Integrated Behavioral Health in Primary Care: Advanced Skills and Applications to Address Social-Emotional Health Issues in Young Children

October 15, 2024

This training is financially supported by ***Health Share of Oregon.***

Welcome!! We Are So Grateful You Are Here Today!

- 33 Attendees registered
  - **29** of which are behavioral health clinicians
- Represent more than **20 Primary Practices Sites**
- Specialty of Providers in Sites:
  - 63% Pediatric
  - 37% Family Medicine
- Work within practices that are attributed over **11,617 children birth to five** within Health Share of Oregon

- We know what it means to take time out of clinic.
- It means so much that a whole half day is dedicated to this birth-to-five population.
- With that – Let's take a picture to document this day!

Who is the Oregon Pediatric Improvement Partnership (OPIP)

oregon-pip.org

Mission: 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 all children and youth in Oregon.

- OPIP projects are supported by **grants and contracts**.
- We are based out of Oregon Health & Science University, Pediatrics Department.

OPIP uses a **population-based approach—starting with child/family** to **improve the quality of child healthcare,** with the larger purpose of improving the health of children and youth.

Learning Collaborative Faculty and Supports Today

Colleen Reuland
Director of OPIP

Dr. Lydia Chiang
OPIP Medical Director

Dr. Andrew Riley
OHSU IBH Clinician & OPIP Consultant

Tessa Kehoe, MPH
OPIP Data and Trainings Coordinator

Vienna Cordova
Projects Coordinator

Reece Jose
Sr. Research Assistant

Introducing Today's Guest Speaker:Kathryn Hallinan Aguilar, MA

- Kathryn Hallinan Aguilar is a licensed marriage and family therapist.
- She works at UCSF working in the 6M Children's Health Center as a HealthySteps Specialist Supervisor as well as Co-Director of Training and Workforce Development, UCSF Center for Advancing Dyadic Care in Pediatrics.
- Kathryn is a Bay Area native, a bilingual Spanish speaker (with Spanish being her second language), and is a mother of a 14-month-old.
- She has held her own private practice in San Francisco and currently teaches a Relationships course at University of San Francisco as a part of the Masters in Counseling Psychology program.
- Kathryn's work is centered on a framework of building relationships and understanding with the families and providers she serves to better support them in their work caring for their children.

Previous Experience:

- Before UCSF, Kathryn worked in San Mateo and San Francisco counties providing **early childhood mental health consultation**, therapeutic shadowing, and counseling for children and the various caregivers in their lives.
- Created a **trauma-informed residential drug treatment program** for women and their children in San Francisco.
- Completed Infant Parent Program at Zuckerberg San Francisco General.

OPIP -Supporting Improvement in Integrated Behavioral Health

We have experience working with integrated behavioral health in primary care on:

- Trainings, tools and implementation support to enhance **social-emotional services** for young children
  - **Training** of integrated behavioral health and how to engage families, external behavioral health referrals
  - Trainings and tools on how to **engage families** of young children in behavioral health services
- Developing **decision trees and summaries of external specialty behavioral health** services to inform best match referrals
- Since Fall of 2024, have led a **Learning Collaborative of Integrated Behavioral Health** in primary care practices that contract with Health Share of Oregon.
  - Today is the 2nd in-person Learning Session
  - Monthly webinars
- Currently leading the Oregon **Transforming Pediatrics for Early Childhood** cooperative agreement in the Portland metropolitan area, which focuses on increasing issue-focused interventions in primary care. Representatives from all four TPEC sites are here today!
  - https://oregon-pip.org/our-projects/transforming-pediatrics-for-early-childhood/

Thank You Health Share of Oregon

- This Learning Collaborative is financially funded and supported by Health Share of Oregon.
- This is one part of Health Share of Oregon's **Action Plan** efforts related to the **System-Level Social Emotional Health for Young Children**.
- Tab 2 of the binder provides an overview of Health Share of Oregon's full and broad efforts related **System-Level Social Emotional Health for Young Children**.

We Welcome from Health Share & OHSU Health Plan Partner:

Katie Unger, MPH
Child, Youth & Families
Program Manger

Peg King, MA
Early Life Health
Partnerships Portfolio Manager

Kristan Jeannis
OHSU Health Services
Clinical Value Analyst

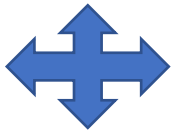
Icons Throughout the Presentation

= E-Binder Tab #

= Primary Care Providers

= Integrated Behavioral Health

= Specialty Behavioral Health



= System Navigation, Referral Management

Today's Agenda

- Where are we now and why is there a need for increased provision of services, 2025 CCO Incentive Metric
- **Overview** of 2024 Webinars Key Topics and Core Concepts
- **Advanced Skills for Specific Populations**
  - Common Concerns for Children with **Autism and Other Developmental Disabilities**
    - Example Cases
  - Addressing **Parental Mental Health** in the Context of Behavioral Services for Young Children
    - Example Cases

Supporting Implementation:

- **Engaging Your Primary Care Providers** to Refer Young Children
- **Engaging Families** in Internal & External Services
  - Insights from Parent Input Sessions
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How Many Children Need CCO-Covered Issue-Focused Interventions?

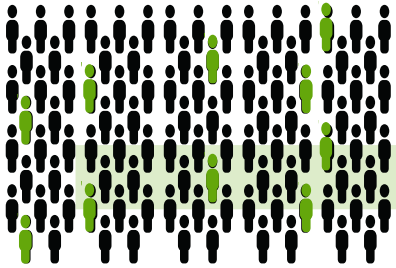
Continuum of CCO-Covered Social-Emotional Services Represented by Specific Claims

30-40%

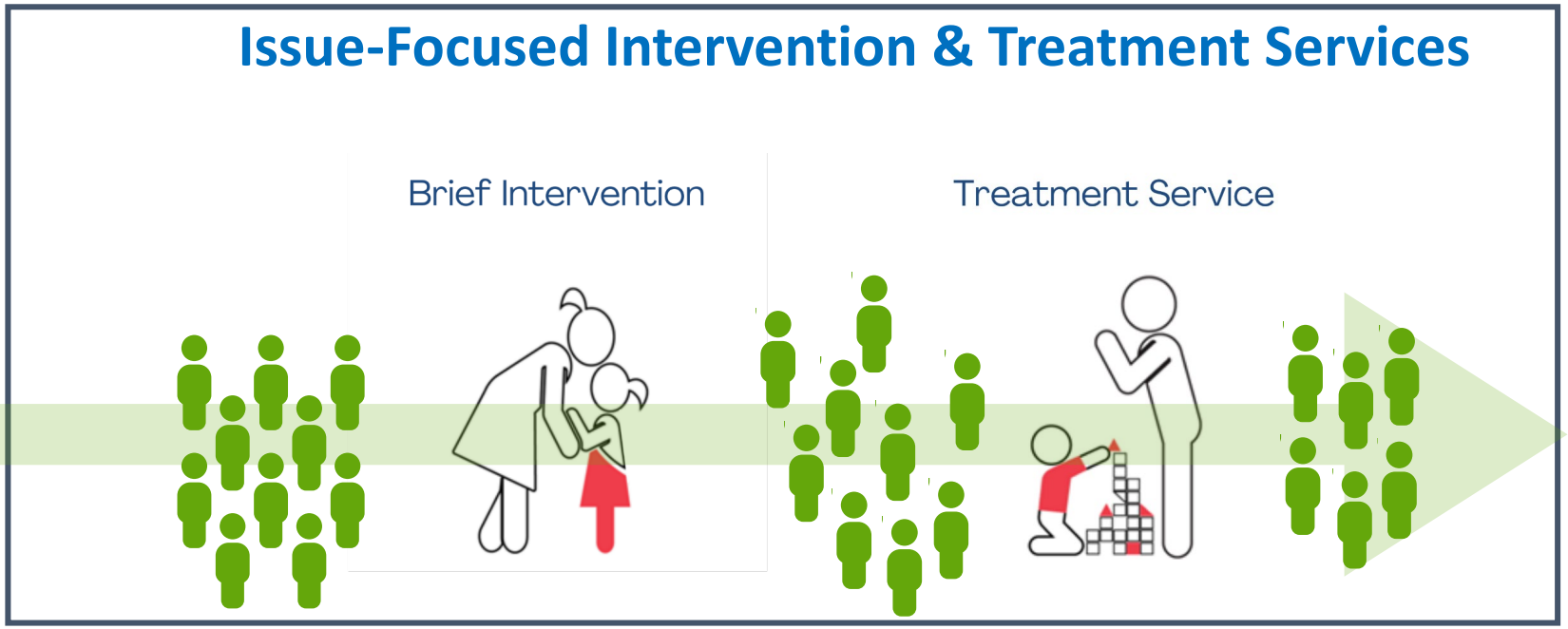
Of Children Have Social Complexity Experiences that Could Impact SE Development and Likely Benefit from Brief Interventions

12-17%

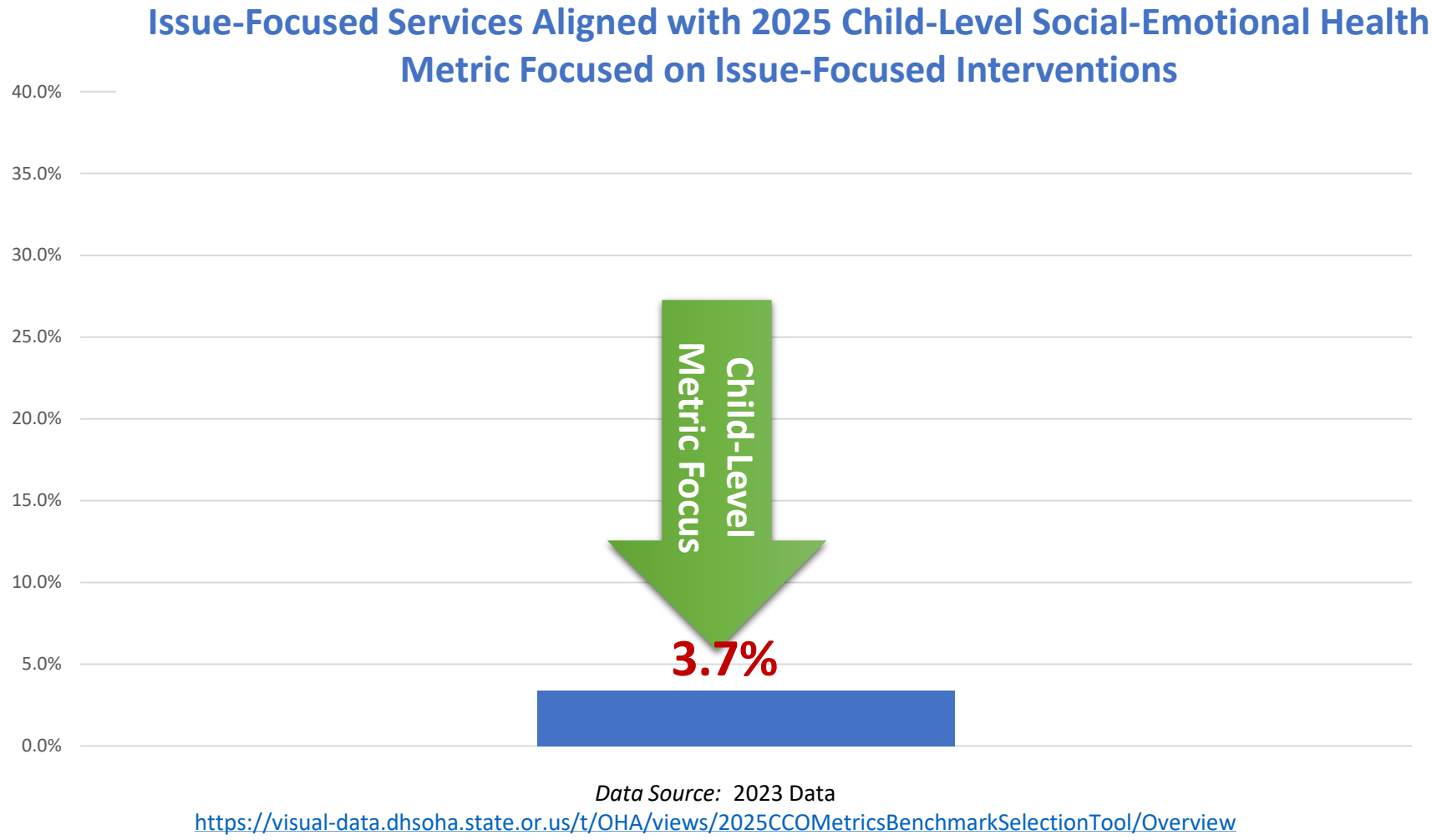
Of Children Will Have a Diagnosis that Would Warrant Treatment Services



Children with Identified Issues ***(Delays, Behavior Concerns, Risk for Problem Behaviors)***



Where Are We Now: Are Children Receiving Clinically Recommended Issue-Focused Interventions from CCO-Contracted Providers Included in the CCO Global Budget? Answer: NO, not yet...!



Data Source: 2023 Data
https://visual-data.dhsoha.state.or.us/t/OHA/views/2025CCOMetricsBenchmarkSelectionTool/Overview

Why There Is a Need to Increase Provision of Services: From Parents of Children Enrolled in CCOs

- "My middle son was kicked out of preschool and then again from kindergarten due to behaviors that no one knew what to do with. We were bounced around multiple systems experiencing layer upon layers of trauma… If there was a metric that supported upstream services for my son, I believe that not only would the cost of long-term services have been less for the involved systems, but my son would not carry the stigma, trauma and historical marginalization that he lives with today because of these experiences." (Tammy Paul, mother of three)
- "When young children are showing signs of mental and emotional health problems, the lack of a metric focused on social emotional wellness effectively denies access. It closes the door to help, and it forces families into more intensive, more costly, and more life altering treatment downstream… if it's not measured and financially incentivized, it's not likely to happen." (Carol Dickey, mother of five children adopted through foster care)
- "For the last decade, we've been fighting an uphill battle to secure the necessary supports for them in the care provided in our CCO. ….When he finally got an evaluation and received a diagnosis, I was just given a list of providers, who all said they didn't see young children or they had enormous waitlists, or they didn't exist. Even the behavioral health coordinator through our CCO has told us there are no services for us." (Karra Crane, mother of two living in Douglas County)
- "From the time my second daughter was in a relief nursery, we noticed behaviors and were really worried. ….. It's really a terrible feeling when you know something is needed. …I feel strongly the health care system has a stigma against providing behavioral health services for young children. Instead, we had to wait until my child was in school and facing bigger behavioral problems." (Krystal Bachman, mother of 5)

2025 Child-Level Metric Focused on Issue-Focused Interventions

Metric is based on Administrative Claims (Services Billed) and Enrollment Data, analyzed for the CCO attributed population

Numerator: Children who received **issue-focused intervention/treatment services** that were billed to the Coordinated Care Organization

No diagnostic pairing required to count for metric!

X 100 = % of Children

Denominator:

Children ages 1-5 who are covered by Oregon Health Plan and enrolled in the Coordinated Care Organizations for 12 months, allowing for a 45 day break

Numerator: The child-level incentive metric **targets services** that are most aligned with **clinically recommended behavioral health services *(and therefore improvements and common codes used by the workforce needed)***

OPIP
Oregon Pediatric Improvement Partnership

*Targets improvements that cover the breadth of brief intervention and treatment services and are most commonly used by the **system of providers** focused on addressing behaviors, across sectors.*

Primary Care & Integrated Behavioral Health (Asset Mapping Years 2-3)

Specialty Behavioral Health (Asset Mapping Years 1-3)

Tab 2

Other Contracted CCO Providers that May Provide a Range of Issue-Focused Interventions (Asset Mapping: Year 3)

Issue-Focused Services Included in Numerator

- List includes targeted service codes (no diagnosis required) covering the breadth of brief intervention and treatment services most commonly used by the **system of providers** addressing behaviors

Primary Care & Integrated Behavioral Health

Specialty Behavioral Health

Tab 2

- Health Behavior Assessment *(96156)*
- Health Behavior Intervention *(96158, 96159, 96164, 96165, 96167, 96168, 96170,96171)*
- Preventive Medicine Counseling *(99401-99404, 99411-99412)*

- Psychiatric Diagnostic Evaluation *(90791)*
- Mental health assessment, by non-physician *(H0031)*
- Individual psychotherapy *(90832-90838)*
- Family psychotherapy *(90846, 90847)*
- Group psychotherapy *(90849, 90853)*
- Multi-Family Group Training Session *(96202-3)*

- Psychiatric Diagnostic Evaluation, by medically licensed professional *(90792)*
- Adaptive Behavior Treatment *(97153-97158)*
- Behavioral health counseling/therapy *(H0004)*
- Skills training and development *(H2014)*
- Behavioral Health Outreach Services *(Used for Intensive, In Home BH Treatment) (H0023)*
- Activity Therapy (G0176)
- Mental health service plan development, by non-physician *(H0032)*

Other contracted providers (such as THWs/CHWs in Community-Based Organizations)

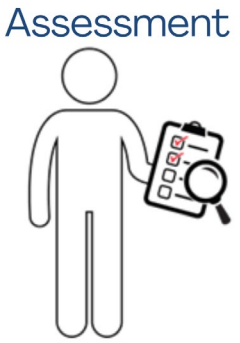
***Likely to include some codes listed above, such as Preventive Medicine Counseling, Group Psychotherapy, Multi-Family Group Training,* Mental health service plan development, by non-physician *(H0032)* **

- Education & Training for Patient Self-Management by Qualified Non-Physician *(98960-98962)*

Role of Integrated Behavioral Health (IBH) in the Metric and Why This Opportunity to Provide You Supports is Being Offered

Children go to **primary care** over a dozen times in the first five years of life

- Primary care sees early flags of opportunities for assessments and interventions
- Families often develop deep trust of their primary care team
- There may be less stigma to accessing services within primary care



There are models that can be used to support **assessments and interventions** provided in 3-6 sessions (brief interventions) that can be conducted in the primary care setting

IBH may identify families that need **external specialty behavioral health** referrals and help support navigation to care.

- There is need for best match referral information, tools, and strategies to engage families.

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- **Welcome:** Oregon Pediatric Improvement Partnership (OPIP) Introductions, Agenda Review
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- **Overview** of 2024 Webinars Key Topics and Core Concepts
- **Advanced Skills for Specific Populations**
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Overview of Topic-Focused Webinars Thus Far

Month	Topic-Focused Webinars
April	4/16/24: 12-1pm | Disruptive Behavior 1 - Positive Parenting Strategies
May	5/21/24: 12-1pm| Disruptive Behavior 2 - Effective Discipline
June	6/18/24: 12-1pm | Early Childhood Anxiety
July	7/16/24: 12-1pm | Enhancing Communication & Coordination with Medical Teams with Dr. Cody Hostutler
August	8/20/24: 12-1pm |Early Childhood Sleep with Dr. Ariel Williamson
September	9/17/24: 12-1pm | Culturally-Informed Motivational Interviewing with Dr. Rachel Herbst
October	10/15/24: In-Person Learning Session TODAY!
November	11/19/24: 12-1pm | Toilet Training and Elimination Problems Registration Link: https://us06web.zoom.us/meeting/register/tZEuduiqpjosGNCw1rOcTgbUvM5bm4mv7Th4
December	12/17/24: 12-1pm | Incorporating Trauma-Informed Principles into IBH with Dr. Kim Burkhart Registration Link: https://us06web.zoom.us/meeting/register/tZcuceGoqjwpH9liz8bWB91uBhtxGIIA1l0A

Tab 3

List Serv for IBH Clinicians

OPIP will maintain beyond 2024

Integrated Behavioral Health Listserv

Tab 3

Background:

- Behavioral health clinicians participating in the Learning Collaborative noted the value of being able to ask each other or the OPIP faculty questions and share information/resources.
- To meet this request and avoid large group emails, OPIP created a listserv for behavioral health clinicians integrated in primary care practices.

What is the ListServ and How Do You Access it

- The listserv name is IBHListserv.edu
- You need to sign up to join the IBHListserv.edu.
- The IBHListserv.edu is a place where folks can share resources, information, open jobs in their clinics, and more!

If you would like to join the listserv, please complete the survey linked below.

- Sign Up Survey Link: https://ohsu.ca1.qualtrics.com/jfe/form/SV_e4l05a0V7U6buaW

The sign-up survey link should only take 2-3 minutes to complete and includes an attestation that you will not share Protected Health Information (PHI) or otherwise confidential information on the listserv.

