2024 Health Aspects of Kindergarten Readiness Measure: System-Level Social-Emotional Health Metric

Measure Basic Information

Name and date of specifications used: The System-Level Social-Emotional measure specifications were developed by the Oregon Pediatric Improvement Partnership (OPIP) and Children's Institute (CI), with support from the Oregon Health Authority.

URL of Specifications: N/A.

Measure Type:

☐HEDIS ☐PQI ☐Survey ■ Other Specify: Attestation Survey Form Completed by CCOs

Measure Utility:

■ CCO Incentive ☐State Quality ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other

Data Sources:

Attestation Survey Form completed by Coordinated Care Organizations (CCOs), inclusive of four different components. Within Attestation Component 1 there is required review of child-level reach metric data (data provided by the Oregon Health Authority).

Measurement Period: Calendar Year (2024)

2024 Benchmark: For MY 3 (2024), CCOs are required to attest to all required items of the following four components, including submission of the following by timeline set by OHA (a) attestation survey; (b) asset maps; (c) action plan

1) Social-Emotional Health Reach Metric Data Review and Assessment
2) Asset Maps of Existing Social-Emotional Health Services and Resources
3) CCO-Led Cross-Sector Community Engagement in Which Components 1 and 2 are Shared Together, Reflections Are Gathered, and Input is Obtained to Inform the Action Plans
4) Action Plan to Improve Social-Emotional Health Service Capacity and Access

Note on telehealth: Not applicable to this Attestation Survey Form

Changes in specifications from MY2023 to MY2024:

- Updated Component 1: Social Emotional Reach Metric by adjusting foster care assessment codes, adding diagnosis codes, updates to the provider taxonomies, and removing old CPT codes no longer in use.
- Made clarifications to Component 2 Asset Mapping:
    - Behavioral Health Services (MY 1-MY3): Added "Promoting First Relationships" as a Therapy Modality;
    - Patient Centered Primary Care Integrated Behavioral Health (MY2-MY3): Capacity now anchored to a historical lookback of 2 months, Added "Parent Management and Generalized

Evidence-Informed Therapies" as a Therapy Modality (aligned with Brief Intervention approaches), Added "Promoting First Relationships as a Therapy Modality"
    - Community-Based CCO Contract Social-Emotional Services (MY3): Added clarification language related to the scope of this asset map and added a row to the asset map of "not applicable."
- Clarified the language focused on treatment services to be "issue-focused intervention/treatment services" (rather than just therapy services). This includes the breadth and depth of services that are addressing identified social-emotional issues/risks through a continuum of intervention and treatment services captured in List 3-5 of the Component 1 Social-Emotional Reach metric rate.

Measure Details

There are four components in this measure:

1) Social-Emotional Health Reach Metric Data Review and Assessment
2) Asset Maps of Existing Social-Emotional Health Services and Resources
3) CCO-Led Cross-Sector Community Engagement in Which Components 1 and 2 are Shared Together, Reflections Are Gathered, and Input is Obtained to Inform the Action Plans
4) Action Plan to Improve Social-Emotional Health Service Capacity and Access

For the self-assessment, **CCOs will answer questions based on actions that have taken place as of December 31 of the measurement year**. Data collection will occur through a survey tool that OHA will distribute to CCOs.

The following are important dates related to data collection and reporting:

- **December 29, 2023.** OHA will post the following final supporting materials on the incentive program webpage here: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx:
    - Fillable version of asset maps for use by CCOs (fillable version of Appendix C)
    - Fillable version of work plan for use by CCOs (fillable version of Appendix E)
- **January 31, 2024.** OHA will post the social-emotional health reach metric data report to each CCO's SharePoint site. CCOs will review these data and engage with partners through the remainder of the measurement year as required in components 1, 3, and 4. This report will include rates of assessments and issue-focused intervention/treatment services for the period October 1, 2022 – September 30, 2023.
- **February 28, 2025**. CCOs must submit:
    - Completed attestation survey (link will be available on the incentive program webpage here: https://www.oregon.gov/oha/hpa/analytics/pages/cco-metrics.aspx)
    - Completed Asset Maps (submit electronic copy tometrics.questions@odhsoha.oregon.gov)
    - Completed Action Plan (submit electronic copy to metrics.questions@odhsoha.oregon.gov)

CCOs must complete all of the required must-pass items for the measurement year. No partial credit will be given. The components intentionally work to build upon each other within each year and from year to year. Descriptions of the work to be accomplished in each measurement year (MY) are briefly summarized in this table, with must- pass requirements and optional activities clearly noted. **Relevant materials provided in appendices as well as complete details about each item are provided following each table.**

