# *Oregon's Integrated Care for Kids (InCK):* *Sharing of* Learnings Related to Metrics 12/14/2021

OPIP

# Proposed Agenda

- High-Level Summary of Learnings related to **Current Metrics**
- Proposed Changes to the **Metrics Program and Considerations**
- Behavioral Health **PIP Metric**
- Behavioral Health **Metrics**

❖ If helpful and desired by PCS, sharing more activities alluded to in their slides for Partnership Council about the work they plan on HAKR SE and leveraging InCK

# InCK Efforts Related to Current Metrics

- Housing screening and connection to services
- Food screening and connection to services

**Current Proposed Components of SDOH Metric**

- Depression screening and follow-up

- Well-Child Visits 3-6
- Preventive Oral

- If helpful or desired, open conversation about PCS plans for HAKR SE metric given Partnership Council slides.

# Learning Relevant to Proposed SDOH Metric Being Developed by OHA

- InCK team developed a memo sent to OHA team leading development
  - Many of those areas of feedback remain,
  - OPIP will be watching for updated specifications and will public comment accordingly.
- As we dove into implementation of the metrics, we have increased concern about the proposal in the metric that starts with system-level attestation, but then goes to person level reporting: (e.g. percent screened)
  - If the purpose of the metric is to be upstream, seems metrics should not be tied to "widgets" such as screening, but rather the outcomes and metric related to outcomes
    - ✓ *Examples for housing: increase in housing supports for Medicaid insured, increase in housing navigators, increase in vouchers used, Stable housing reported by members,*
    - ✓ *Example for food: Increase access of food supports, increase in availability of culturally appropriate food, increase in food distribution in places outside a foodbank, reduction in food insecurity reported in systems that report.*
  - If the purpose is to focus on upstream determinants of health, it seems that **prioritizing and ensuring systems and processes for children** should be a foundational component given lifelong impacts
    - Assumption that if done for all, will be done for children has not been shown to be true.
    - Housing insecurity associated with out of home placement, health care costs, school absenteeism
    - Value of ensuring a START with pediatric populations

# Learnings Relevant to Metric Anchored to Person-Level Reports of Screening and Connection to Services for Children

Importance of **family-centered approach**

- Social complexity data shows the number of settings parents access that may be screening
- Consideration of and incentives in the model that avoid over screening
  - Example of what a family with multiple children could experience
  - Example of prenatal screening and then screening in well-child experience
  - Example of how to count and coordinate on screening done at PCS (Member support, ICC)
- Consideration for how to “count” a connection of service that may happen through care for one child, but then impacts the full family of children insured and potentially the family
- Meaningful and authentic engagement of persons with lived experience about the process that are proposed in the metric and proposed metric components and if that aligns
- Development of processes that can screen at time of enrollment, more centrally
- Barriers noted by multiple partners of getting health complex people to sign Connect Oregon forms, so chose to do more personal outreach

## Learnings Relevant to Metric Anchored to Person-Level Reports of Screening and Connection to Services for Children

If emphasis is on screening in **clinical setting**, consideration of the components that impact it being meaningful, relevant, and family-centered approach

- Implications of a mandatory reporting settings (Example from CHAOS, Mosaic)
- Implications of sharing in a clinical setting and related judgements
  - COPA experience of half the parents not agreeing to complete the form
- Implications of no billing code across payors
- Implications of Z codes on stigma and child-factors
  - Need for engagement of persons with lived experience
- Provider burn out when they do things that don't result in positive experiences or services for their children
  - CHAOS example
- Importance of the strategy OPIP developed around tools that are meaningful and relevant. Pitfalls of picking one tool or one set of tools.

# Learnings Relevant Connection to Housing and Supports

*Meaningful connection to Housing for health complex children will require:*

- Trauma informed approaches, safety in the context of parents with children
- Housing that is available and that doesn't deprioritize based on health complex factors
  - ✓ Parental social complexity (e.g. parental incarceration, parental sud)
  - ✓ Medical complexity
  - ✓ Multiple children
  - ✓ Connection to school
  - ✓ Potential for co-location of services
- Referral pathway that is supportive and helps family navigate process, forms, and connection
  - ✓ Marion and Polk Coordinated Entry
  - ✓ Need for Housing Navigation supports articulated across partners
  - ✓ Assistance on housing voucher
- Focus on equity
  - ✓ Housing available in rural regions
  - ✓ Housing that co-locates behavioral health
- Ability to track – at family unit – those connected to services
  - ✓ At end of convos, not yet possible with Connect Oregon

# Learnings Relevant Connection to Food

- Importance of trauma informed strategy
- Value of doing a listening session of those that have already implemented screening and their experiences
  - Majority note the family already knew about the foodbank
  - Fear of reporting or answering questions
- Value of doing a listening session of persons with lived experience about the process
- Income/eligibility requirements for WIC and SNAP which often serve as primary connection to long-term food supports
  - Referrals and Engagement in WIC/SNAP are also the most easily "tracked" and documented referral by practices/CBOs
- Value of incentivizing creative approaches that are missed with the "widget based count" but that are aligned with the aim of reducing food insecurity
  - Food boxes in clinical settings
- Complicated nature of "referrals" for some "food" in Connect Oregon