Today's Agenda

- **Welcome:** Oregon Pediatric Improvement Partnership (OPIP) Introductions, Agenda Review
- **Setting the Context** & Role of Integrated Behavioral Health in the 2025 Child-Level Social-Emotional Health CCO Incentive Metric (starting January 2025)
- **Overview** of 2024 Webinars Key Topics and Core Concepts
- **Advanced Skills for Specific Populations**
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Objectives

1. Review the prevalence of common behavioral concerns amongst children with autism spectrum disorders and other developmental disabilities.
2. Identify evidence-based treatment approaches to common concerns including disruptive behavior, sleep problems, and selective eating.
3. Articulate how to refine behavioral guidance for children with autism in primary care settings.

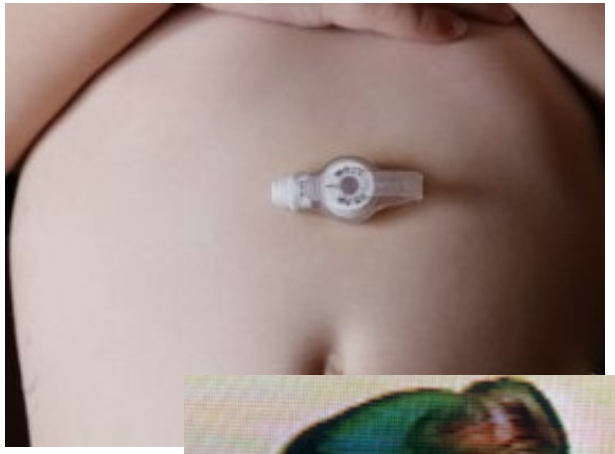
Autism Spectrum Disorders

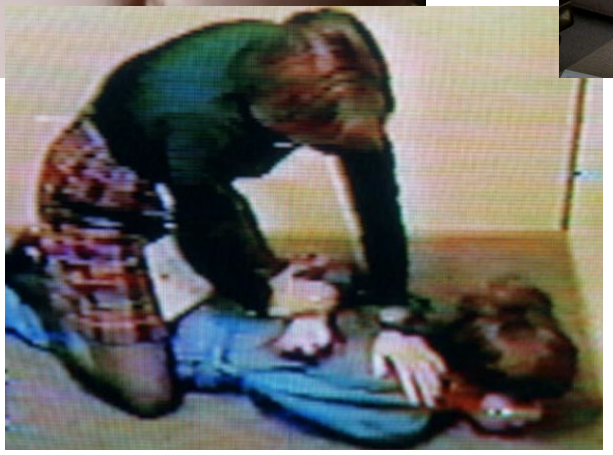
- **Autism Spectrum Disorder (ASD)** core deficits
  - Social-emotional communication and interaction
  - Restricted and repetitive patterns of behavior
- Associated features
  - Intellectual disability
  - Language impairment/idiosyncrasy
  - Motor deficits
  - Sensory hyper/hypo-sensitivity

Common Problem Behaviors

- Feeding problems: 46-89%
  - Autism: 46-89%
  - Down Syndrome: 50-80%
  - Fetal Alcohol Spectrum Disorder (FASD): 26-37%
- Sleep problems:
  - Autism: 50-80%
  - Down Syndrome: 50-76%
  - FASD: 58-80%
- Aggression
  - Autism: 53-68%
  - Down Syndrome: < 15%
  - FASD: Most common concern
- Self-injurious behavior
  - Autism: 42%
  - Down Syndrome: 15%

Quality of Life Impacts





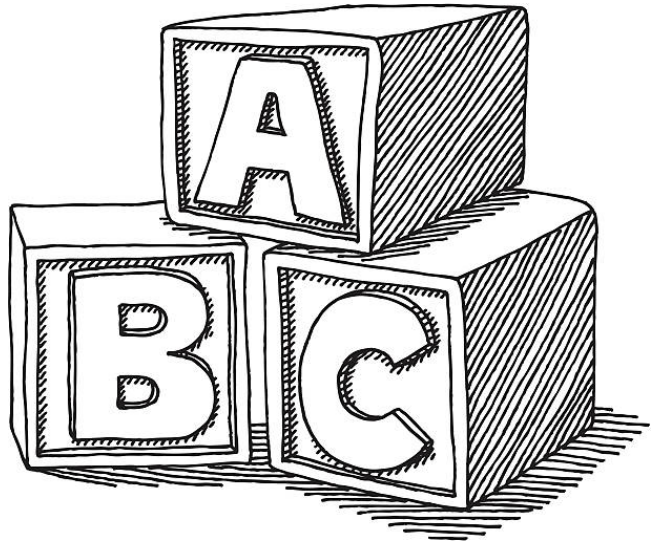
Oregon Senate passes bill banning locking students in 'seclusion cells'

Changing Behavior is *Challenging*

- Children with developmental delay (DD) are highly heterogeneous, and interventions often need to be individualized
- Some similarity to “usual” behavioral guidance, but greater *intensity* and *precision* is often required
- Greater potential for adverse effects
- Most effective interventions were developed for specialized settings
  - Neurobehavioral units
  - Intensive outpatient
  - School-based
  - Home-based

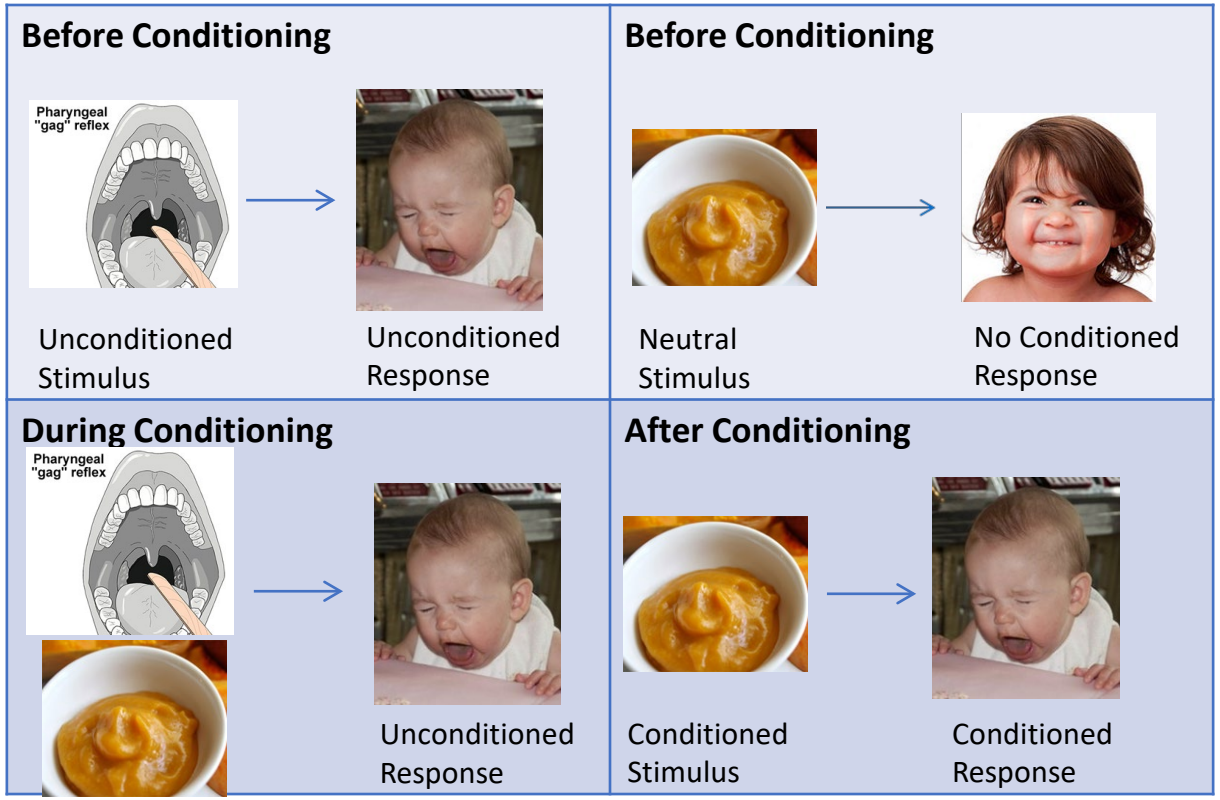
Meeting the Challenge

1. Utilize fundamental principles of learning
2. Function over form
3. Where can you get your foot in the door?



Fundamental Learning Processes

- Most effective interventions are grounded in:
  - Association – Respondent (Classical) Conditioning
  - Consequences – Operant Conditioning



Fundamental Learning Processes

- Most effective interventions are grounded in:
  - Association – Respondent/Classical Conditioning
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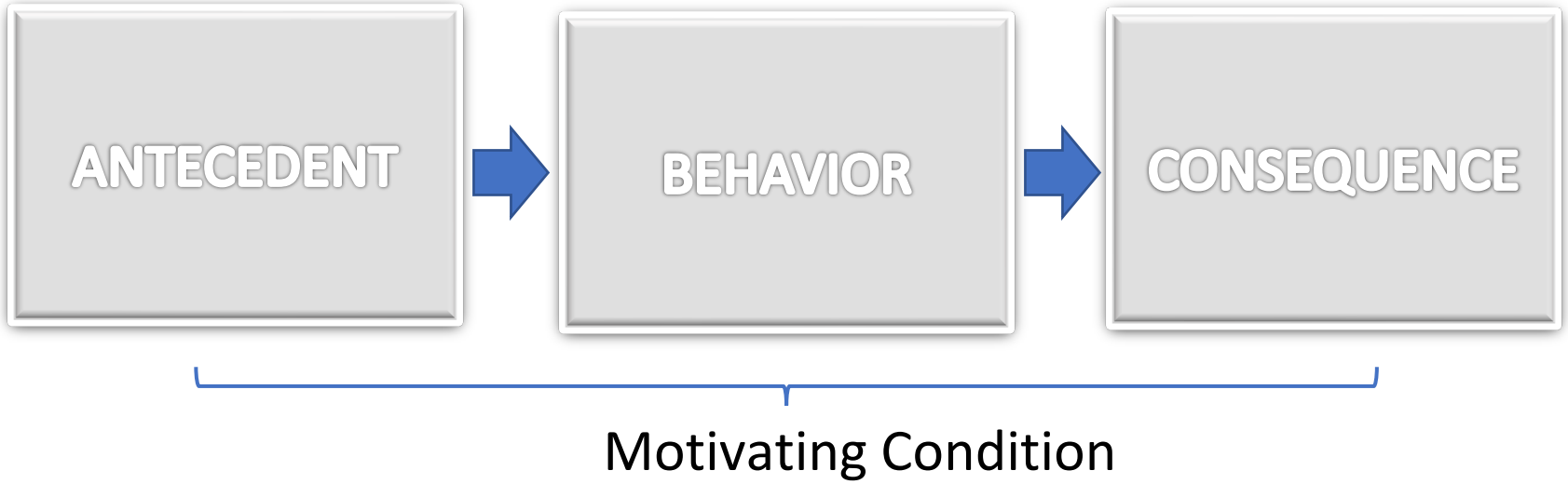
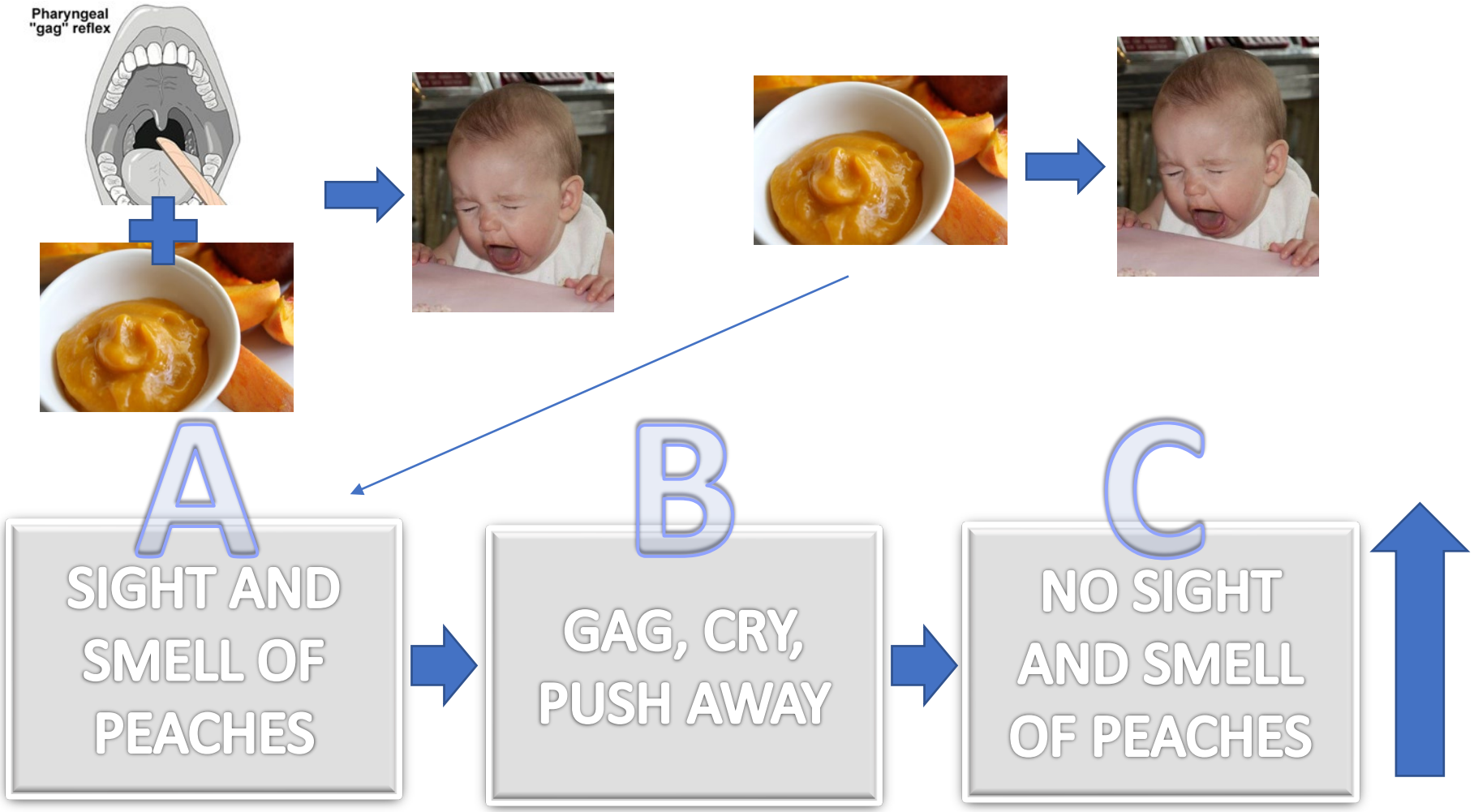
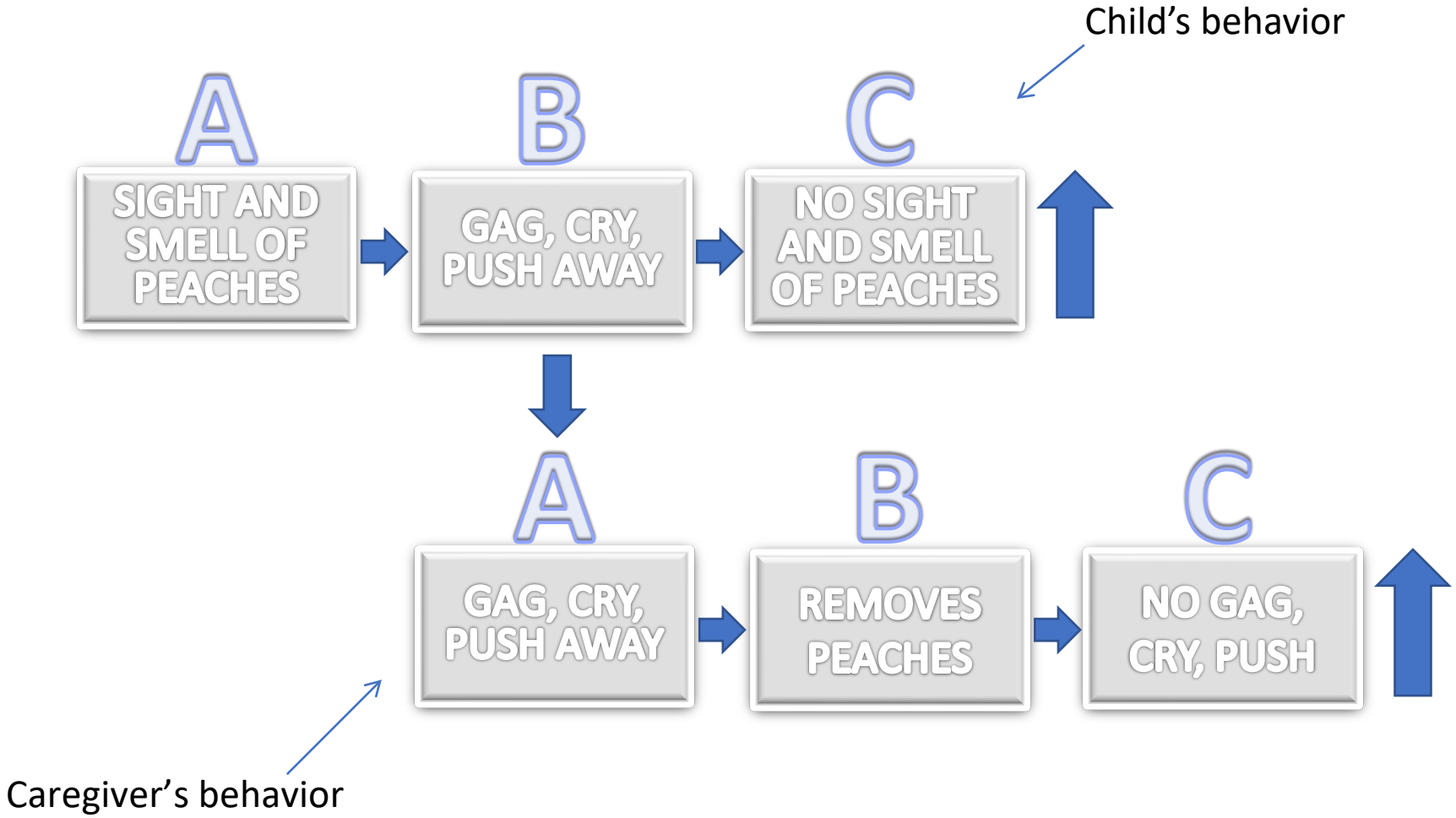


Fundamental Learning Processes



Fundamental Learning Processes



Case 1: Sleep Onset

- Cecelia is a 3 yo girl with autism, profound intellectual disability, and self-injurious scratching and hitting
- Often takes 3-4 hours to fall asleep with yelling and self-injurious behavior if left alone
- Parents have implemented a consistent bedtime routine on advice from pediatrician
- Tried Ferber Method/graduated extinction, but outbursts were intolerable
- Sleep meds have been ineffective or poorly tolerated
- Mom has been sleeping on a mattress on the floor next to Cecelia's bed for some time

Learning by Association: Sleep Onset

- Conceptualization:
  - Caregivers attempt bedtime before a child is physically sleepy
    - Children with ASD may have atypical circadian rhythms
  - The bedtime routine and sleep environment (i.e., *neutral stimuli*) are not effectively paired with the context that occasions sleep (i.e., *unconditioned stimuli*)
- Solution
  - Alter bedtime such that the bedtime routine is consistently paired with sleepiness, so they become associated
- Strategy
  - Faded bedtime

Learning by Association: Sleep Onset

Before Conditioning

Unconditioned Stimuli

Unconditioned Response

Before Conditioning

Neutral Stimuli

No Conditioned Response

During Conditioning

Unconditioned Response

After Conditioning

Conditioned Stimuli

Conditioned Response

Faded Bedtime

1. Determine baseline sleep onset - *when does the child usually fall asleep?*
2. Establish a new bedtime – *30 min past typical sleep onset*
3. "Fade" the bedtime depending on onset latency – *move up 15 min following two nights of "success" (e.g., sleep onset <15-30 min)*
4. Fade until desired bedtime is achieved based on developmental norms and parental preference

Note: Avoids most side effects of extinction-based methods

Delemere, E., & Dounavi, K. (2018). Parent-implemented bedtime fading and positive routines for children with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, *48*(4), 1002-1019.