Component 1: Social-Emotional Health Reach Metric Data Review and Assessment

	MY 1 Requirements	MY 2 Requirements	MY 3 Requirements
1.1 The CCO has reviewed the 1) **aggregate reports** and 2) **child-level data file** provided by OHA in the Social-Emotional Health Reach Metric Data Report for children ages 1 –5 years (Appendix A).	Yes/No (Must Pass)	Yes/No (Must Pass)	Yes/No (Must Pass)
1.2 The CCO has examined the Social-Emotional Health Reach Metric **data for at least one population with historical inequitable outcomes**, using CCO data available (Examples: race, ethnicity, use of translator, geographic region).	Yes/No (Must Pass)	Yes/No (Must Pass)	Yes/No (Must Pass)
1.3 The CCO has **assessed payment policies and contracts for the claims and services** included in the Social-Emotional Health Reach Metric to ensure there is a continuum of services that address Social-Emotional health from prevention to treatment, including community options and arrangements.	Yes/No (Must Pass)	Yes/No (Must Pass)	Yes/No (Must Pass)
Optional: 1.4 The CCO has identified missing assessment or service claims and intends to submit additional data capturing children accessing services not yet reflected in the reach metric results. (Documentation for proposed enhancement of the data to be based on CCO-provided claims for OHA measure validation.)	Yes/No (Optional) If applicable, incorporate into OHA Validation Process	Yes/No (Optional) If applicable, incorporate into OHA Validation Process	Yes/No (Optional) If applicable, incorporate into OHA Validation Process

Relevant Materials:

Appendix A: Example Social-Emotional Health Reach Metric Report Based on Statewide Data (CCOs would receive reports specific to their member population)

Appendix B: Compendium of Codes included in Social-Emotional Health Reach Metric Data

Required Item Details:

1.1 Reviewed the aggregate and child-level reports provided in the Social-Emotional Health Reach Metric Report. The aggregate report provides the CCO-level findings over time and specifically by the child health complexity data for social complexity factors, a number of which are anchored to adverse childhood experiences (ACEs) correlated with social-emotional health needs and with which social-emotional health assessments are particularly recommended.

- **Answer yes** if applicable CCO staff have reviewed both the aggregate and child-level reports provided in the Social-Emotional Health Reach Metric Report. Roles within the CCO that may benefit from reviewing the data include: Population Health, Quality Staff, Quality Improvement, Data Analysts, teams focused on Child Health.
- **Otherwise, answer no.**

1.2 Examined the data for at least one population with historical inequitable outcomes, using CCO data available. Specific examples provided are anchored to stakeholder and data findings such as examining data by race, ethnicity, use of translator, geographic region.

- **Answer yes** if you have examined the data provided in the aggregate or child-level file broken down to at least one population with historical inequitable outcomes to understand the population(s)

served by your CCO.

- **Otherwise, answer no.**

1.3 Assessed payment policies and contracts for the claims and services included in the Social-Emotional Health Reach Metric to ensure there is a continuum of services.

- **Answer yes** if you have reviewed your CCO's written payment policies and contracts with entities that could provide services that support Social-Emotional health to better understand opportunities for clarification and improvement, and gaps in payment policies and contracts that could be focusedon.
- **Otherwise, answer no.**

Component 2: Asset Map of Existing Social-Emotional Health Services and Resources

	MY 1 Requirements	MY 2 Requirements	MY 3 Requirements
2.1 The CCO **has developed Asset Map(s)** to capture contracted services and resources in the CCO region that address Social-Emotional health for children birth-to-five, including key characteristics of services and providers to assess capacity and gaps.	CCO completes Asset Map form provided, summarizing the capacity and characteristics of **contracted behavioral health therapy services**. (Must Pass)	CCO updates Asset Map for contracted behavioral health services (from MY 1) and completes Asset Map form summarizing the capacity and characteristics of **social-emotional health services, specific to issue-focused Interventions/treatment services and assessments/screening provided within Patient Centered Primary Care Home integrated behavioral health (MY2).** (Must Pass)	CCO updates Asset Maps for contracted behavioral health services, integrated behavioral health in PCPCH, and **other community-based social-emotional health services that the CCO is exploring adding as a CCO-contracted provider.** (Must Pass)
Optional: 2.2 The CCO has discussed key considerations and reflection questions as part of their asset mapping process, to be shared with community partners in Component 3.	Text entry (Optional)	Text entry (Optional)	Text entry (Optional)

Relevant Materials:

Appendix C: Asset Map Form Describing Required Elements to be Provided in the Asset Map(s)

Required Item Details:

2.1 Within the measurement year, the CCO needs to develop Asset Map(s) to capture contracted services and resources in the CCO region that address social-emotional health for children birth-to-five by including, at a minimum, the components below and in the standardized form in Appendix C which are anchored to evidence-based services and with specific indicators impacting access to services.

