-readiness/

Information about System-Level Social Emotional Health Metric

- https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx
- https://childinst.org/first-in-the-nation-health-metric-aims-to-address-social-and-emotional-health/