Case 2: Food Refusal

- Ben is a 4 yo boy with autism, moderate ID. He does not speak but has some signs to request basic needs.
- He eats only starches, dairy, and some plain chicken, typically with ranch dressing.
- He is growing okay, but there are concerns for mineral deficiency.
- He often requests more food after meals. His parents have tried to make this contingent on eating some fruit or vegetables, which he passes on.
- Because he does not eat much during meals, they supplement with snacks (granola bars, string cheese) in between.
- He will often gag/retch when presented with non-preferred foods.

Learning by Association: Food Refusal

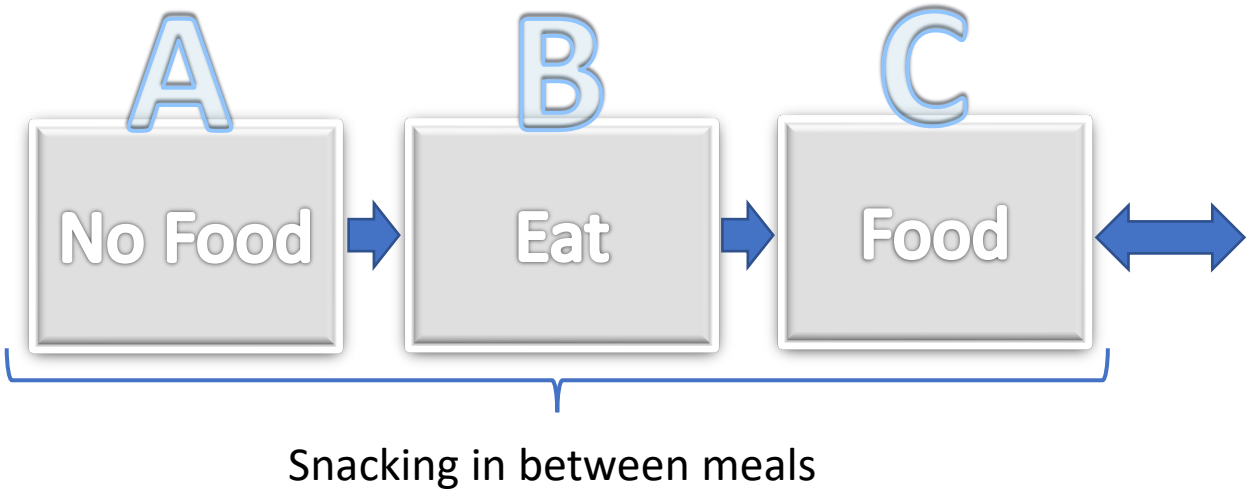
- Conceptualization
  - Multiple exposures to new food are needed prior to acceptance, but initial attempts are often unsuccessful, then abandoned
- Solution
  - Pair non-preferred foods (NPF; neutral stimuli) with preferred foods (PF; unconditioned stimuli) to increased acceptance
- Strategy
  - Simultaneous Presentation

Simultaneous Presentation of Preferred & Non-Preferred Food

- Present NPF and PF together, repeatedly
- How foods are paired may vary greatly (e.g., on the same plate, one topped/mixed with other, blended together)
- "We already tried that."
  - Consider *ratio*, where can you be successful?
  - Ratio can be faded gradually over time
  - Consider taste, smell, texture, sight

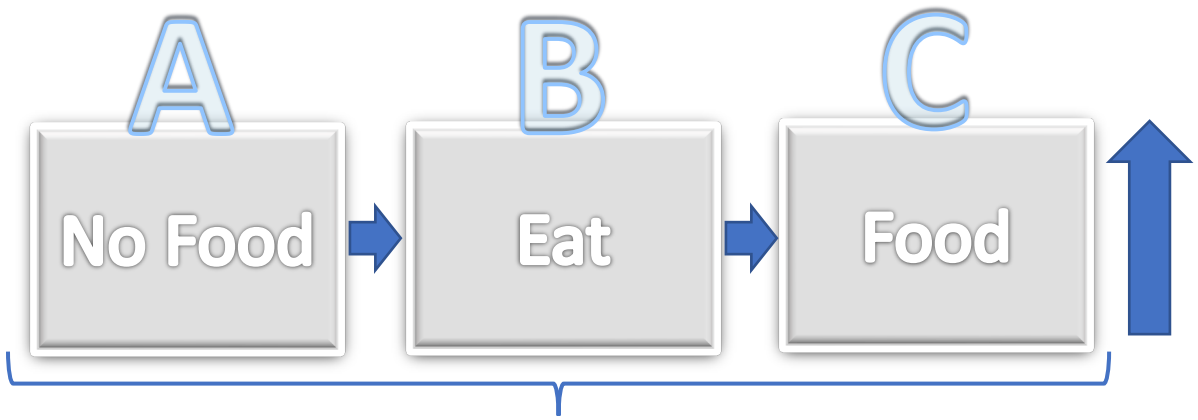
Ahearn, W. H. (2003). Using simultaneous presentation to increase vegetable consumption in a mildly selective child with autism. *Journal of applied behavior analysis*, *36*(3), 361-365.

Learning by Consequences: Food Refusal



- Food is not effectively reinforcing eating behavior

Learning by Consequences: Food Refusal



Snacks are restricted

- Restricting snacks *establishes* the reinforcing value of food

Kerzner, B., Milano, K., MacLean, W. C., Berall, G., Stuart, S., & Chatoor, I. (2015). A practical approach to classifying and managing feeding difficulties. *Pediatrics*, *135*(2), 344-353.

Case : Aggression

- Caleb is a 5 yo boy with autism, moderate intellectual disability, and minimal verbalizations
- Repeated instances of aggressive and destructive behavior in his kindergarten
- His teacher knows that “time-out” can help, so she started sending him to the hallway when he acts out.
- Also provides him a vibrating toy, because the sensory input seems to soothe him.

Function > Form

- Problem behavior develops because it is reinforced under motivating conditions
- Function (purpose of behavior) is more important than topography (type of behavior)
- Usual Suspects (> 90% of problem behaviors)
  - Attention
  - Escape/Avoidance
  - Tangible
  - Automatic (non-social)

Melanson, I. J., & Fahmie, T. A. (2023). Functional analysis of problem behavior: A 40-year review. *Journal of Applied Behavior Analysis, 56*(2), 262-281.

Functional Analysis Outcomes

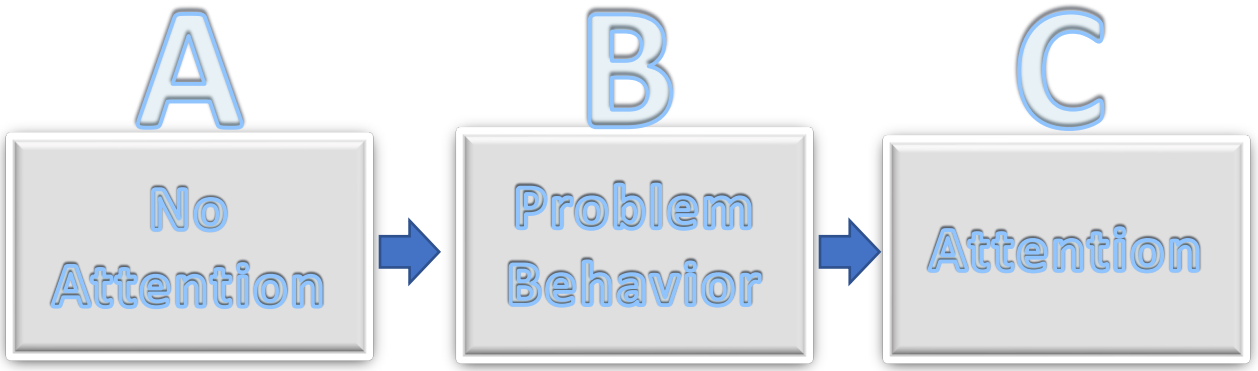
TABLE 5 Summary of functional analysis outcomes

Topography	Undiff	Diff	Esc	Attn	Tang	Auto	Other	Mult
Self-injury	19 (41)	103 (385)	20 (103)	5 (68)	12 (46)	44 (120)	0 -	21 (47)
Aggression	24 (36)	149 (244)	55 (96)	19 (40)	29 (45)	1 (3)	0 -	45 (60)
Property destruction	1 (1)	22 (31)	8 (10)	7 (9)	1 (3)	3 (4)	0 -	3 (5)
Pica	0 (0)	16 (27)	0 (0)	2 (3)	0 (0)	12 (20)	0 -	2 (4)
Disruption	5 (5)	11 (37)	4 (15)	1 (4)	0 (1)	0 (7)	0 -	6 (10)
Vocalizations	10 (13)	47 (106)	11 (26)	15 (32)	6 (12)	2 (12)	1 -	12 (23)
Noncompliance	0 (0)	21 (46)	8 (17)	6 (15)	1 (4)	0 (0)	0 -	6 (10)
Elopement	2 (2)	36 (51)	1 (1)	6 (11)	10 (14)	1 (1)	0 -	18 (24)
Stereotypy	6 (7)	115 (161)	1 (8)	3 (3)	1 (1)	107 (140)	0 -	3 (9)
Tantrums	0 (0)	16 (24)	1 (4)	3 (4)	4 (6)	0 (0)	0 -	8 (10)
Inappropriate mealtime behavior	4 -	54 -	16 -	3 -	0 -	0 -	0 -	35 -
Other	0 (0)	49 (79)	6 (12)	12 (18)	3 (4)	20 (31)	1 -	8 (14)
Aberrant	48 (69)	575 (891)	125 (245)	28 (100)	85 (117)	18 (20)	13 -	306 (396)
Total number[a]	119 (178)	1,214 (2,136)	256 (553)	110 (310)	152 (253)	208 (358)	15 -	473 (647)
Percentage of sample[b]	8.9 (7.7)	91.1 (92.3)	21.1 (25.9)	9.1 (14.5)	12.5 (11.8)	17.1 (16.8)	1.2 -	39.0 (30.3)

Note. Undiff = undifferentiated results, Diff = differentiated results, Esc = maintenance by escape, Attn = maintenance by attention, Tang = maintenance by tangible reinforcers, Auto = maintenance by automatic reinforcement, Mult = multiple sources of control. A dash indicates data were not reported in Beavers et al. (2013) or Hanley et al. (2003).

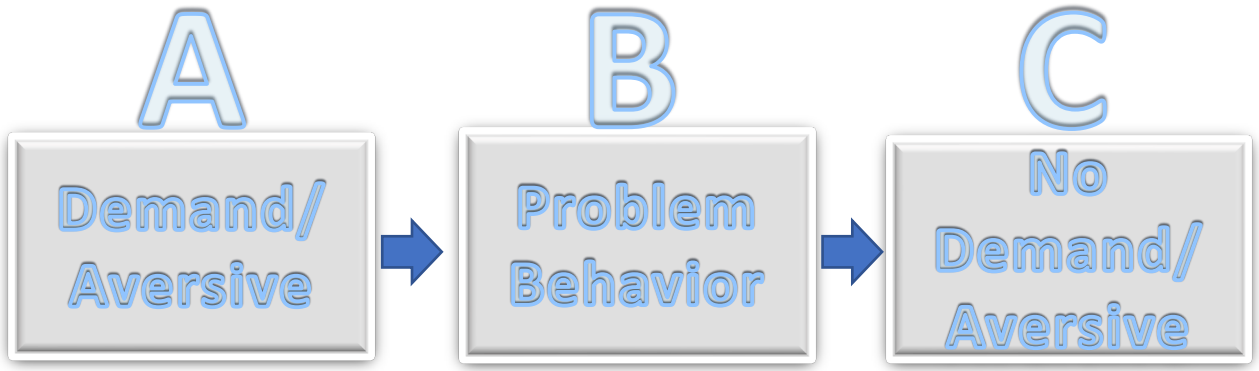
Melanson, I. J., & Fahmie, T. A. (2023). Functional analysis of problem behavior: A 40-year review. *Journal of Applied Behavior Analysis, 56*(2), 262-281.

Function Clues: Attention



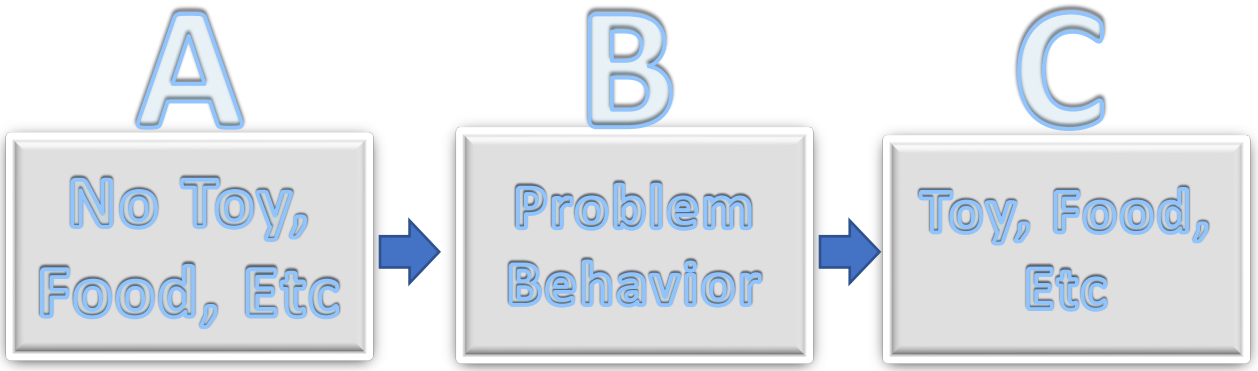
When?	Why?	Env Response?
• When others are talking/turned away • When alone or ignored for awhile • When you start to leave	• Seems to want to be reprimanded • Wants a reaction • Wants to engage	• React to misbehavior • Talk a lot about misbehavior • Emotional responses • Soothing

Function Clues: Escape



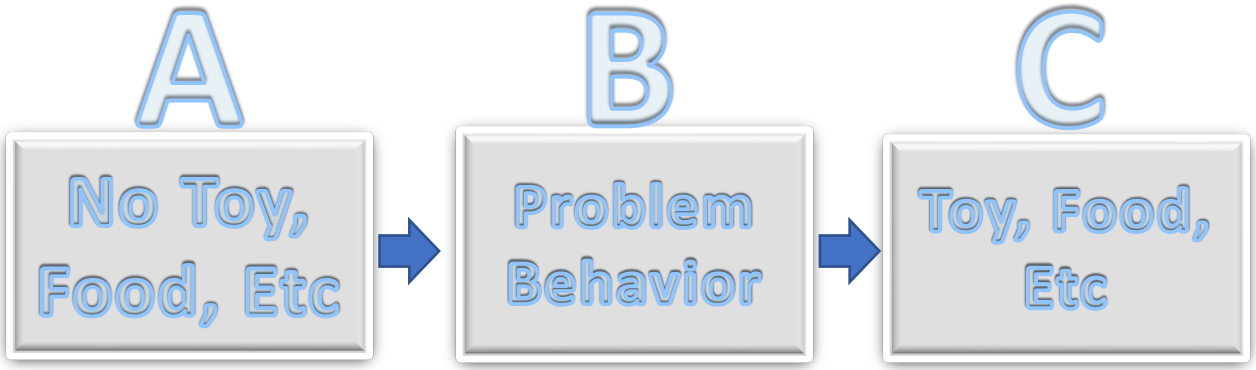
When?	Why?	Env Response?
• When given an instruction/task • During procedures • When being approached	• Seems uncomfortable or fearful • Wants to be left alone • Seems bored	• Moving away • Pulling back • Leaving area

Function Clues: Tangible



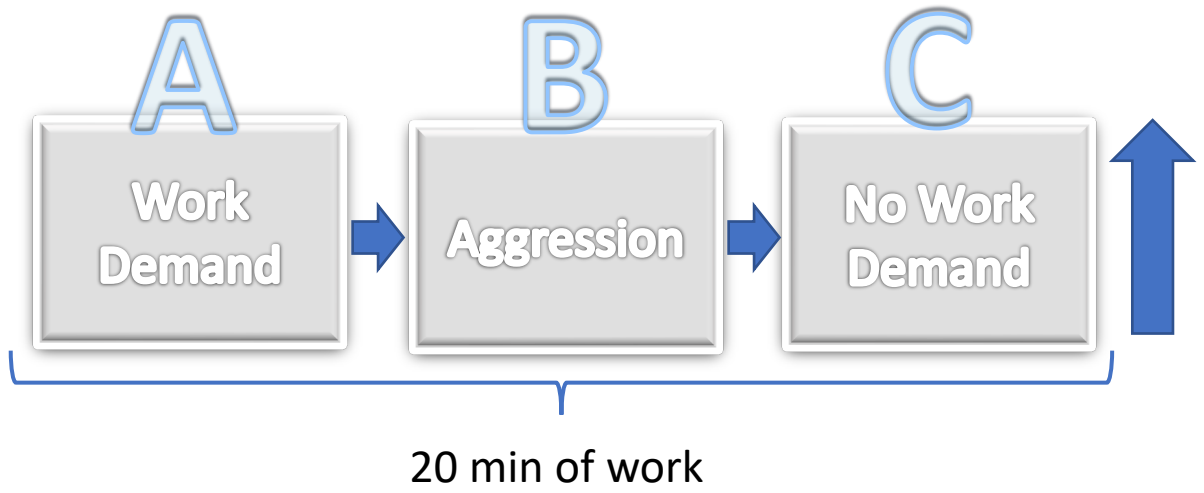
When?	Why?	Env Response?
• Something is taken away • Access denied or told no	• Wants some physical thing or activity • Hungry/thirsty	• Provide toy, snack, iPad, blanket, etc.

Function Clues: Automatic



When?	Why?	Env Response?
• Something is taken away • Access denied or told no	• Wants some physical thing or activity • Hungry/thirsty	• Provide toy, snack, iPad, blanket, etc.