The CCO must provide information for each component noted below to pass this required item. **Appendix C** also provides the information that must be included in the Asset Maps, and CCOs can use this form to guide collection of asset mapping information in a way that will allow the CCO to meaningfully attest to this requirement. In MY 1-3 the CCO will develop an asset map for contracted behavioral health providers, in MY 2-3 the CCO will develop an asset map for applicable Patient Centered Primary Care Home integrated behavioral health providers who serve children birth to age five, and in MY 3 the CCO will develop an asset map for other CCO-contracted community-based social-emotional health services.

- **To receive credit** the CCO will upload the developed asset maps to attest to the completion of this

task, using the standardized forms provided in Appendix C, or individualized forms that ensure all components of the standardized form in Appendix C are included. Additionally, this Appendix includes example key considerations and reflection questions that can be considered as part of the asset mapping process and that can be shared with community partners.

- **For the Contracted Behavioral Health asset map (MY1-3),** the asset map *must **include*** the following components:
    - Location of Clinic or Program Site
    - County(ies) served by Clinic or Program Site
    - Number of Providers who Currently Serve Young Children Birth to Age Five
    - Capacity for New Referrals (Clarification: New Referrals Specifically to Serve Young Children Birth to Age Five)
    - Race, Ethnicity of Provider(s)
    - Language(s) Spoken by Provider(s)
    - Service Modalities Provided (For Contracted Behavioral Health These are Therapy Treatment Services)
- **For the PCPCH Integrated Behavioral Health asset map (MY 2-3)**, the asset map ***must include*** the following components:
    - Location of Clinic or Program Site
    - County(ies) served by Clinic or Program Site
    - Number of Providers who Currently Serve Young Children Birth to Age Five
    - Average Capacity of Services for Children Birth to Age Five (Clarification: A look back at historical data to understand capacity and provision of services. See Appendix C for details.)
    - Race, Ethnicity of Provider(s)
    - Language(s) Spoken by Provider(s)
    - Service Modalities Provided (Screening & Assessments, Brief Interventions, Treatment Therapy Services)
- **For Community-Based Social Emotional Services (MY 3): If there are Contracted Community-Based Social Emotional Services or Community-Based Social Emotional Providers the CCO is Exploring to Become a CCO-Contracted Provider,** the asset map ***must include*** the components bulleted below. (**If the CCO is NOT exploring addition of these agencies as a CCO-contracted provider, then they can answer that this section is not applicable and are not required to complete this asset map).**
    - Social emotional services provided by the CCO-contracted community-based organizations or social emotional services provided that the CCO is exploring contracting for
    - Eligibility requirements for those services for publicly-insured children
    - If there is availability for more children birth-to-five to be served by the program
    - County(ies) served by Clinic or Program Site
    - If there is a focus on populations with historical, inequitable outcomes.
    - Whether this provider can perform issue-focused intervention/treatment services
    - Whether this provider can submit a claim for these services.
    - Whether the CCO provides supports or investments to the program.

Component 3: CCO-Led Cross-Sector Community Engagement

For measurement year 3: CCO must complete all the parts outlined below (3.1-3.4) within MY 3 (2024) in order to meet Component 3 requirements.	Attest to Each of the Following Requirements Aligned with the Section	
	Yes	**No**
Attestation for 3.1: The CCO engaged cross sector community partners to review and discuss: • Social-Emotional Health Reach Metric data (Component 1.1, 1.2) • Asset Maps of CCO contracted Social-Emotional Health Services and Providers (Component 2.1) • With a focus on barriers and opportunities to improve Social Emotional Health services that can inform the CCO's Action Plan to address service capacity and access.		
A. Shared 1.1 The CCO **presented the updated MY3 Social Emotional Health Reach Metric data for the aggregate population (1.1) and shared CCO reflections about the implications of the findings for the Action Plan** intended to increase access and capacity of CCO covered Social Emotional services, and this sharing included the required partners in List 1, List 2 and List 3 of partners on Page 9 of the specifications.	☐	☐
B. Shared 1.2: The CCO **presented updated MY3 Social-Emotional Reach Metric data findings for at least one population with historical inequitable outcomes** (examples: social complexity factors, race, ethnicity, or geographic region) (1.2) **and shared CCO reflections about the implications of the findings for the Action Plan** intended to increase access and capacity of CCO-covered Social-Emotional services, and this sharing included the required partners in List 1, List 2 and List 3 of partners on Page 9 of the specifications.	☐	☐
C. Shared 2.1: The CCO **presented a summary** of the information gathered **in the CCO's following Asset Maps (2.1)** (updated for this MY3-2024) and this sharing included the required partners in List 1, List 2 and List 3 of partners on Page 9 of the specifications.		
Updated Asset Map of Specialty Behavioral Health – MY 3 (2024)	☐	☐
Updated Asset Map of Integrated Behavioral Health – MY 3 (2024)	☐	☐
If Applicable: Asset Map of Community Based Providers	☐	☐
Attestation for 3.2: The CCO engaged communities experiencing historical and contemporary injustices* to review and discuss: • Social-Emotional Health Reach Metric data (Component 1.1, 1.2) • Asset Maps of CCO contracted Social-Emotional Health Services and Providers (Component 2.1) • With a focus on barriers and opportunities to improve Social Emotional Health that can inform the CCO's Action Plan to address service capacity and access.	Select All 3 (Must Pass)	
Attestation for 3.3: Select Strategies for Engagement		
Attestation for 3.4: Submit a summary of reflections from conversations with cross-sector community partners and families. Reflections may include steps the CCO took to minimize harm and specific lessons learned about engaging communities experiencing historical and contemporary injustices*	Text entry (Must Pass)	