# Learnings Relevant to Transportation

- Trauma informed approaches in mandatory reporting environments.
- Consistently noted by Parents, Youth and Young Adult Advisory group as a barrier
- Barriers to transportation when you have multiple children and how to navigate getting supports available.
- Negative experiences and stigma when used
- Adolescents accessing transportation and unique barriers
- Transportation for medically complex to Portland for multi-day trips, when have other children and related childcare barriers

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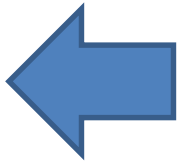

- Well-Child Visits 3-6
- Preventive Oral

# Depression Screening and Follow-Up

- Grateful for the advocacy and distillation done by OHA and PCS on this and feel that the full team understood the nuances
- The component of work OPIP had been really interested in was focused on meaningful follow-up for adolescents identified
  - Previous pilots OPIP had done with clinics across the state showed that a majority of adolescents didn't end up getting best match treatment
    - Screen for suicidality
    - Ongoing services (within integrated BH, to specialty behavioral health)
    - Barriers parents/adolescents noted to accessing services due to traditional hours of service, location of services, pro/con of telehealth
  - In Central Oregon, interesting opportunity to explore pathways to behavioral health in SBHC
    - Note potential unintended consequence of reassignment
    - Importance of cross practice communication

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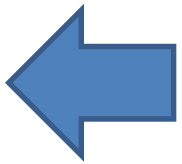
- Well-Child Visits 3-6 
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# Well Visits for 3-6

Implementation would have focused on:

- Root barriers to families of health complex 3-6 year olds accessing well-child care
  - Community & population based approach to those not coming in that is not solely on PCPCH
  - Importance of examining disparities by region, by health complexity, by REAL-D
- Component of a high quality well-child visit & how to feasibly implement in a COVID environment
  - Trauma informed approaches given descriptive information about health complex children
  - Including assessment of and brief interventions related to social-emotional health
  - Oral health and connection to dental
- Meaningful follow-up and connection to services for the screens and assessment meant at well-child, working with the community based providers on those connections.
  - Value of the asset map on the “Who, What, and Where” is available

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# Preventive Oral

Oral was not a component of INCK

Some area of input and guidance from OPIP

- HAKR originally called for preventive DENTAL as poor dental health and caries is highly associated with low kindergarten attendance and a primary factor identified in past literature
- Barriers noted by parents in accessing dental services when needed
  - Overall
  - Particularly in rural regions
- While not a topic within the Parent, Youth and Young Adult Advisory Group, it was raised by multiple parents
  - Dental services
  - Orthodontic services

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# Proposed Changes to the Metrics Program and Considerations

- Significant concern that the 'downstream" metrics focused on health care limited to federal Core Measure Reporting when Medicaid/CHIP is the safety net for CYSHCN, a majority of which have social complexity
  - No metrics on CYSHCN as a population
  - Limited metrics on behavioral health
  - No metrics on care coordination
  - No metrics on integration
- Etiology of CYSHCN
  - Not all conditions are preventable by upstream activities, like is true for many adult chronic conditions
  - Again, highly problematic to then lose any financial incentives, through metrics, for this population when Medicaid/CHIP is the safety net for them and what is paid for is what is focused on
- Significant concern there remain no metrics of hospital and specialty based care
  - Driver of costs and experiences for health complex children
- How things are measured drive what action occurs
  - Committee structure undervalues technical knowledge or expertise or assessment of metric proprieties
    - Yet, we have learned that is exactly what and how is measured will be focused on
  - Need to support those that develop community informed and community driven metrics.

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# Behavioral Health PIP Metric

- Opportunity to ask to examine data on persons with diagnosis and their access for children.
- Recommend stratification by
  - Birth to Five
  - School Age
  - Adolescents with right to consent to services (14 and up)
- Potential to align improvement work with goals of InCK to increase access for children and families with social complexity
  - Dyadic services (adult in CCO and child attachment)

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# Behavioral Health Metrics

- What is measured, what is incentivized is paid for
  - Concern that we see limited metrics on behavioral health for six to 21 (and overall)
- Concern about lack of behavioral health metrics available, developed and in process for consideration
  - IN 2022 and potentially in 2023 for HPQMC and Metrics and Scoring
  - This was TOP gap noted by HPQMC
  - Noting a gap and noting wanting metrics – doesn't result in metric
- Concern about current committee progress, representation related to metric

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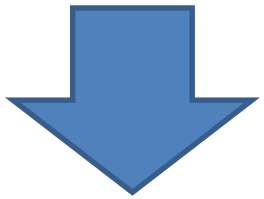

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