Functional Assessment: Aggression



- Aggression is reinforced by escape from work, which is *established* as reinforcing after 20 min

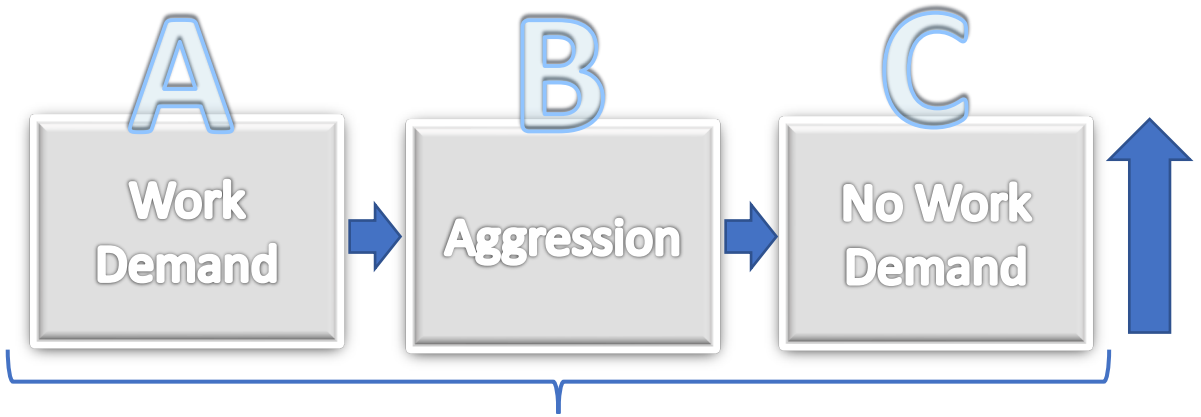
Function-Based Intervention

- **A**ntecedent intervention – Change the conditions that motivate the function
  - *Pro:* Preventative, often easiest to implement, low risk
  - *Con:* Does not teach any skills

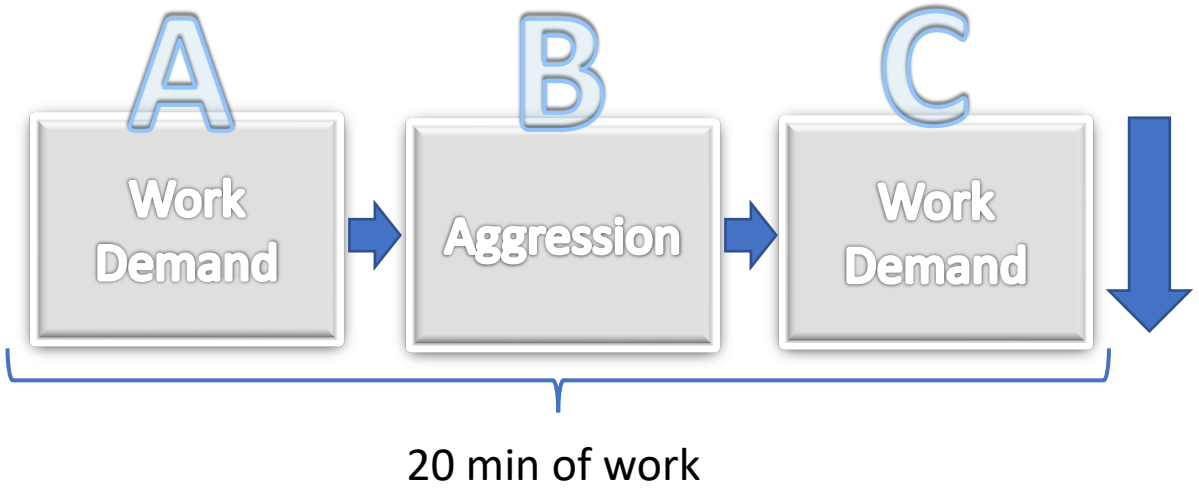
- **B**ehavior intervention – Teach a new, appropriate behavior that fulfills the function
  - *Pro:* Teaches a needed skill and reduces problem behavior
  - *Con:* Requires more time/precision to implement

- **C**onsequent intervention – Prevent the problem behavior from fulfilling the function or “reverse” effect
  - *Pro:* Can reduce problem behaviors quickly
  - *Con:* More potential for harm; does not teach skill; ethical considerations

Function-Based Intervention: Aggression

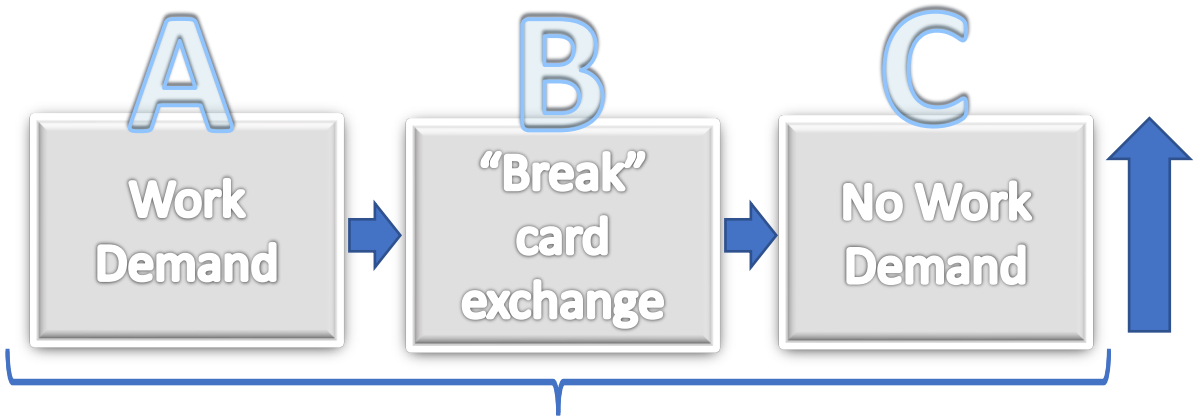


Function-Based Intervention: Aggression



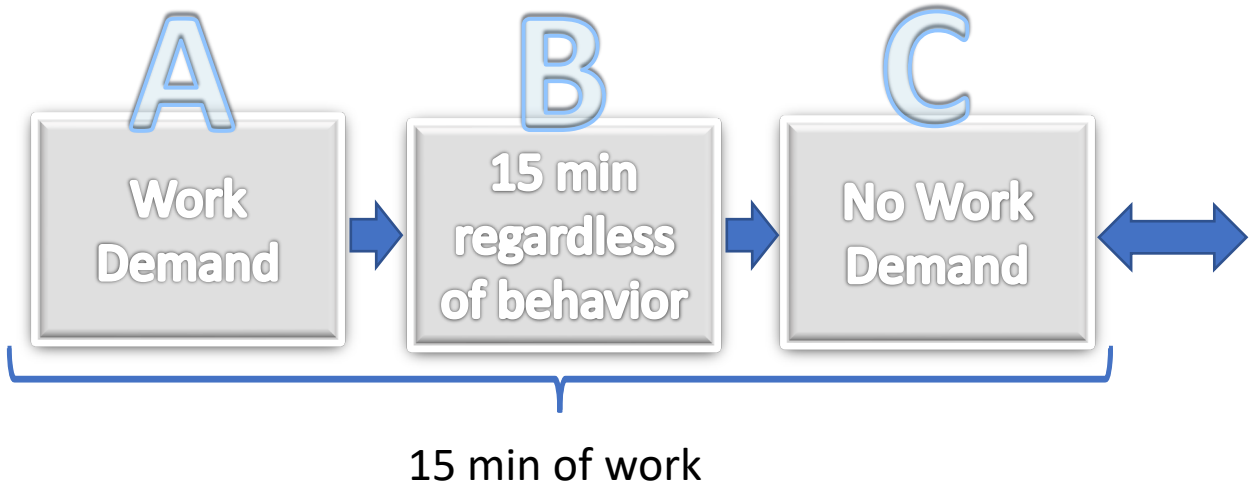
- Extinction will reliably produce an *extinction burst,* which may not be tolerable.

Function-Based Intervention: Aggression



- Functional Communication Training

Function-Based Intervention: Aggression



- Non-contingent reinforcement

Considerations

- Even seemingly bizarre or extreme behavior usually makes sense *in context*
- Consider feasibility and collaborate with caregivers
  - Antecedent interventions are often most feasible in non-specialized settings
- Is an extinction burst tolerable?
- Is there a skill that needs strengthening?
- Focus on small steps
- Change is gradual
- Referral will often be the best option, but primary care can help in the meantime.

Questions and Case Examples

"In an American school if you ask for the salt in good French, you get an A. In France, you get the salt."

—B.F. Skinner

In your binder is a handout on common function-based interventions for treating problem behavior

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Addressing Parental Mental Health in the Context of Behavioral Services for Young Children

Kathryn Hallinan Aguilar, LMFT
Oregon Pediatric Improvement Partnership
October 15, 2024

Let's Break the Ice!
--Translated Rant--

- Find a partner, take a seat and choose who will be Partner A and who will be Partner B.
- Each partner take a moment to think of something that really drives you crazy (pet peeve) and hold that thought in mind until your turn to share.
- Partner A spend 60 seconds ranting about what drives you crazy and why. Partner B listen without speaking for the following:
  - *What do they care about and value?*
  - *What's important to them?*
- Partner B reflect what they learned about Partner A, "you value… you care about…" Do not include any of the negative rant. Partner A listens and has a chance to respond and share how accurate this feels.
- Now switch roles and Partner B give your rant.

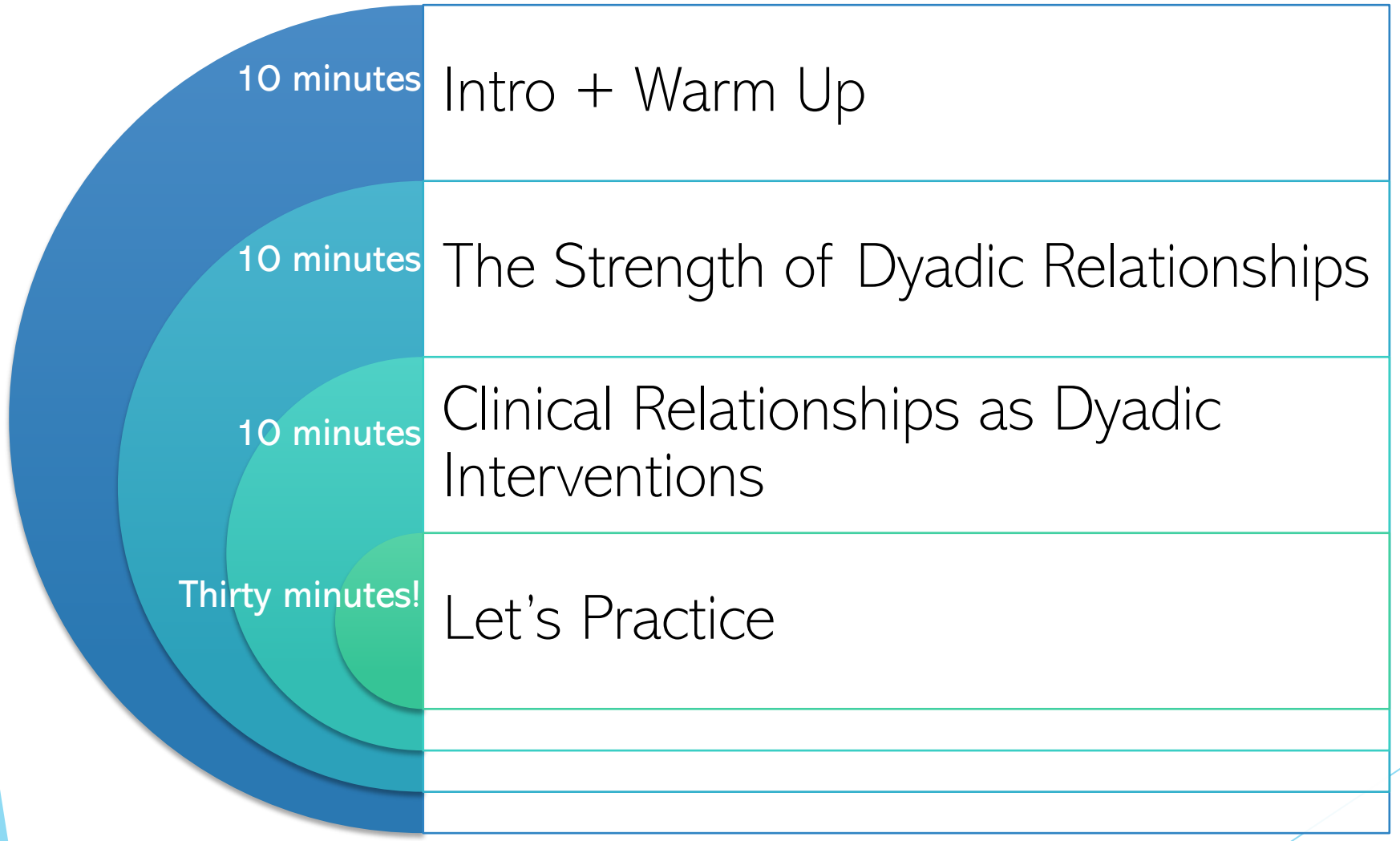
Objectives

Examine the potential for change through the caregiver child relationship

Recognize the importance of the clinical relationship as a dyadic intervention

Increase comfort with dyadic approaches that target the caregiver need as well as the child's

Our Time Together Today…



The Strength in Dyadic Relationships

Why We Target the Caregiver Child Relationship in Dyadic Care

The parent[caregiver]-child connection is the most powerful mental health intervention known to mankind

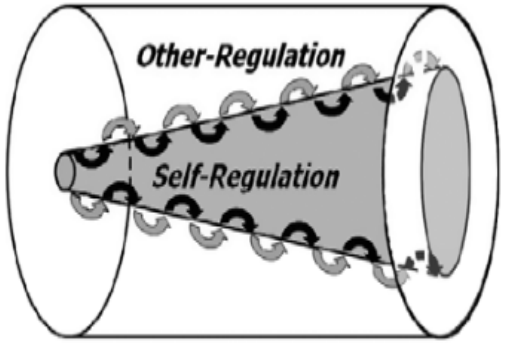
-Bessel van der Kolk

Co-regulation: Emotional Regulation in Caregiver + Child Relationships

When a caregiver can calm themself down, a child can learn to calm down

We learn how to regulate from other people helping us

When caregivers help us more early on, we help ourselves more later



CHILD DEVELOPMENT

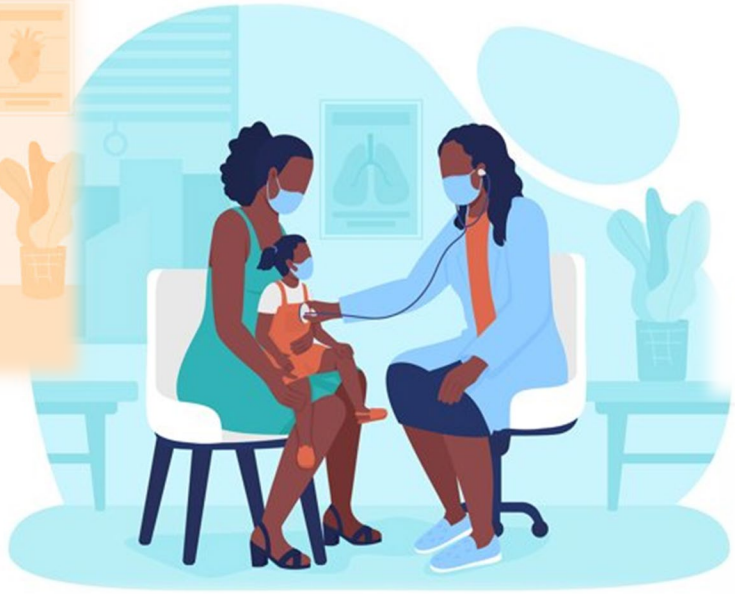
Child Development, January/February 2010, Volume 81, Number 1, Pages 6–22

A Unified Theory of Development: A Dialectic Integration of Nature and Nurture

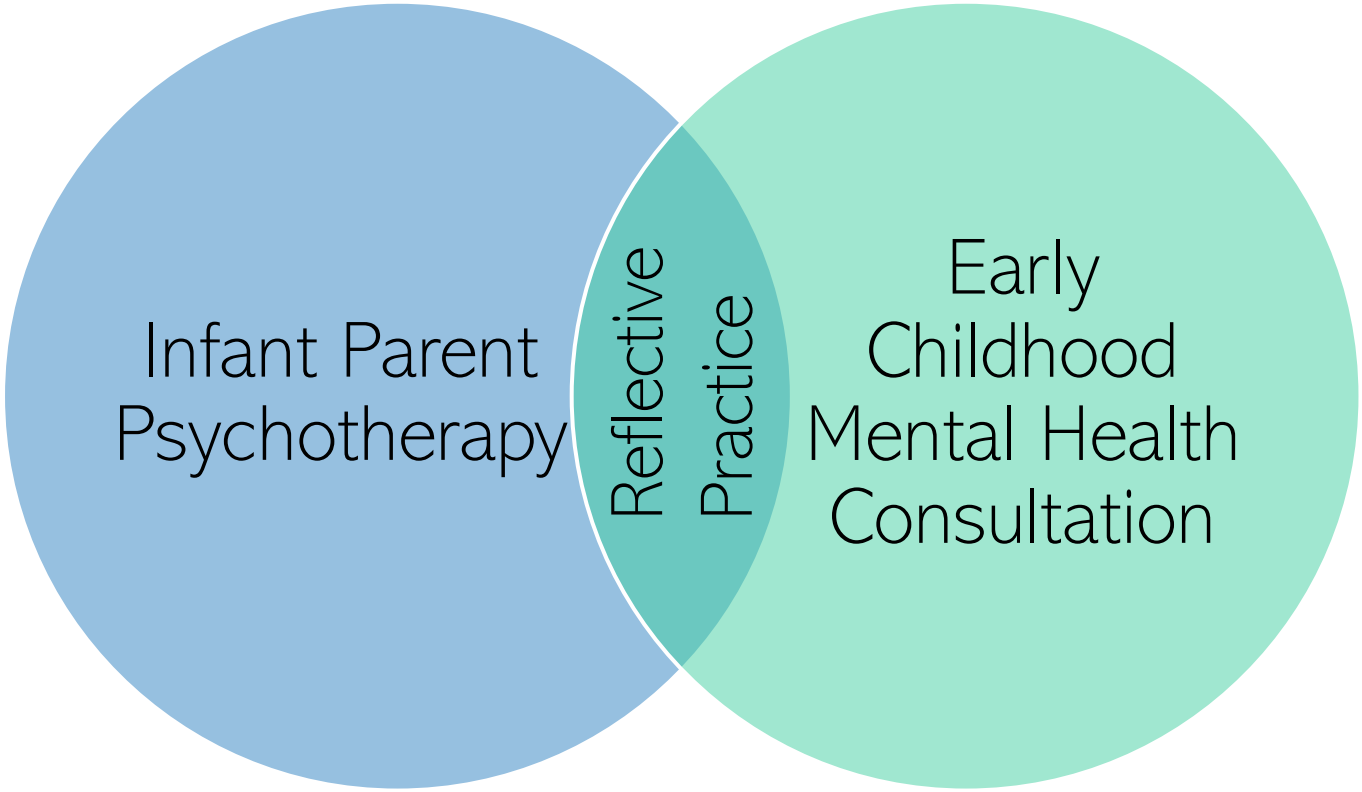
Arnold Sameroff
University of Michigan

Clinical Relationships as Dyadic Interventions

Why Our Clinical Relationship Matters So Much



Clinical Framework for Dyadic Work Targeting Caregiver/Parental Mental Health



Guiding Principles for "Being" and "Doing" with Infants, Toddlers, and Families

UCSF Infant Parent Program – Infant Parent Psychotherapy
Let's Talk Kids: "Don't Just Do Something... Stand There!" | NPR Illinois

Behavior is meaningful	Everyone wants things to be better	You are yourself and your role
Don't just do something, stand there and pay attention	Remember relationships	Do unto others and you would have others do unto others

Slide Reference: PERSPECTIVES: Reflections From the Field: Reflecting on "How You Are Is as Important as What You Do": Jeree H. Pawl's Enduring Influence in Contemporary Infant and Early Childhood Mental Health Practice | ZERO TO THREE

Early Childhood Mental Health Consultation: Attributes of a Consultant

Requires a "stance" of wonderment, curiosity, non-judgment and genuine desire to understand, connect and learn

- Cultural sensitivity
- Relationships with families
- Relationships with staff
- Knowledge of early childhood mental health best practices
- Adequate support and supervision

Slide Reference: Consultant Attributes Reading by Mary Allen & Beth Green

Reflective Practice: The Interpersonal Center of the Work That We Do (Jeree Pawl)

Trust in parents

Inclusive interaction	Mutual clarity		Maintaining an appropriate role
	Hearing and representing all voices	Hypotheses, not truth	Knowledge, beliefs, biases and meanings

“

How you are is just as important and what you do

”

Jeree Pawl

Modeling/Parallel Process

- Showing healthy communication and meaningful connection with a caregiver to support the ability to provide that for their child
- Acknowledging the stressors for the dyad and validating the challenge of managing stress
- Replicating a healthy caregiving relationship through the clinician – caregiver dyad to in turn support the caregiver – child dyad

>>>>>>>>>>>THINGS TO WATCH OUT FOR<<<<<<<<<<<

Stepping in during a visit to help the child without Caregiver consent

Jumping ahead of the rapport building to name a caregiver mental health issue and assuming they want to focus on that

Blaming the caregiver for the issue of the child

What Can I Say or Do?

"It is so wonderful to see you today. How have things been? I remember last time you were getting ready for your family's reunion…"

Acknowledging any logistical issues that come up (wait time, space, scheduling errors, etc.) and expressing appreciation for their presence

Observing interactions and responses and using that as your lead to follow/open questions and conversations

"I see _____, is that what you were talking about when you mentioned _____?"

Psychoeducation

- Sharing information about what is expected for developmental age
- Giving insight into ways to address and respond
- Normalizing behaviors and building up capacity of caregiver to "know"

What Can I Say or Do?

"When young children do not have easy ways to communicate it can be quite common to see more tantrums and moments of frustration. Sometimes it can help to name the emotion you see, call out what was happening when they got upset and then take some guesses at what they are wanting to communicate"

>>>>>>>>>>>THINGS TO WATCH OUT FOR<<<<<<<<<<<

Becoming the expert on all things about the child

Assuming a Caregiver knows all about child development and behaviors

Judging a Caregiver who is asking questions

Reflective Practice

- Holding space to understand the impact of a referral
- Noticing our own ideas, desires, and potential bias
- Exploring the role our presence plays for a family and in the clinic

>>>>>>>>>>>THINGS TO WATCH OUT FOR<<<<<<<<<<<

Making determinations on the cause of issues or necessary treatment plan without understanding the full picture or considering the Caregiver's expertise

Assuming that your service is needed or that the Caregiver is on board with addressing their own mental health

What Can I Say or Do?

