Summary Brief of Key learnings in Providing Proactive & Targeted Developmental Promotion and Behavioral supports to Children from Highly Socially Complex Families

Background and Context: Supports for children from socially-complex families was identified as a priority track of work in Pathways from Screening to Services. This track of work supported stakeholder interviews with various agencies that provide behavioral health services to adults that are socially complex to identify potential pathways of supports the dyad of adults with young children. Incorporation of learnings from this track were folded into two tracks of work that OPIP helped to facilitate 1) the **Integrated Care for Kids (InCK)** cooperative application and Pre-Implementation work to ensure an explicit focus on young children birth to five, and 2) incorporation into components of the **System-Level Social Emotional Health System-Level metric** that is proposed for inclusion in the CCO Incentive Metric pilot.

Key Learnings Relative to Opportunities and Potential Levers in Central Oregon: Recognizing that this novel work requires cross sector collaborations, OPIP is providing a distilled summary of the learnings relative to the opportunities that we see could be supported within existing efforts within the Central Oregon Health Council, Early Learning Hub of Central Oregon, and other community-based partners.

1) **Integrated Care for Kids: Service Integration for Children Identified by the Needs Assessment in Level 2 and Level 3**
   - Informed by the learnings from Pathways and to ensure alignment with the community-level feedback heard about what is needed to support building health and resilience for these children, the following was incorporated into InCK:
     - **Children birth to five** with any type of medical complexity (not just chronic complex) were included in the Needs Assessment for **Service Integration Level 2**. This will ensure that InCK will require a focus on young children with medical and social complexity factors. As part of the Service Integration trainings that OPIP will be developing, we will incorporate principles of connection, parent supports, addressing transportation, and addressing barriers to dyadic therapies raised by stakeholders. Third, partially informed by the current payment models and lack of pathways from adult behavioral health providers to their child providers that would focus on attachment, the Oregon InCK model included a proposed alternative payment model that would support care coordination and assurance of a "dyadic" approach to care provision and care components for behavioral health providers that serve both the adult and the child.
     - **Children birth to five** who have experienced foster care (aligned with the incentive metric) are included in **Service Integration Level 3A**. This will ensure that InCK will have a focus on young children who are foster care involved, with medical and social complexity factors. As part of the Service Integration trainings that OPIP will be developing we will be incorporation principles of assessment that include behavioral health assessments (currently not included in DHS CCO incentive metric), considered a young child & foster parent centered plan of care, and more holistic strategies of care coordination across core service providers who may support the foster child and family.

2) **System-Level Social Emotional Health Metric**
   - A number of the learnings from the Pathways project were incorporated in the system-level metric. If the metric were adopted in July 2021 for 2022 implementation, this has the potential to sustain and deepen the pilot work that was piloted through the Pathways project. This includes:
     - Review of the child health complexity data and receipt of Social-Emotional health screenings, assessments and/or services for children in the region overall & for historically marginalized populations.
     - Asset mapping of Social-Emotional health services that exist in the region overall, by county, and by other factors that impact equitable access.
     - Community engagement of cross-sector partners and of parents of young children from historically marginalized populations on how to design an action plan that takes into account the current health complexity and access data, the assets available in the community, and the gaps between need and receipt of services.
     - Development of a CCO led, but community-informed Action Plan. This could include implementation and spread of a number of the trainings, tools and strategies that were piloted in this Pathways project including the training of the integrated behavioral health provider, convening specialty providers, engagement of the early learning community, and convening community-level meetings to identify solutions to address gaps in capacity.
   - The metric also provides an opportunity to deepen and expand pilots, as part of the proposed CCO Action plan that were identified in the Pathways project including the following:
     - Referral pathways from Early Intervention to Specialty Behavioral Health.
     - Pilots to enhance closed loop referrals to behavioral health providers.
     - Improved communication and coordination with county mental health providers.
     - Training of early learning providers of behavioral health supports available for socially complex children and pilot of pathways from early learning to these more intensive supports.

3) **Child Health Complexity Data Reports in 2021 and 2022**
   - OHA is committed to continuing to release the public facing child health complexity reports by CCO and by county in 2021 and 2022 and the CCO-level child-level data. The next reports are expected in fall 2022. As we saw through the Pathways project, there is value in sharing this data publically across stakeholders in the community to inform and guide improvement efforts. It may be valuable for the COHC and ELHCO to consider ways in which they can support sharing and use of the data within the meetings that each organization already holds.

4) CCO Performance Improvement Project (PIP) focused on Behavioral Health

   - OHA is currently working with all CCOs on a required statewide Performance Improvement Project (PIP) focused on behavioral health for children. The topic focus of the PIP is expected to be determined by June 2021. If the focus includes young children, it may be

valuable to be align with and inform the PCS-Central Oregon on activities from the Pathways project and the related opportunities to spread the tools, strategies, and approaches that were piloted in this project.

5) Opportunities & Learnings to be Shared within COHC RHIP Workgroups to Inform Next Phase Work

As has been noted before, the learnings from InCK related to dyadic-based supports needed to align with the following COHC priority metrics of current focus and could be leveraged:

COHC Priority Area	Metrics	Opportunity Build off Learnings from Pathways on How to Build Health and Resilience for Socially Complex Children
Address Poverty & Enhance Self Sufficiency	• Increase high school graduation rates among economically disadvantaged students • Decrease food insecurity • Decrease percent of individuals living at poverty level and income constrained • Decrease housing and transportation costs as a percent of income	❖ Opportunity to consider a pilot for adults who have recently been released from prison that focuses on attachment with their children and dyadic approaches to connection. Convening of the entities that support the adults that can consider family-based approaches including access to basic needs like food and housing.
Behavioral Health: Increase Access & Coordination	• Increase availability of behavioral health providers in marginalized areas of the region • Increase timeliness and engagement when referred from primary care to specialty behavioral health • Standardize screening processes for appropriate levels of follow-up care across services	❖ Increase in breadth and depth of dyadic modalities and therapies in the region. ❖ Increase in diversity of the workforce. ❖ Increase in access to supports in Jefferson and Crook counties. ❖ Addressing financial and payment barriers to providing home based dyadic based services.
Substance Abuse & Alcohol Misuse	• Decrease binge drinking among adults • Decrease vaping or e-cigarette use among youth • Increase additional services for alcohol or drug dependence for individuals newly diagnosed • Reduce mental health/substance abuse emergency department visits	❖ Pilot of services for newly diagnosed alcohol or drug dependent individuals who have young children. The pilot of services could include: ○ Dyadic approaches to alcohol or drug dependence that also includes a focus on attachment and Social-Emotional health of the young child(ren) ○ Development of feasible care plans that incorporate the services to address alcohol/drug dependence and attachment.
Upstream Prevention	• Increase letter name recognition at kindergarten • Increase third-grade reading proficiency • Increase proportion of pregnancies that are intended • Increase two-year-old immunization rates • Increase the number of people who feel they belong in their community	❖ Parents with social complexity, and their children, often feel isolated and unconnected to other parents with social complexity, so strategies to increase belong in the community could target this population. ❖ Pathways was overall focused on increasing kindergarten readiness in a way meant to support kindergarten success and school success, which can be associated with 3rd grade reading.