"Sometimes when I meet families, I find out that they aren't sure how they would want to work with me, do you have ideas on how I might be able to support you and your child?"

"I noticed when I heard your child crying, I started to feel worried but didn't know what they needed. Would you tell me more about what it is like for you when she screams like that?

[Internal thought: Why won't she get up to check on the baby when he is crying? Doesn't she notice or care?] "What is it like for you when your child cries like that?"

Let’s Practice!

Discussing Case Examples with Collaborative Problem Solving

A 2-year-old was referred by their PCP due to a report of high concern for feeding and behavior issues as reported by Mother of child. PCP noted in discussion that child uses limited words and seems to be very cautious of the medical provider during visits. Of note, the Mother of child has been very worried and anxious with a new concern and lengthy discussion at every visit.

On our first visit, I met with both the Mother and the Father and provided space to think a little about what it means for us to work together, what is my role (limits to confidentiality and nature of dyadic work), and asked questions focused on better understanding the family. The Mother had a lot of questions for me and the Father often stepped in rewording her question or clarifying my response for her.

Through my assessment, I learned that Mother and Father are very loving toward the child and each other and have spent a great deal of time trying to find a solution because they want to be the very best for their child. As we discussed the feeding issues the Mother shared about how the child had rejected her attempts at breastfeeding from birth leaving her feeling distant from him ever since. When I asked how the PCP has supported this concern the Mother became visibly frustrated sharing how she feels unheard, she has repeatedly told her the worries they have about child's lack of eating and overall feeling something is off but the PCP always shows them the growth curve and tells them the child is fine.

The focus of my work became:

- Repair with PCP

- Psychoeducation
  - around the growth chart as a tool for reassurance
  - on the importance of making mealtimes as stress free as possible to encourage eating (counterintuitive)
  - On the impact that stress and worry can have on relationships early on

- Deeper dive into the meaning of being rejected when breastfeeding did not work

- Asking about history and how her relationship with her own mother is as well as any history of anxiety or perfectionism

- Exploration of Mother's expectations of herself as a parent and what she has found helps her (referral discussion for individual and/or dyadic therapy)

- Acknowledgement of Mother's worry about the disconnect and discuss potential programs/supports to feel she is counteracting that

Clinical Vignette – Caregiver with Depression

Tab 4

Referral Reason	3-year-old with developmental screener showing concern for communication delay
Observations	• Child seeks Caregiver often during visit for help with things by reaching, grabbing, pointing, touching. Caregiver responds with flat affect and limited engagement; they are on their phone for majority of visit • Child spends time on tablet watching educational shows during the day, is watched at home by Caregiver or Grandparent
Questions	
Perceived Concerns + Challenges	
Potential Interventions	

Clinical Vignette – Caregiver with Anxiety

Tab 4

Referral Reason	1-year-old with difficulty sleeping through the night, breastfeeding/weaning challenge
Observations	• Caregiver does not agree with any "cry it out" methods for sleep training, believes that crying will negatively impact child's overall wellness • Child is co-sleeping and breastfeeding happens when they wake in the night to stop the crying and get them back to sleep • Caregiver screener shows increase in mood swings and feeling of overwhelm • Caregiver shares they are up all night worried about child's safety co-sleeping
Questions	
Perceived Concerns + Challenges	
Potential Interventions	

Clinical Vignette – Caregiver with history of ACEs

Tab 4

Referral Reason	4-year-old with intense emotional outbursts, Caregiver wondering about Autism
Observations	• Caregiver shows video with child screaming, crying, throwing objects and hitting and shares these happen every day multiple times a day for up to an hour • Caregiver expressed fear of child and concern she might resort to physical punishment soon (which she wants to avoid passing along this generational parenting technique as they were on the receiving end) • Child is calm and open to engaging in play with you at first but once something goes wrong in the play, they get dysregulated and begin an outburst • Caregiver mentions tension with Father (recent release from jail due to IPV incident) and her own feelings of being triggered by desire to hit child
Questions	
Perceived Concerns + Challenges	
Potential Interventions	

Thank you very much for you time and presence today

If you would like to connect in the future, please do not hesitate to reach out to me at Kathryn.Hallinan@ucsf.edu

Break time!

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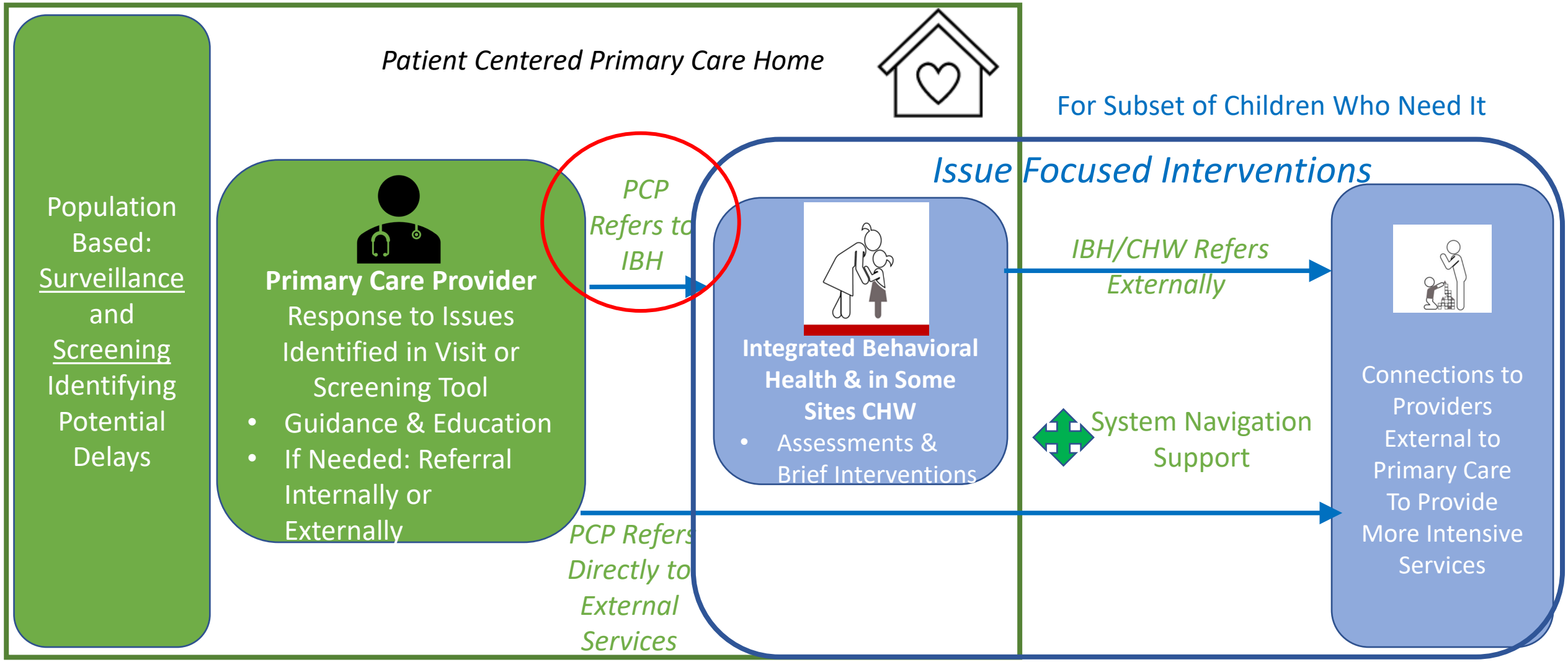
Engaging Primary Care Providers to Refer Young Children



Visual developed for **Oregon Transforming Pediatrics for Early Childhood (OR TPEC)**

Common Themes from OPIP's Work with Primary Care Practices

- **It is not: "If you build it, they will come"**
  - Many IBH who have enhanced their skills to serve birth-to-five have noted that it took work and time to ensure they received referrals for this age group
  - Presenting once about what services you provide is often not enough
  - Some primary care providers may not have awareness or previous experience with IBH serving this population
  - Some primary care providers may feel that they need to save their referrals to you for kids/adults with bigger problems

- **You can be a powerful enzyme of improvement in your practice**
  - Good quality improvement focuses on <u>systems</u> and <u>processes</u>
    - *Increase knowledge*
    - *Prioritize standardizing systems and processes*
    - *Communicate*

Engaging Your Primary Care Providers to Refer Young Children

Building awareness and knowledge

Naming the need,
Standardizing processes

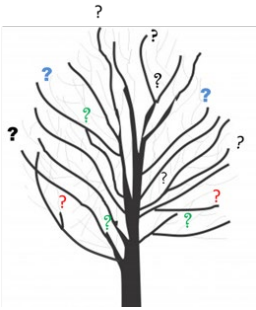
Sharing the table

Engaging Your Primary Care Providers to Refer Young Children

Building awareness and knowledge


- ❑ Share what services you are able to provide. Create "cheat sheet" of who to tap for specific needs
- ❑ Share education materials and tips for young children
- ❑ Provide talking points, parent handouts
- ❑ Consider IBH spotlights at monthly provider meetings

Naming the need, Standardizing processes

- ❑ Standardize the process: Develop decision trees to standardize follow-up and referral processes
- ❑ Create chart scrubbing process to identify potential need for support
- ❑ Share what external services are available and how IBH can support

Sharing the table


- ❑ Routine huddles
- ❑ Warm handoffs
- ❑ Communication back after referral

Examples for Engaging Your PCP to Refer

All the following materials can be found in Tab 5 of your binder 

Example for Building Awareness and Knowledge: Explain What You Do and Who To Refer To for Specific Needs

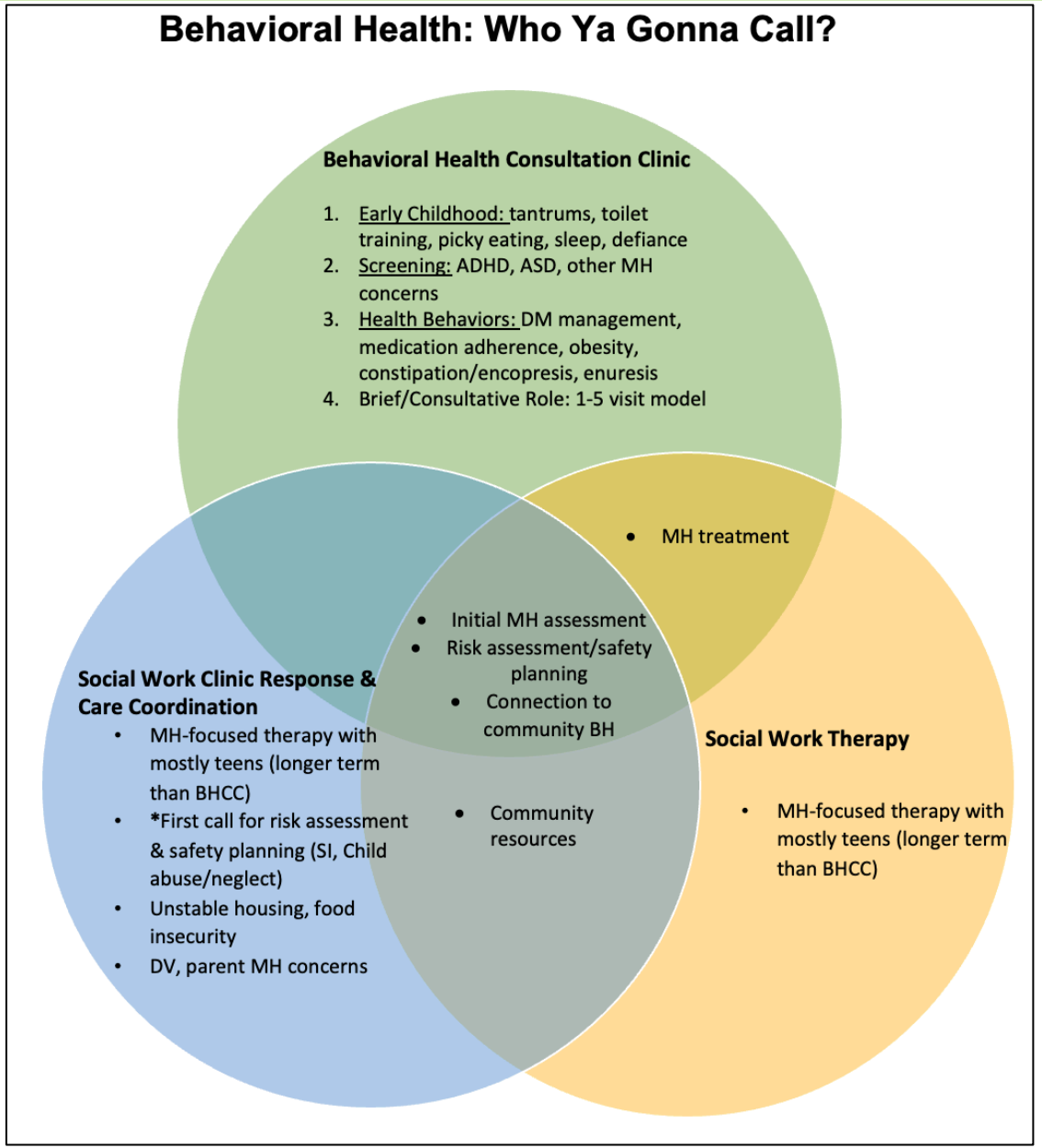
Behavioral health provider #1	Behavioral health provider #2	Behavioral health provider #3
Spanish speaking Acculturation concerns Ages 0-5 Anger Picky Eating Toileting	Post partum Above 5 years old Parents of kids below 5 yr old Grief/loss Relationships	Teens/Tweens/Young Adults Grief/loss Anxiety/Depression LGBTQ+ Eating Disorder
Referrals that wouldn't necessarily be appropriate:		
• Patients that already have a lot of systems involvement from speech, OT, developmental peds, outside counseling, etc. Providers would need to have a very specific agenda/reason for this pt to be seen by BHP. • Autism/Severe developmental delays • Psychosis (please refer out) • Patient that are already connected with an outside provider or mental health counselor • Family therapy or high conflict divorce • Recent sexual abuse or child abuse (need to be specialized treatment, please refer out) • Really intense SI or self-harm, BHP can be used as a bridge, but providers need to utilize Hawthorne or WashCo. Crisis line AND make another outside mental health referral. Please see SI flowchart. • Forest School District families with school related issues should not go to BHP #2.		
Initial appointments: • Referring a pt 13 an under, parent (not grandparent, not older sibling, etc) needs to be present at first initial appointment to discuss mandatory reporting, confidentiality, and informed consent. They don't have to stay the whole time. We need perspectives from all. • 14 + can consent for own tx, but we still need to involve parent at some point, given the option. • We need providers to reinforce this when discussing behavioral health as an option with pts.		

☑ Create "cheat sheet" of who to tap for specific needs

From the Hillsboro Pediatric Clinic Behavioral Health Referral Sheet

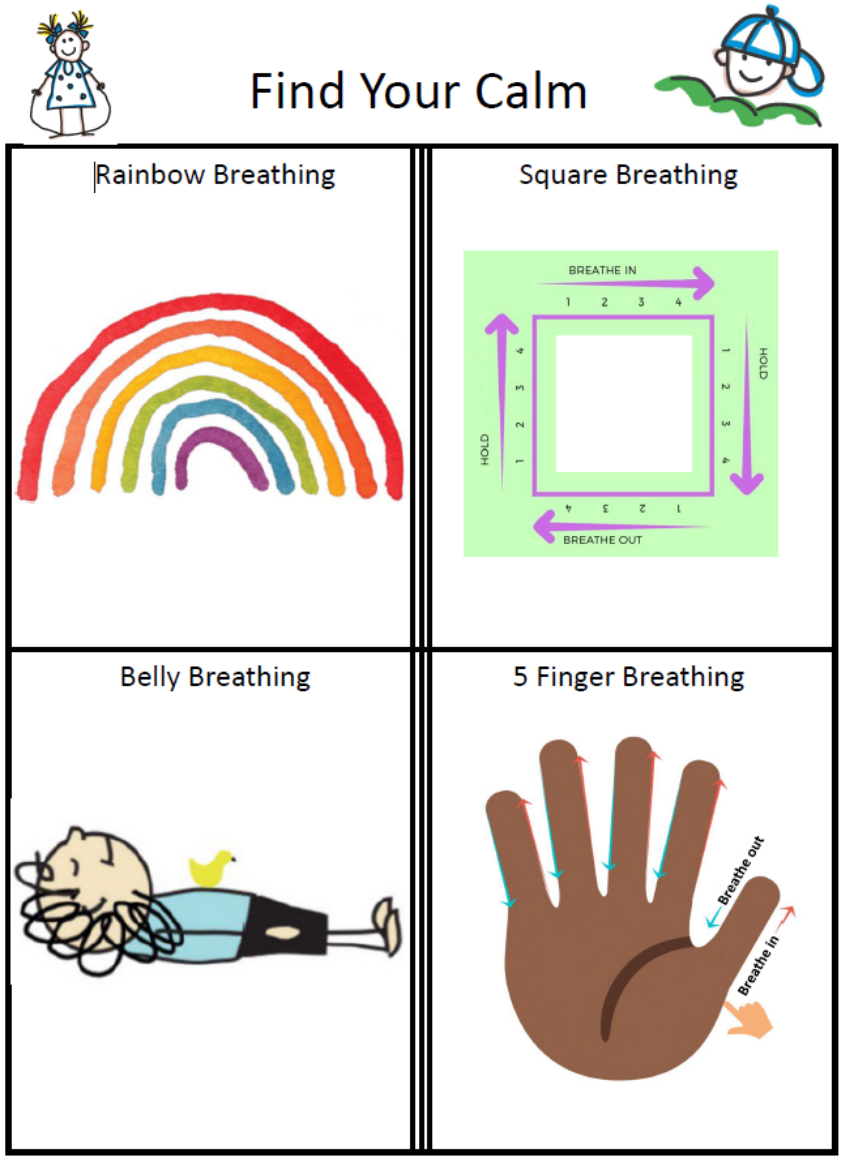
Example for Building Awareness and Knowledge: Explain What You Do and Who To Refer To for Specific Needs

☑ Create "cheat sheet" of who to tap for specific needs



OHSU Gen Peds Venn Diagram of BH Services

Example for Building Awareness and Knowledge: Education Materials that Support PCPs in Guiding Families and in Referring to You



☑ Share education materials and tips for young children

Example for Building Awareness and Knowledge: Education Materials that Support PCPs in Guiding Families and in Referring to You

DOERNBECHER CHILDREN'S Hospital OHSU

Figuring Out Frustration

Everyone gets frustrated, angry, or upset sometimes, and young children are still learning how to handle their emotions. By using some of these tips, most children will learn how to handle difficult emotions, allowing them to become more self-reliant and confident. You can watch a video on this topic clicking this link or scanning the above QR code with your mobile device.

Steps for Building Frustration Skills

- **Stay calm (at least on the outside).** It can be difficult to feel calm when your child us upset, but if you can act calmly, it helps them know things are okay and provides a positive model.
- **Be supportive and encouraging.** Say a few words that tell your child you understand their frustration. Younger children will especially need more support labelling their own emotions.
- **Have them try again.** Once your child has calmed, encourage them to approach the frustrating situation again. This helps them learn that problems are challenges to be overcome, not obstacles that need to be avoided.
- **Praise improvements and persistence.** Any time your child handles a difficult situation, tell them how well they did! Anything you like and want to see more of should get praise

Things to Avoid when Kids are Upset

- **Getting upset yourself.** It's natural to feel distressed when your child is upset, but showing how upset you are can make the situation worse.
- **Distracting from the problem.** Distraction can be a great tool *before* a child become upset if you are able to prevent it, but once they have become very upset it's better to wait until the child starts calming down naturally. This helps children learn self-soothing.
- **Asking too many questions.** When children are very upset, asking them questions feels overwhelming and can make the situation worse. Instead of asking "What's wrong?" say something like, "You're frustrated because that toy isn't working."

Created by Andrew R. Riley, PhD

DOERNBECHER CHILDREN'S Hospital OHSU

The Power of Praise

Every day kids should get messages from parents that they are good and loved. When kids get the message that they are loved and seen as good through their parents' eyes, they feel better about themselves, and it strengthens the parent child bond. To watch a video about this topic, clink this link or scanning the above QR code with your mobile device.

The more kids hear about their good behavior, the less they will want to misbehave. Plus, it feels better for parents and kids to be hearing more about good behavior. Following the tips below will help your praise be the best it can be.

Be excited and enthusiastic

- To help kids notice the praise, parents should show excitement through tone and gestures.
  - *Example:* A flat, monotone "Good job!" is very different to a kid than an excited "Way to go! You listened right away!" with a high-five.
- Giving a more noticeable response helps show to the child your praise and how much their good behavior means to you. It's important that praise for good behavior is more energetic and stimulating for kids than responses to misbehavior.

Be specific by using "Labeled Praise"

- The more specific your praise is, the easier it is for kids to know what you want to see from them, so it's good to label exactly what you like.
  - *Example:* Instead of using a general praise like, "Good job!" label specific behaviors like, "I really like how you are using a nice quiet voice like I asked you to!"

Be Immediate

- Parents should be on alert to "catch them being good" and praise appropriate behavior right away. This helps kids understand the connection between their behavior and your reaction.
- Especially for younger kids, the longer parents wait to praise, the harder it is for them to remember their good behavior and learn to do it again.

What to do if kids misbehave a lot?

- When kids are acting up often, it can be hard for parents to think about what good behaviors they want to praise. One good way to identify targets for praise it to think about the "positive opposite" of misbehavior. What would you like your child to do instead?
  - *Example:* "Bad" behavior like hitting other kids can be switched for praise when child does "good" opposite behavior like playing nicely

Example Misbehaviors	Example Positive Opposites
Being too rough or aggressive with peers	Playing nicely or gently
Running off	Walking patiently with parent
Whining or demanding	Asking nicely

Created by Andrew R. Riley, PhD

DOERNBECHER CHILDREN'S Hospital OHSU

Tips on Time-Out

Sometimes kids do things that are unsafe, harmful, or hurtful, including aggression, darting/running off, breaking things, or regularly not listening to adults. When done right, Time-Out can be a good way to help kids learn that these types of behaviors are not okay and to do them less over time. You can watch a video on this topic at this link or by scanning the above QR code with your mobile device.

The Key to Effective Time-Outs

- **Make it boring.** Time-Out is about creating a specific type of experience right after kids misbehave. It means removing anything fun or interesting right away (including attention). The point of Time-Out is to make things as *boring* as possible as *quickly* as possible.
  - Time-Out should happen away from activities and items like screens, toys, and books. It should be in a place parents can monitor but don't have to hover. For some families, entryways, hallways, dining areas, or quiet corners work well. For toddlers, on the floor turned away often works just fine.
  - Try to use a space that makes it clear where the child needs to stay. For example, use a chair or small rug on the floor.

Starting Time-Out

- **Label misbehavior.** Right after doing something dangerous or aggressive, the child should be briefly told why they are being put in Time-Out. Then, try to say nothing else and avoid arguing.
  - Example: "You hit, now you have to go to Time-Out."
  - *Note:* If a child is being sent to Time-Out for not listening, it's okay to give one warning such as, "If you don't pick up those toys like I told you, you're going to Time-Out." Wait a short time (about 10 seconds) to see if they listen. If not, a parent can say, "You didn't listen, you have to go to Time-Out."
- **Place in boring spot quickly.** Immediately and gently, take your child to Time-Out by gently taking the child to the boring spot. Once the child is in the Time-Out, quickly walk away or turn your back.
- **Ignore attempts to avoid Time-Out.** Ignore any whining, negotiating, fussing, yelling, or continued aggression from your child. They may try several ways to get a reaction from you.
  - Remember, Time-Out need to be boring to work. Your attention is very interesting to kids, so any attention at this point makes it so that Time-Out is not boring.

During Time-Out

- **Keep Time-Out boring.** Kids will try to end Time-Out by crying, screaming, pleading, threatening, cajoling, and everything else. You should ignore all of this behavior, because if parents talk to their kids during Time-Out, it's not boring enough. *Don't respond to your child in any way* until Time-Out is over.

Created by Andrew R. Riley, PhD

☑ Provide talking points, parent handouts

Example for Building Awareness and Knowledge: Education Materials that Support PCPs in Guiding Families and in Referral to You

Behavioral Health in the Hillsboro Pediatric Clinic

What is a Behavioral Health Provider?
Good health care involves paying attention not just to physical health, but also stress, relationships, emotional health, habits, and behaviors, and how those things interact with each other and medical conditions. A behavioral health provider can help you or your child get the information, skills, and emotional support needed to help your child feel better, be healthier, regain control of life, and live more fully despite stress, pain, or illness.

Who are Behavioral Health Care Providers?
Behavioral health providers at Hillsboro Pediatric Clinic are licensed professional counselors who specialize in helping people develop skills and make changes to improve their overall health and manage their health conditions. Hillsboro Pediatric Clinic has partnered with Lifeworks Northwest to make this service available to the patients at our clinic. The behavioral health provider is part of your medical team and will consult with your child's provider and the rest of the team to ensure thorough and coordinated care.

What does it mean to be referred to a Behavioral Health Provider?
A referral to the behavioral health provider means that your child's provider believes the behaviorist may be able to help your child feel better and improve their health and medical condition. All symptoms are real and will be taken seriously so that your child can get better. Behavioral health providers understand how thoughts, feelings, behaviors, habits, stress, and relationships with friends and family can affect physical and emotional well being.

How will the Behavioral Health Provider work with you?
This may be a difficult time in your family's life, or you may be having difficulty reaching your child's health related goals. The HPC behavioral health provider will typically see you for one to five brief sessions of about 20 to 30 minutes each. To begin, the behavioral health provider will want to talk to you about your child's needs, goals, and how they are functioning. We also want to look at your child's symptoms and how you are coping with them. Then together we will set a goal for your child, and decide how to reach that goal. We may recommend some things to do at home between meetings. We may discuss your child's medications and how they are working or not working for your child with your provider.

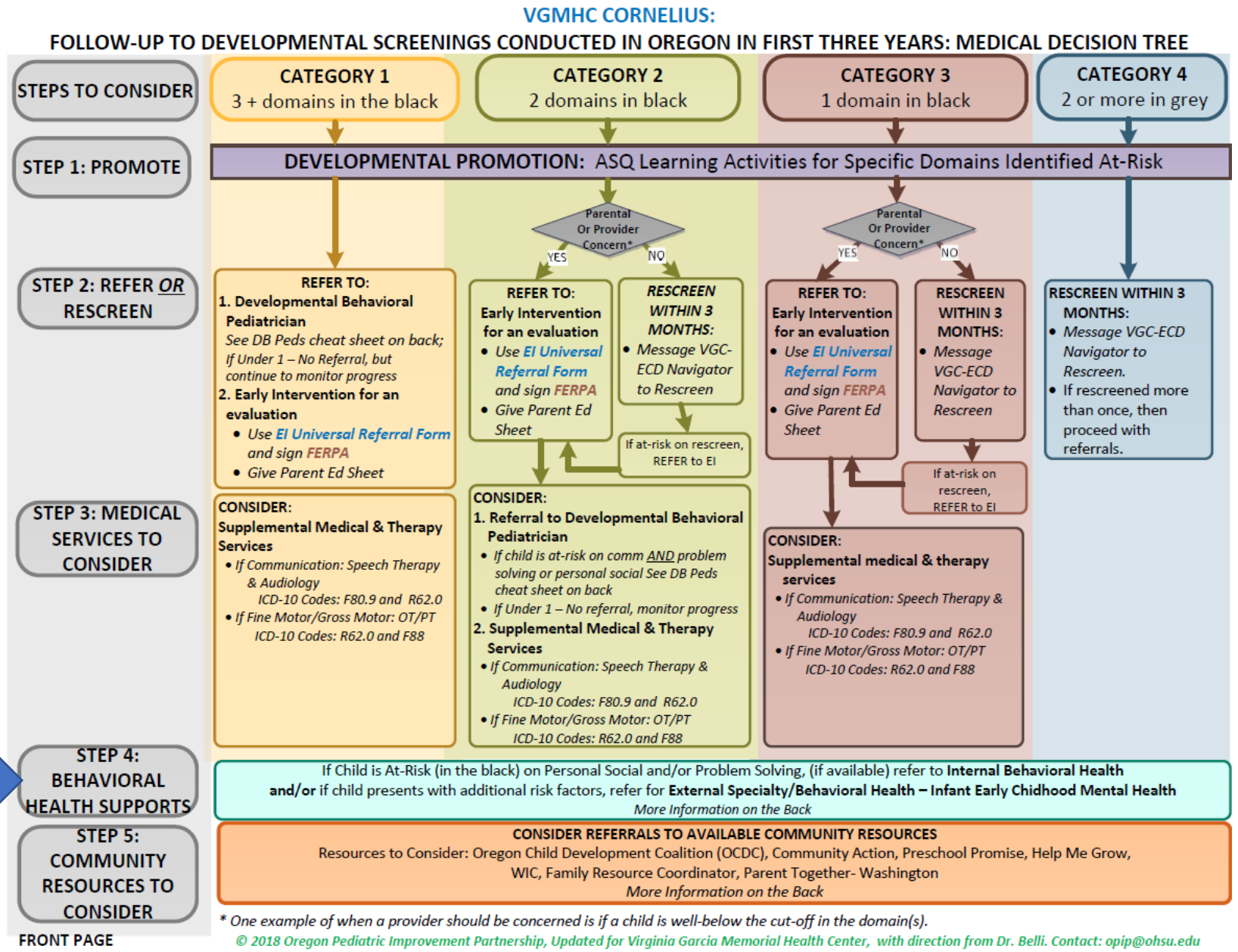
Ask your child's provider for a referral if you would like to be referred to meet with a behavioral health provider.

☑ Provide talking points, parent handouts

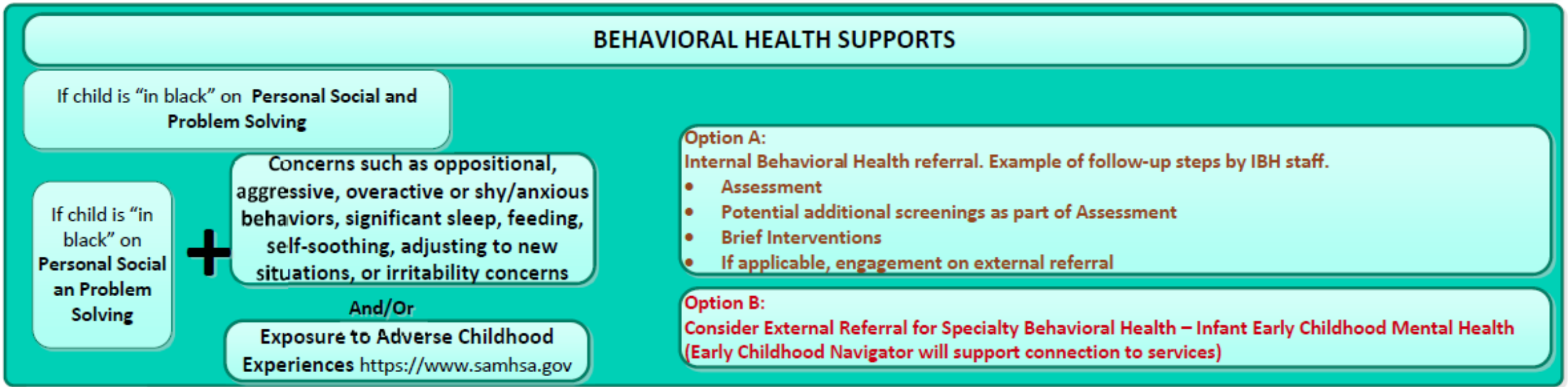
Example for Naming the Need and Standardizing Processes: Decision Tree for Referrals to IBH based on ASQ Screen

Decision Tree for PCPs to follow based on results of developmental screening with ASQ – **Step 4 specific to BH supports**

- ☑ Develop decision trees to standardize follow-up and referral processes



Back of Decision Tree: Behavioral Health Referrals



Example for Naming the Need and Standardizing Processes: Decision Tree for Referrals to IBH based on PPSC Screen

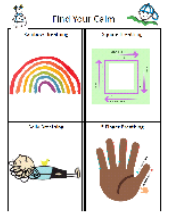
”Quick Tips” sheet for PCPs to follow when young child identified on SE screening tool (>= 9 on Preschool Pediatric Symptom Checklist)

- Referral Code to Use
- Diagnosis Code to Use

☑ Develop decision trees to standardize follow-up and referral processes

Follow-Up to the **Preschool Pediatric Symptom Checklist (PPSC): Quick Tips**

Child Identified at Risk = Score is 9 or More



Steps to Take:

1. **Provide the Find Your Calm Education Sheet**

2. **Refer to Internal Behavioral Health**
   - **9085 Internal Referral to Behavioral Health** Must select “Child/Adolescent Behavioral Health Screen” under Reason field to facilitate reporting/data pulling
   - **Diagnosis: R46.89 Behavior concern**

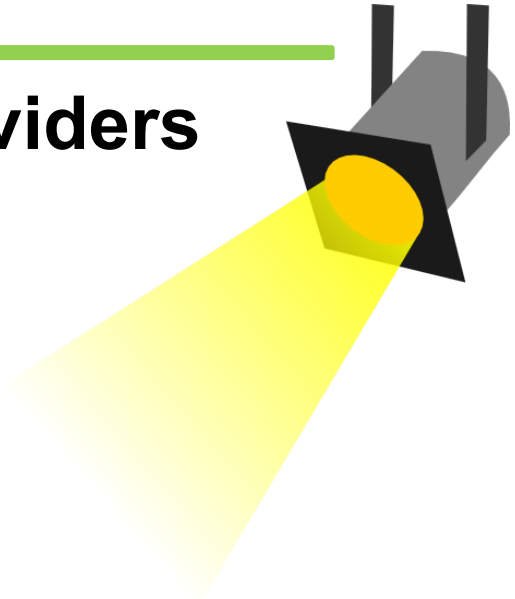
3. Check the Behavioral Health Box and Other Applicable Item in the **Shared Decision Making and Parent Education Sheet**: “Follow Up to Screening: Howe We can Support Your Child” (In English and Spanish) and provide to Parent

4. **Consider Referral to Early Childhood Navigator**
   - **9997 VGC-ECD Navigator**
   - **If refer, provide one pager on the position to the parent.**

5. **Consider other handouts provided by Dr Riley.**
   - Giving Great Instructions
   - 3 Step Prompting
   - Figuring Out Frustration
   - Paying Attention
   - Tips on Time-Out

Example of Info Sheet Serving Multiple Purposes

One Page Handout for Primary Care Clinicians/Providers



Includes:

- *Topic* (Sleep, Healthy Weight, Feeding)
- *Education*
- *Evidence-Based Screening Questions* (e.g., BEARS)
- *Why/When to get BHC*
    - You know the "what," let us help with the "how."
    - Save you time in the room
- *What BHC will do*

Request of the Week;
Robinson & Reiter, 2016

Cody Hostutler, PhD
Cody.Hostutler@NationwideChildrens.org

Increase education about BH topics

Increase productivity

Increase referrals for specific conditions

- ☑ Share what services you are able to provide
- ☑ Standardize the process for who to refer
- ☑ Warm handoffs

Warm-Handoff Spotlight: Healthy Weight!

Benefits of consulting your BHC for Healthy Weight

- You know the "**what**," let the BHC help with the "**how**"
- Saves you time having to problem-solve barriers in the room.

Weight Status Category	Percentile Range
Underweight	< 5th percentile
Healthy Weight	5th - 84th percentile
Overweight	85th - 94th percentile
Obese	95th percentile or greater

When to Get the BHC

- Low motivation for treatment
- Body image issues: negative body image, body dissatisfaction, low self-esteem
- Social-emotional consequences: poor quality of life, withdrawal
- Psychological comorbidities: depression, anxiety, behavior problems, binge eating
- School problems: bullying, academic concerns, school refusal
- Lack of progress despite motivation
- Anytime you think the patient/family would benefit!

Things Your BHC Can Do to Help

Assessment

- Comprehensive assessment to help with identifying barriers to health behavior recommendations and current impact of weight management problems on patient and family functioning

Problem-solving with family to increase adherence to PCP recommendations

Intervention

Example of Problems	Examples of Interventions
Psychological factors affecting medical condition	Assessment of psychosocial factors; Broad-band, narrow-band screening
Lack of motivation	Motivational interviewing
Low self-efficacy	Goal setting, self-monitoring, cognitive restructuring
Noncompliance with treatment recommendations	Behavior modification E.g., Premack Principle, Stimulus Control Motivational Interviewing
Behavior problems in response to recommendations	Behavior management E.g., Positive reinforcement, behavioral contracting

Goals of WHO Spotlight

Cody Hostutler, PhD
Cody.Hostutler@NationwideChildrens.org

Today's Agenda

- **Welcome:** Oregon Pediatric Improvement Partnership (OPIP) Introductions, Agenda Review
- Where are we now and why is there a need for increased provision of services, 2025 CCO Incentive Metric
- **Overview** of 2024 Webinars Key Topics and Core Concepts
- **Advanced Skills for Specific Populations**
  - Common Concerns for Children with **Autism and Other Developmental Disabilities**
    - Example Cases
  - Addressing **Parental Mental Health** in the Context of Behavioral Services for Young Children
    - Example Cases

Supporting Implementation:

- **Engaging Your Primary Care Providers** to Refer Young Children
- **Engaging Families** in External Services
  - Insights from Parent Input Sessions
  - Supporting Referrals to External Behavioral Health Services in Portland Metro & System Navigation Supports
- Supporting Meaningful Improvement Aligned with the 2025 Incentive Metric
- **Wrap Out** and Completion of Evaluation Survey, **Provision of Lunch**

Engaging Families in Services

Part 1: Engaging Families in the Referral

1. Informed by parents, key talking points
2. Parent Education Sheet on External Referrals (Tab 6)
3. Frequently Asked Questions (FAQ) Parents May Have and Answers (Tab 6)

Part 2: Knowing Where to Refer: Updated 2024 Asset Map of Services (Tab 7)

1. Overview of **Evidence-Based Specialty Behavioral Health Services** for Children Birth to Five
   - Currently only describes services that are reported to available for Health Share of Oregon-enrolled children.

2024 Updates: Summary Information about Contracted Providers within Health Share of Oregon

2. Overview Visual of **Therapeutic Modalities for Children Birth to Five** available in the Portland Metro Region, by presenting needs
3. Detailed Summary by Presenting Needs: **specific organizations** that provide that provide specific modalities**,** with information about location of services**.**
4. Detailed Summary by **Location (County):** List of Providers in these three counties: Washington, Multnomah and Clackamas (**New!! Developed based on your input!)**
5. Detailed Summary to **Support Access to Culturally and Linguistically Best Matched Services:** Organizations by provider-reported race/ethnicities; Provider reported spoken language)

Insights from Parent Input Sessions

We spoke with three parent advisors who have lived experience of accessing behavioral health services for their children.

We asked them:

1. What words and talking points were best to use with families when trying to engage them in specialty behavioral health referrals.
2. Feedback on a parent education sheet to give to parents who have received a specialty behavioral health referral. (Tab 6)
3. Feedback on a Frequently Asked Questions (FAQ) document for parents about what behavioral/social emotional health is for young kids, what accessing therapy looks like, etc. (Tab 6)

Insights from Parent Input Sessions: Talking Script

Things you can do to make the parent feel heard:

- Listen and validate the parents' concerns.
- Talk through the information sheet about the referral and/or FAQ before giving it to them.
- Acknowledge with parents that this is a daunting experience and give them a contact person to help them navigate the referral process if you are able (a patient navigator or care coordinator from your clinic).

Talking points that resonate with parents:

- Addressing challenging behaviors early can prevent larger issues down the road.
- Reassure parents that these behaviors are more common than they might realize.
- Therapists can provide valuable expertise on managing behavior challenges and equip both parents and children with effective tools to navigate them.
- It’s important for parents to remain committed and consistent in applying what they learn in therapy at home to achieve meaningful results.

Insights from Parent Input Sessions: Parent Education Sheet on Referrals

Parenting Young Children Can Be Hard, but There are Resources That Can Help!

Why Getting Supports Early is Important and What Parents Can Expect

Parenting can be challenging. Nearly one in five children face emotional, behavioral, or self-regulation issues. Fortunately, therapists and other experts in behavior can help by providing insights into these behaviors and offering evidence-based strategies. Investing time and effort now can significantly impact your child's social and emotional well-being.

Where am I getting referred? Many behavioral health services for young children are part of agencies that also cater to adolescents and adults. When scheduling an appointment, keep in mind that the organization may provide services beyond what your child needs. We're here to help you find the right organization that meets your child's specific needs.
What can I expect these services to look like? Therapy and other services for young children birth through five often looks like play time for the child. A therapist will spend time with you and your child to learn your relationship and any challenges you experience. They will help you learn strategies to strengthen the parent-child relationship, build new skills, and manage difficult behaviors. By working together, you'll gain the tools and confidence to support your child's development and apply what you've learned in you and your child's daily life.

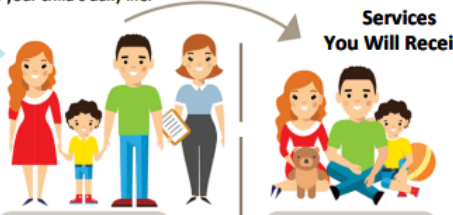
Parents/Caregiver Next steps:

You need to contact the organization you were referred to and schedule an assessment. What you can expect:

- You will be asked a few questions about your child and health care insurance.
- They may ask you to fill out a number of forms about your child's behavior. Let your primary care provider know if you need help with these forms.
- The first session is usually a 1.5-2 hour in-person assessment with you and your child.

If you run into any barriers, we are here for you! Please contact:

Services You Will Receive



The therapist meets regularly with the family to monitor progress and provide support.

Between sessions, parents practice using the skills they've learned from the therapist.

After the sessions end, families continue to experience improved behavior and reduced stress.

For more information about challenging behaviors and supports, go to:
https://www.nimh.nih.gov/health/publications/children-and-mental-health/index.shtml

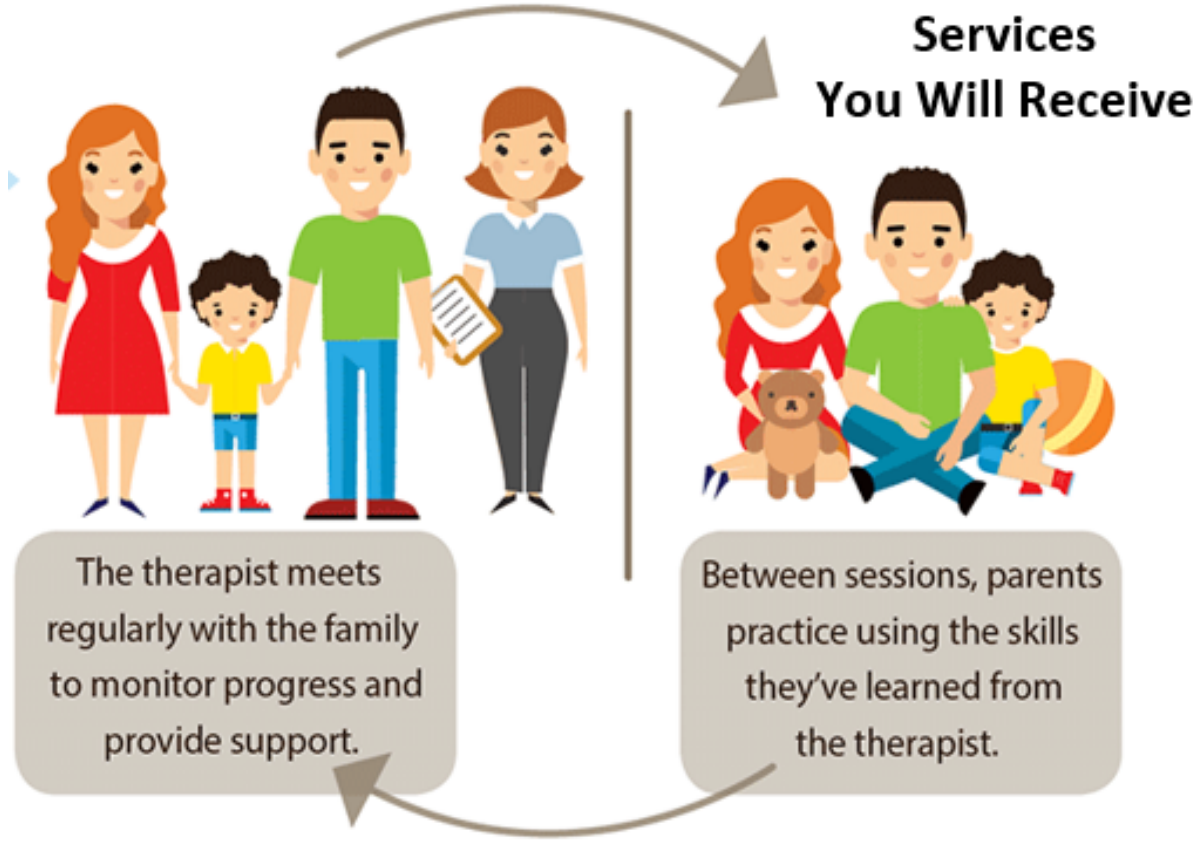
What Parents will Learn

Parents will learn and model skills to teach their children how to better manage their emotions or behaviors, leading to improved functioning at childcare/day care (and in the future school), home and in relationships. Learning and practicing these new skills requires time and effort, but it has lasting benefits for the child.

Materials and graphics adapted from CDC Vital Signs parent education sheet: https://www.cdc.gov/ncbddd/adhd/behavior-therapy.html

Updated 10/3/2024 Edited and distributed by the Oregon Pediatric Improvement Partnership

Tab 6



After the sessions end, families continue to experience improved behavior and reduced stress.

Insights from Parent Input Sessions: Frequently Asked Questions

Tab 6

What questions did we address?

1. What is “Behavioral Health” or “Social-Emotional Health” for Young Children?
2. Why would my child need additional services to address behaviors?
3. What are behaviors that these services will help address?
4. What can I expect these services to look like?
5. Is behavioral health the same as mental health? Why is my young child being referred to a mental health agency?
6. Will my child receive a diagnosis or “label”?
7. What if the providers don't understand my family's values, background, culture, or language?
8. I have had bad experiences in the past with mental or behavioral health services – can I trust it for my child?

Frequently Asked Questions: Services for Young Children to Address Challenging Behaviors & Emotions

As a parent, you want your child to grow up healthy, happy, and thriving. Some children have unique needs and behaviors that require extra attention to support their development. We believe every child should have access to the best possible care for their physical and social-emotional development. Here are some common questions that families ask about receiving behavioral health services for their young child.

Question: What is “Behavioral Health” or “Social-Emotional Health” for Young Children?

Answer: Behavioral or social-emotional health refers to a child's ability to control how they share their feelings, how they behave, and how they play and interact with others. It is a vital part of their overall health and development.

Key aspects of social-emotional health include:

- Building strong, loving relationships with family, friends, and other important people in their life
- Understanding and expressing their feelings and behaving in a healthy way
- Learning and growing in different places such as home, school, and in their community

Question: Why would my child need additional services to address behaviors?

Answer: Every child needs help managing their feelings and behaviors, but some require additional support due to unique ways of processing their emotions and surroundings. It’s common for young children to need these extra services—one in five struggles with emotional or behavioral health issues. Addressing behavioral health concerns with children when they’re young is more effective (both treatment and cost-wise) than waiting to address the issue when the child is older or when the problem becomes overwhelming. If your family faces difficult emotions and behaviors regularly, a trained therapist or expert in these behaviors can offer strategies to help support your child and teach them new skills.

Question: What behaviors will these services help address?

Answer: Here are some common behaviors that children may exhibit that providers with experience and expertise can help you address, tailored to your child’s brain and temperament:

- Temper tantrums
- Hard time calming down
- Hard time playing with other children
- Not following instructions
- Being aggressive or angry

- Hard time with new places or people
- Seeming very worried or scared
- Seeming very sad, unhappy, or upset
- Sleep problems
- Toileting issues

Question: What can I expect these services to look like?

Answer: Therapy and other services for young children birth through five often looks like play time for the child, allowing the therapist to observe their interactions with objects and people. A therapist will spend time with you and your child to learn your relationship and any challenges you experience. They will help you learn strategies to strengthen the parent-child relationship, build new skills, and manage difficult behaviors. By working together, you'll gain the tools and confidence to support your child's development and apply what you've learned in you and your child’s daily life.

Created and distributed by the Oregon Pediatric Improvement Partnership (2024)

Part 2: Materials Provided Today: Updated 2024 Summary of Services in Portland Metro Region for Children Insured through Health Share of Oregon

Five Resources Provided in Your Binder: 

1. Overview of **Evidence-Based Specialty Behavioral Health Services** for Children Birth to Five
   - Currently only describes services that are reported to be available for Health Share of Oregon-enrolled children.

Summary Information about Contracted Providers within Health Share of Oregon Network:

2. Overview Visual of **Therapeutic Modalities for Children Birth to Five** available in the Portland Metro Region, by presenting needs
3. Detailed Summary by Presenting Needs: **specific organizations** that provide specific modalities**,** with information about location of services**.**
4. Detailed Summary by **Location (County):** list of providers in Washington, Multnomah and Clackamas county (**New!! Developed based on your input!)**
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Tab 7

VERSION: SEPTEMBER 2024

Infant & Early Childhood Mental Health Services with Health Share of Oregon Contract for Publicly Insured Children Birth to Five in the Portland Metro Area: Summary Developed Based on Information Collected by Care Oregon as part of the System-Level Social Emotional Health Metric

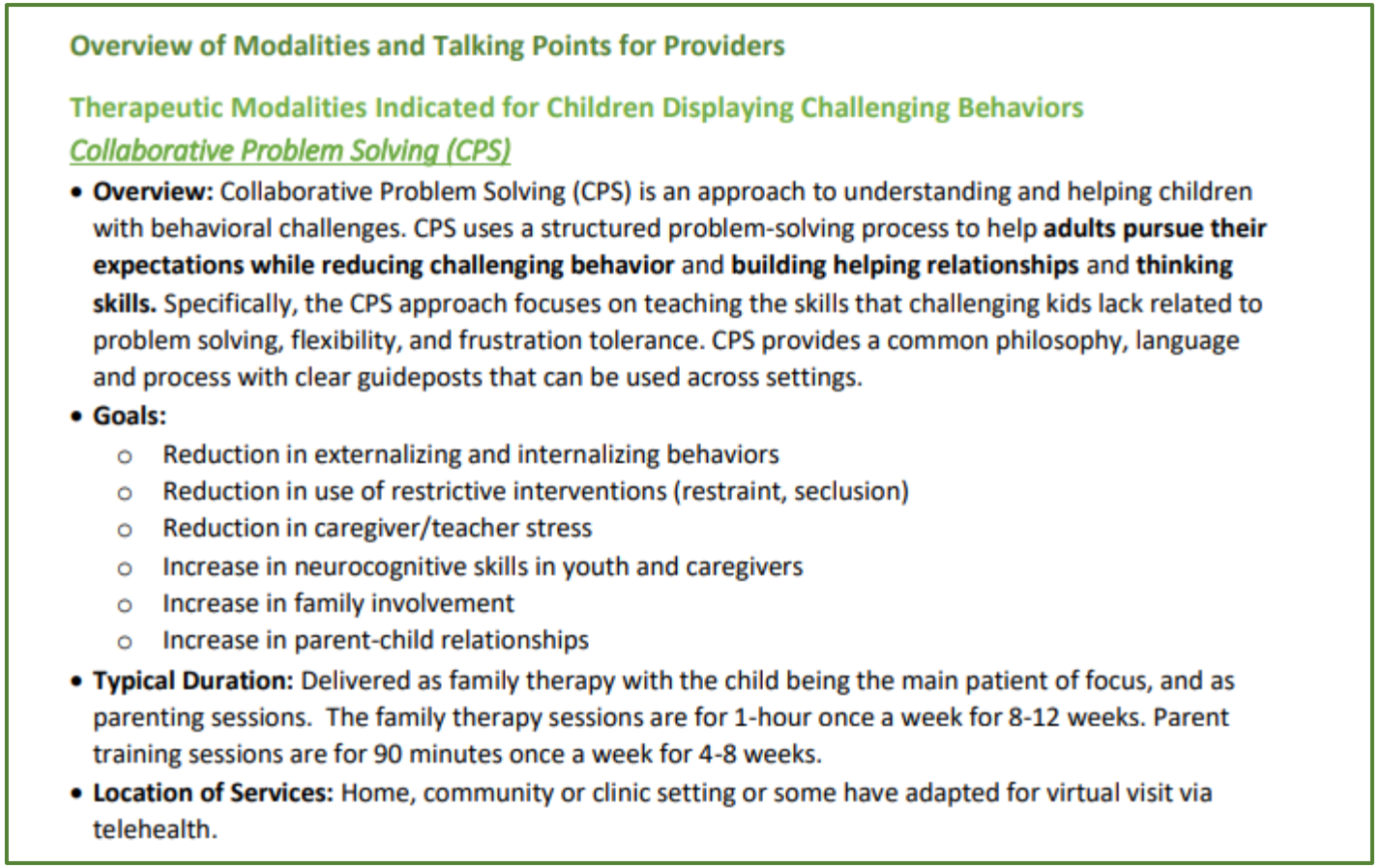
Table of Contents

1_Overview of **Evidence-Based Specialty Behavioral Health Services** for Children Birth to Five**.pdf**

Overview of Evidence-Based Behavioral Health Services (Infant & Early Childhood Mental Health) for Children Birth to Five

- Describes modalities currently available in the Portland Metro Region (i.e. does not include all evidence-based services, just those that are in the Asset Maps)
- Created to address feedback we heard that Primary Care doesn't necessarily know what the modalities are and how to describe them to families
- Updated based on 2024 Information (Some of your IBH received the 2023 Version)

1_Overview of **Evidence-Based Specialty Behavioral Health Services** for Children Birth to Five**.pdf**



Overview of Modalities and Talking Points for Providers

Therapeutic Modalities Indicated for Children Displaying Challenging Behaviors

Collaborative Problem Solving (CPS)

- **Overview:** Collaborative Problem Solving (CPS) is an approach to understanding and helping children with behavioral challenges. CPS uses a structured problem-solving process to help **adults pursue their expectations while reducing challenging behavior** and **building helping relationships** and **thinking skills.** Specifically, the CPS approach focuses on teaching the skills that challenging kids lack related to problem solving, flexibility, and frustration tolerance. CPS provides a common philosophy, language and process with clear guideposts that can be used across settings.
- **Goals:**
  - Reduction in externalizing and internalizing behaviors
  - Reduction in use of restrictive interventions (restraint, seclusion)
  - Reduction in caregiver/teacher stress
  - Increase in neurocognitive skills in youth and caregivers
  - Increase in family involvement
  - Increase in parent-child relationships
- **Typical Duration:** Delivered as family therapy with the child being the main patient of focus, and as parenting sessions. The family therapy sessions are for 1-hour once a week for 8-12 weeks. Parent training sessions are for 90 minutes once a week for 4-8 weeks.
- **Location of Services:** Home, community or clinic setting or some have adapted for virtual visit via telehealth.

Updated 2024 Asset Map of Services : Summary of Services in Portland Metro Region for Children Insured through Health Share of Oregon

Updated 2024 Asset Map of Services

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Structure of the Asset Maps: Informed by Front Line Quality Improvement Work

Identified **three elements providers** can use (gathered in your assessments and interventions) to guide you in identifying the right resources, and created summaries anchored to these factors:

1. **Presenting factors** found in screening and, if conducted, assessment and brief interventions (Color coded below)
   - Challenging Behaviors
   - Trauma Experiences
   - At-Risk for Behavior Problems
2. **Location** of the Services
3. Provider that can support **culturally and linguistically** best matched services

2. Overview Visual of **Therapeutic Modalities for Children Birth to Five** Available in the Portland Metro Region

Tab 7

2_ Overview Visual of Therapeutic Modalities for Children Birth to Five available in the Portland Metro Region.pdf

Key Structural Points:

- Color Coded by **Presenting Need** (Primary care providers and parents have told us that they consider when identifying a best match external resource)
- Columns to inform further best match services:
  - Delivery Method
  - Age of Child For Which Modality Has Been Tested
  - Evidence Rating
  - Number of Organizations
  - Number of Providers

Organizations in Health Share of Oregon Contract That Reported Providing Behavioral Health Services for Children Birth to Five

Selected Parent-Child Programs for Children Birth to Five with a Scientific Rating of 1-3

Therapy/ Program Name	Delivery Method[1]	Age of Child	Scientific Rating	Organization(s) in the Health Share of Oregon Contract	Number of Provider(s)
Some Providers trained in multiple service modalities targeting different presenting needs will be reflected more than once throughout.					
SERVICES TARGETED TO CHILDREN WITH CHALLENGING BEHAVIORS					
Parent Child Interaction Therapy (PCIT*)	Dyadic	2-7	1	14	49
PCIT is also effective program for children with known trauma history (see categories below).					
Generation-PMTO	Dyadic, Family	2-18	1	1	1
Triple P Positive Parenting Program	Level 3 - Dyadic	0-12	2	1	9
	Level 4 - Group		1		
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3					
Collaborative Problem Solving	Family	3-21	1	11	22
Play Therapy	Family, Individual	3-12	NA	19	50
Helping the Non-Compliant Child	Dyadic	3-8	3	3	5
SERVICES TARGETED TO CHILDREN WITH BEHAVIORS AS A RESULTS OF TRAUMA HISTORY					
Attachment Regulation and Competency (ARC)	Dyadic, Family, or Individual	Birth -21	NR	1	1
Child Parent Psychotherapy (CPP)	Dyadic	0-5	2	9	11
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3					
Trauma Focused Cognitive Behavior Therapy	Dyadic	3-18	1	13	64
Eye Movement Desensitization & Reprocessing (EMDR)	Individual	4-17	1**	5	7
SERVICES TARGETED TO CHILDREN WITH AT-RISK FOR BEHAVIOR PROBLEMS					
Family Check-Up	Dyadic	2-17	1	3	3
Incredible Years*	Dyadic or Group	4-8	1	4	14

Updated 2024 Asset Map of Services

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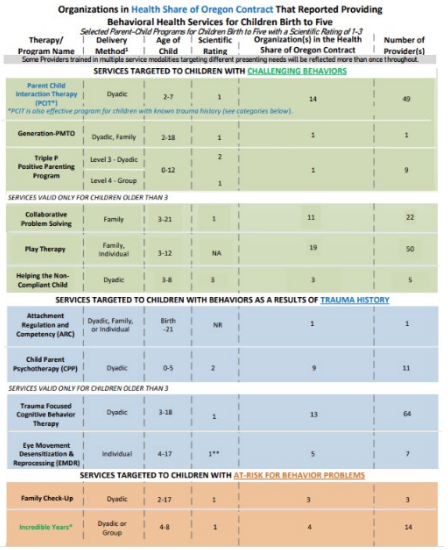
3. Specific Information on Modalities Offered by Organization and Location


Organizations in Health Share of Oregon Contract That Reported Providing Behavioral Health Services for Children Birth to Five

Selected Parent-Child Programs for Children Birth to Five with a Scientific Rating of 1-3

Therapy/ Program Name	Delivery Method[1]	Age of Child	Scientific Rating	Organization(s) in the Health Share of Oregon Contract	Number of Provider(s)
Some Providers trained in multiple service modalities targeting different presenting needs will be reflected more than once throughout.					
SERVICES TARGETED TO CHILDREN WITH CHALLENGING BEHAVIORS					
Parent Child Interaction Therapy (PCIT*)	Dyadic	2-7	1	14	49
*PCIT is also effective program for children with known trauma history (see categories below).					
Generation-PMTO	Dyadic, Family	2-18	1	1	1
Triple P Positive Parenting Program	Level 3 - Dyadic	0-12	2	1	9
	Level 4 - Group		1		
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3					
Collaborative Problem Solving	Family	3-21	1	11	22
Play Therapy	Family, Individual	3-12	NA	19	50
Helping the Non-Compliant Child	Dyadic	3-8	3	3	5
SERVICES TARGETED TO CHILDREN WITH BEHAVIORS AS A RESULTS OF TRAUMA HISTORY					
Attachment Regulation and Competency (ARC)	Dyadic, Family, or Individual	Birth -21	NR	1	1
Child Parent Psychotherapy (CPP)	Dyadic	0-5	2	9	11
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3					
Trauma Focused Cognitive Behavior Therapy	Dyadic	3-18	1	13	64
Eye Movement Desensitization & Reprocessing (EMDR)	Individual	4-17	1**	5	7
SERVICES TARGETED TO CHILDREN WITH AT-RISK FOR BEHAVIOR PROBLEMS					
Family Check-Up	Dyadic	2-17	1	3	3
Incredible Years®	Dyadic or Group	4-8	1	4	14

Pages 3-5 of third document: 3_Health Share Specialty Behavioral Health Asset Maps.pdf

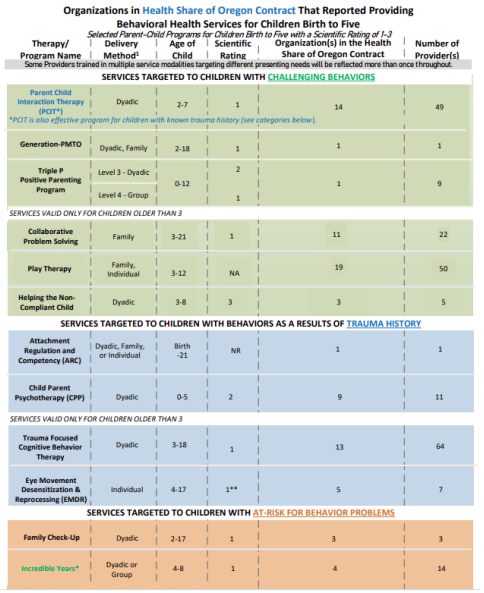
- Delivery Method Bullets
- County

Health Share of Oregon & CareOregon Behavioral Health Therapy Service Modalities for Children Birth to Five

Therapy/ Program Name	B-5 Delivery Method[1]	Age of Child	Scientific Rating	Regions Available	Organization*	Number of Providers
Some Providers trained in multiple service modalities targeting different presenting needs will be reflected more than once throughout.						
SERVICES TARGETED TO CHILDREN WITH CHALLENGING BEHAVIORS						
Parent Child Interaction Therapy (Also, for children with behaviors resulting from trauma)	Dyadic	2-7	1	W	Barcelona Counseling	2
				M	C. Love Therapeutic Care	1
				M	Cascadia Health	1
				C	Clackamas Health Centers	2
				C, M	Creative Counseling Services	1
				M	Happy Valley Counseling	1
				C, M, W	Life Stance Health	12
				C, M, W	Lifeworks NW	3
				C, M	Morrison Child and Family Service	4
				C	Neurotherapeutic Pediatric Therapies	1
				W	NW Counseling Associates	1
				C, M, W	Options Counseling and Family Service	6
				C, M, W	Pacific Psychology and Comprehensive Health	5
				C, M, W	Wolf Pack	9
Generation-PMTO	Dyadic, Family	2-18	1	C	Options Counseling and Family Service	1
Triple P Positive Parenting Program	Level 3: Dyadic Level 4: Group	0-12	2 1	C, M, W	Wolf Pack	9
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3						
Collaborative Problem Solving	Family	3-21	3	W	Barcelona Counseling	2
				M	C. Love Therapeutic Care	1
				W	Centria Healthcare	1
				C, M	Creative Counseling Services	1
				C, M, W	Life Stance Health	2
				C, M, W	Lifeworks NW	4
				C, W	Neurotherapeutic Pediatric Therapies	2
				W	NW Counseling Associates	2
				C, M, W	Options Counseling and Family Service	5
				M	Portland Mental Health and Wellness	1
				M	Willamette Health and Wellness	1
Play Therapy	Family, Individual (5 and up)	3-12	N/A	C	Alliance Counseling Center	3
				W	Barcelona Counseling	2
				M	C. Love Therapeutic Care	1
				W	Centria Healthcare	2
				C, M	Creative Counseling Services	1

Tab 7

Specific Information on Modalities Offered by Organization and Location



Organizations in Health Share of Oregon Contract That Reported Providing Behavioral Health Services for Children Birth to Five

Selected Parent–Child Programs for Children Birth to Five with a Scientific Rating of 1–3

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SERVICES TARGETED TO CHILDREN WITH CHALLENGING BEHAVIORS					
Parent Child Interaction Therapy (PCIT*)	Dyadic	2-7	1	14	49
*PCIT is also effective program for children with known trauma history (see categories below).					
Generation-PMTO	Dyadic, Family	2-18	1	1	1
Triple P Positive Parenting Program	Level 3 - Dyadic	0-12	2	1	9
	Level 4 - Group		1		
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3					
Collaborative Problem Solving	Family	3-21	1	11	22
Play Therapy	Family, Individual	3-12	NA	19	50
Helping the Non-Compliant Child	Dyadic	3-8	3	3	5
SERVICES TARGETED TO CHILDREN WITH BEHAVIORS AS A RESULTS OF TRAUMA HISTORY					
Attachment Regulation and Competency (ARC)	Dyadic, Family, or Individual	Birth -21	NR	1	1
Child Parent Psychotherapy (CPP)	Dyadic	0-5	2	9	11
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3					
Trauma Focused Cognitive Behavior Therapy	Dyadic	3-18	1	13	64
Eye Movement Desensitization & Reprocessing (EMDR)	Individual	4-17	1**	5	7
SERVICES TARGETED TO CHILDREN WITH AT-RISK FOR BEHAVIOR PROBLEMS					
Family Check-Up	Dyadic	2-17	1	3	3
Incredible Years*	Dyadic or Group	4-8	1	4	14

SERVICES TARGETED TO CHILDREN BEHAVIORS AS A RESULT OF TRAUMA HISTORY						
Attachment Regulation and Competency (ARC)	Dyadic, Family	0-21	NR	C	Clackamas Health Centers	1
Child Parent Psychotherapy	Dyadic	0-5	2	C	Alliance Counseling Center	1
				M	Cascadia Health	1
				C	Clackamas Health Centers	1
				C ,M	Creative Counseling Services	1
				W	Lifeworks NW	1
				C	Morrison Child and Family Service	1
				C, W	Neurotherapeutic Pediatric Therapies	1
				M, W	Options Counseling and Family Service	3
				C, M, W	Willamette Health and Wellness	1
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3						
Trauma Focused Cognitive Behavioral Therapy	Dyadic	3-18	1	W	Barcelona Counseling	3
				M	C. Love Therapeutic Care	1
				M	Cascadia Health	1
				C	Clackamas Health Centers	2
				C, M	Creative Counseling Services	1
				M	Happy Valley Counseling	2
				C, M	Kinship House	10
				C, M, W	Life Stance Health	27
				M, W	Lifeworks NW	2
				C, M	Morrison Child and Family Service	3
				W	NW Counseling Associates	2
				M	Willamette Health and Wellness	1
				C, M, W	Wolf Pack	9
Eye Movement Desensitization & Reprocessing	Individual	4-17	1[2]	W	Barcelona Counseling	3
				C, M	Creative Counseling Services	1
				M	Happy Valley Counseling	1
				M	Life Stance Health	1
				W	Morrison Child and Family Service	1

- Delivery Method Bullets
- Age of Child
- County ** (Remember OPIP's Disclaimer, Important to Confirm)

Specific Information on Modalities Offered by Organization and Location

Organizations in Health Share of Oregon Contract That Reported Providing Behavioral Health Services for Children Birth to Five

Selected Parent-Child Programs for Children Birth to Five with a Scientific Rating of 1-3

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Therapy/ Program Name	Delivery Method[2]	Age of Child	Scientific Rating	Organization(s) in the Health Share of Oregon Contract	Number of Provider(s)
SERVICES TARGETED TO CHILDREN WITH CHALLENGING BEHAVIORS					
Parent Child Interaction Therapy (PCIT*) *PCIT is also effective program for children with known trauma history (see categories below).	Dyadic	2-7	1	14	49
Generation-PMTO	Dyadic, Family	2-18	1	1	1
Triple P Positive Parenting Program	Level 3 - Dyadic	0-12	2	1	9
	Level 4 - Group		1		
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3					
Collaborative Problem Solving	Family	3-21	1	11	22
Play Therapy	Family, Individual	3-12	NA	19	50
Helping the Non-Compliant Child	Dyadic	3-8	3	3	5
SERVICES TARGETED TO CHILDREN WITH BEHAVIORS AS A RESULTS OF TRAUMA HISTORY					
Attachment Regulation and Competency (ARC)	Dyadic, Family, or Individual	Birth -21	NR	1	1
Child Parent Psychotherapy (CPP)	Dyadic	0-5	2	9	11
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3					
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Eye Movement Desensitization & Reprocessing (EMDR)	Individual	4-17	1**	5	7
SERVICES TARGETED TO CHILDREN WITH AT-RISK FOR BEHAVIOR PROBLEMS					
Family Check-Up	Dyadic	2-17	1	3	3
Incredible Years*	Dyadic or Group	4-8	1	4	14

SERVICES TARGETED TO CHILDREN WITH AT-RISK FOR BEHAVIOR PROBLEMS						
Family Check-Up	Dyadic	2-17	1	M	C. Love Therapeutic Care	1
				W	Centria Healthcare	1
				W	Lifeworks NW	1
Incredible Years (Also, for Children with Challenging Behaviors)	Dyadic or Group	4-8	1	C	Clackamas Health Centers	3
				C, M	Creative Counseling Services	1
				W	Options Counseling and Family Service	1
				C, M, W	Wolf Pack	9

Updated 2024 Asset Map of Services

Summary Information about Contracted Providers within Health Share of Oregon Network:

2. Overview Visual of **Therapeutic Modalities for Children Birth to Five** available in the Portland Metro Region, by presenting needs
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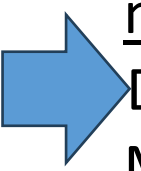

Detailed Summary by **Location (County):** List of Providers in three counties: Washington, Multnomah and Clackamas (This is new based on BHC feedback)

5. Detailed Summary to **Support Access to Culturally and Linguistically Best Matched Services:** Organizations by provider-reported race/ethnicities; Provider-reported spoken language)

4. Detailed Summary by Location (County): List of Providers in Each of These Three Counties: Washington, Multnomah and Clackamas

Pages 6-12

Thanks for your feedback!

You noted a key and primary factor for the parent/family may be geographic location and ability to get there.

- Created summaries by county and then by city.
- Data based on office location and based on the organization report to asset mapping.
- We may find services reported only at specific clinic sites, but are not able to decipher that at this time

Health Share of Oregon/CareOregon
SOCIAL EMOTIONAL HEALTH BEHAVIORAL HEALTH ASSET MAP SUMMARY by CITY
2024

CareOregon manages the behavioral health (mental health and substance use disorder) benefits on behalf of **Health Share of Oregon CCO**. Within this document, you will find a summary of contracted behavioral health providers who are able to serve children birth to five years old. It is important to note, this information was gathered as a "point in time" in June 2024 and may not reflect current or future staffing availability or access. We do hope this information is helpful in identifying behavioral health providers in our network who are trained in early childhood mental health and social emotional health care.

CareOregon Contracted Behavioral Health Providers that Serve Birth to Five in MULTNOMAH COUNTY
By Location (City) of Office Where Services are Delivered

Office Location	Organization	Number of Providers	Modality	Number of Providers by Modality
Portland	Lifeworks NW	8	Collaborative Problem Solving	2
			Parent Child Interaction Therapy	2
			Trauma Focused CBT	1
	Cascadia Health	2	Parent Child Interaction Therapy	2
			Trauma Focused CBT	1
	Climb Behavioral Solutions	4	Play Therapy	4
	C. Love Therapeutic Care LLC	1	Helping the Non-Compliant Child, Collaborative Problem Solving, Family Check-Up, Parent Child Interaction Therapy, Play Therapy, Trauma Focused CBT	
	Morrison Child and Family Services	14	Parent Child Interaction Therapy	1
	Pacific Psychology & Comprehensive Health	2	Parent Child Interaction Therapy	2
			Play Therapy	2
	Happy Valley Counseling	4	Collaborative Problem Solving	1
			Eye Movement Desensitization and Reprocessing	1
			Parent Child Interaction Therapy	1
			Trauma Focused CBT	2

1

Version Developed September 2024 with input from the Oregon Pediatric Improvement Partnership

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Pages 13 -15

- Created by CareOregon and provided at July 2024 Community Meetings
- Highlights organizations with providers who speak languages other than English, with modalities & county provided
- Highlights organizations with providers who identify as people of color, modalities & county provided

CareOregon Contracted Behavioral Health Providers that Serve Birth to Five Providing Culturally & Linguistically Best Matched Services – By Service Delivery Language Availability			
Language	Organization	County	Therapeutic Modalities Available
American Sign Language	Positive Behavior Supports	M	Applied Behavior Analysis
French	Positive Behavior Supports	M	Applied Behavior Analysis
Spanish	Barcelona Counseling	W	Helping the Noncompliant Child, PCIT, Play Therapy (3+), CPS (3+), TFCBT (3+), EMDR (4+)
	Clackamas Health Centers	C	PCIT, Play Therapy (3+), Incredible Years, ARC, TFCBT (3+)
	Creative Counseling Services	M	CPS (3+), Play Therapy (3+), PCIT, Incredible Years, CPP, EMDR (4+)
	Happy Valley Counseling	C, M	PCIT, CPS (3+), TFCBT (3+), EMDR (4+)
	Kinship House	M	Attachment & Trauma Focused Treatment
	LifeStance Health	C, W	Trauma Focused CBT (3+), Other Modalities Offered
	Mindsights	M	Other Modalities Offered
	Morrison Child and Family Services	M	TFCBT (3+), Other Modalities Offered
	Options Counseling and Family Services	W	PCIT, TFCBT (3+)
	Positive Behavior Supports	M	EMDR (4+), Applied Behavior Analysis
Tagalog	WolfPack Consulting and Therapeutic Services	W	PCIT, CPS (3+), Theraplay (3+), Triple P, TFCBT(3+), Incredible Years
Hindi	LifeStance Health	M, C	Other Modalities Offered
Russian	Lifestance Health	C, M, W	PCIT

Color Code: DISRUPTIVE BEHAVIOR PROBLEMS, TRAUMA HISTORY, AT-RISK PARENTS/ FAMILIES, ADDITIONAL SERVICES
Modality Code: PCIT: Parent Child Interaction Therapy, CPS: Collaborative Problem Solving, Triple P: Positive Parenting Program, TFCBT: Trauma Focused Cognitive Behavioral Therapy), CPP: Child Parent Psychotherapy, ARC: Attachment Regulation and Competency
Location Site: M: Multnomah, C: Clackamas, W: Washington

Tab 7

Today's Agenda

- **Welcome:** Oregon Pediatric Improvement Partnership (OPIP) Introductions, Agenda Review
- Where are we now and why is there a need for increased provision of services, 2025 CCO Incentive Metric
- **Overview** of 2024 Webinars Key Topics and Core Concepts
- **Advanced Skills for Specific Populations**
  - Common Concerns for Children with **Autism and Other Developmental Disabilities**
    - Example Cases
  - Addressing **Parental Mental Health** in the Context of Behavioral Services for Young Children
    - Example Cases

Supporting Implementation:

- **Engaging Your Primary Care Providers** to Refer Young Children
- **Engaging Families** in Internal & External Services
  - Insights from Parent Input Sessions
  - Supporting Referrals to External Behavioral Health Services in Portland Metro & System Navigation Supports
- Supporting Meaningful Improvement Aligned with the 2025 Incentive Metric
- **Wrap Out** and Completion of Evaluation Survey, **Provision of Lunch**

Looking Ahead: Going Back to Where We Started

- Beginning in 2025 Coordinated Care Organizations will be measured on & incentivized to improve the proportion of children aged 1-5 years old who receive issue focused interventions in the system of providers CCOs contract with.
- Primary care is one part of the system that plays a critical role in:
  - Identifying children with social-emotional needs and responding to parents who identify needs for supports
  - Providing **brief interventions** within **the primary care office**
  - Connecting families to external issue-focused interventions & therapies

Primary Care & Integrated Behavioral Health

Specialty Behavioral Health (Asset Mapping Years 1-3)

Other Contracted CCO Providers that May Provide a Range of Issue-Focused Interventions

Looking Ahead: Supporting Meaningful Improvement Aligned with the 2025 Incentive Metric

- You can be a powerful enzyme of improvement in your practice
  - Good quality improvement focuses on systems and processes
    - ✓ *Increase knowledge*
    - ✓ *Prioritize standardizing systems and processes*

- OPIP created a cheat sheet based on some approaches you might use as you consider how to support improvements in your practice

- Is there a Quality Improvement team in your practice now? Could this be a focus of that team?

- If not, could you form a team in your practice to talk about how to improve these systems, and include primary care providers, integrated behavioral health, care coordination team, etc?

Opportunities Supporting Meaningful Improvement Aligned with the 2025 Incentive Metric

Consider which improvement opportunities you may prioritize based on the information provided today.

Tab 8

Behavioral Health Clinicians In Your Practice: Advancing Your Skills

- ❑ Develop a training for other behavioral health clinicians on the advanced skills topics discussed today.
- ❑ Develop templates that you can use for your patients that are built off today's training and materials.

Engaging Primary Care Providers to Refer Young Children To Integrated Behavioral Health

- ❑ Develop a presentation and overview for the primary care providers about the services you can provide to children birth-to-five
- ❑ Develop an overview document of what services you provide, and in general, which young children should be referred to you or other members of your team (psychologist, social worker, traditional health worker, care coordinator etc).
- ❑ Request a standing time at provider meetings to share tips and highlight recent cases.
- ❑ Develop a script for providers to use to engage families in a referral to behavioral health.
- ❑ Work with the clinical team to develop standardized decision trees, anchored to the screenings conducted, of which children should be referred to behavioral health. Examples of screening tools to develop standardized decision trees:
  - Maternal depression screening
  - Developmental screening
  - Autism Spectrum Disorder Screening
  - Social-Emotional/Behavioral health screening
- ❑ Develop a chart scrubbing process to identify patients coming in that would likely benefit from a behavioral health consult based on screening results and other presenting factors.
- ❑ Develop a process for routine huddles about patients who may need future supports and patients who are currently getting services, sharing back on services provided.
- ❑ Your idea_____

Education Materials for Common Social-Emotional Health Issues in Young Children

- ❑ Develop a packet of parent education sheets about common social-emotional health issues. Identify priority handouts from the ones provided today.
- ❑ Train primary care providers on the education materials and how they can use them in a visit to guide families and to engage in a behavioral health referral.
- ❑ Your idea_____

To Support Connections to Specialty Behavioral Health

- ❑ Develop a parent education sheet about external behavioral health services and why they are important to consider.
- ❑ Develop a curated list from the larger Health Share of Oregon Asset Map of best match resources for your patients.
- ❑ Develop a standardized process and set of roles and responsibilities to support families accessing services.
- ❑ Develop a tracking process of families identified with a need, whether they connected to services, and summary of clinical information, including a loop back for the referring primary care provider.
- ❑ Your idea_____

- **Take five minutes to identify your priority next steps, considering these items**
- **Set an appointment for yourself in two weeks to see if you have started**

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  - Example Cases
- **Advanced Skills for Specific Populations:** Addressing **Parental Mental Health** in the Context of Behavioral Services for Young Children
  - Example Cases
- **Engaging Your Primary Care Providers** to Refer Young Children
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  - Supporting Referrals to External Behavioral Health Services in Portland Metro & System Navigation Supports
- Supporting Meaningful Improvement Aligned with the 2025 Incentive Metric
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Remaining Webinars and Case Consultation Opportunities

- Only two more webinars remain within this 2024 Learning Collaborative
- Only two more case consultation opportunities remain within this 2024 Learning Collaborative

Month	Topic-Focused Webinars & Person-Specific Registration Links (Third Tuesday of the Month)	OPTIONAL Office Hours & Zoom Links (First Tuesday of the Month)
November	**11/19/24: 12-1pm | Toilet Training and Elimination Problems| Registration Link:** https://us06web.zoom.us/meeting/register/tZEuduiqpjosGNCw1rOcTgbUvM5bm4mv7Th4	**11/5/24: 12-12:30pm | Zoom Link:** https://us06web.zoom.us/j/89365465702
December	**12/17/24: 12-1pm | Incorporating Trauma-Informed Principles into IBH with Dr. Kim Burkhart | Registration Link:** https://us06web.zoom.us/meeting/register/tZcuceGoqjwpH9Iiz8bWB91uBhtxGIIA1l0A	**12/3/24: 12-12:30pm | Zoom Link:** https://us06web.zoom.us/j/89365465702

This training is financially supported by ***Health Share of Oregon.***