**Communities experiencing historical and contemporary injustices include but are not limited to:*

- *Families who identify as Black, Indigenous, and people of color (BIPOC)*
- *Families experiencing social challenges including poverty, substance use disorder, mental illness, child welfare involvement, parental incarceration, parental disability, parental death, or language access barriers*
- *Other groups, depending on the community history and context (e.g., families living in a geographically isolated area of the region)*

Relevant Materials:

Appendix D: Inventory of Recent Family and Community Engagement Efforts on Social Emotional Health created by the Children's Institute.

Required Item Details:

3.1 The CCO engaged cross-sector community partners to review and discuss Component 1 (the Social-Emotional Health Reach Metric data for the aggregate population and at least one population with historical inequitable outcomes) and Component 2 (Asset Maps of Social-Emotional Health Services), shared the CCO reflections, and obtained input about **barriers and opportunities** to improve Social-Emotional Health service capacity and access to inform the Action Plan. This engagement must include the content described below, address the partners listed in Lists 1, 2 and 3 below, and include one or more group-level meeting(s) with the proposed entities collectively to ensure shared understanding and input.

During the meeting(s), the CCO must display or provide copies of the findings from **Component 1.1, Component 1.2 and Component 2.1** in order to ensure that the community engagement to inform the Action Plan is anchored to a shared understanding of: 1) The current state of child-level **CCO-covered social emotional services** that are within scope of the metric, 2) An understanding of the current network of CCO-covered service providers identified in the Asset Maps (Component 2), and 3) Descriptive characteristics about the service providers including contracted services available and factors that impact access, capacity, and service modality availability that address the needs of children in the community.

Answer yes if in the meeting(s), the CCO shared Component 1.1, 1.2, and Component 2.1 and discussed CCO reflections:

For Components 1.1 and 1.2, the CCO shared:

- The Social-Emotional Health Reach Metric data presented in the CCO aggregate report and CCO reflections about the implications of the findings for the Action Plan intended to increase access and capacity of CCO-covered Social-Emotional services (1.1).
- The Social-Emotional Reach Metric data findings for at least one population with historical inequitable outcomes (examples: social complexity factors, race, ethnicity, or geographic region) and CCO reflections about the implications of the findings for the Action Plan intended to increase access and capacity of CCO-covered Social-Emotional services (1.2).

For Component 2.1, the CCO shared:

- A summary of the information gathered in the CCO's Asset Maps. This should include the overall number of providers identified, and a summary for each of the descriptive information variables listed in the Asset Map (i.e. rows in the table). This also includes the capacity of the current providers for new referrals and the descriptive factors collected (*i.e. each row in the Asset Map about the services that impact access and availability of service modalities that meet the needs of children*). The CCO should share their reflections on the findings from the Asset Maps and implications of the findings for the Action Plan needed to increase access and capacity of CCO covered Social-Emotional services.

AND your CCO engaged the required cross-sector community partners from the following three categories:

1) **List 1: All the required cross-sector community partners included in this menu:**
   - Primary care practices/providers
   - Behavioral health programs/providers that serve children
   - Early Learning Hub(s)
   - Tribal government(s) and/or the Urban Indian Health Program - To answer 'yes' CCOs are required to reach out to tribal government(s) and/or the Urban Indian Health Program. Whether tribal government(s)/UIHP choose to participate is at their sole discretion. So long as the CCO invited tribal government(s)/UIHP to participate, the CCO may answer 'yes,' regardless of whether the tribal government(s)/UIHP chose to respond or participate.
   - Regional Education Service District(s), including the Early Intervention and Early Childhood Special Education program
   - If applicable, any other CCO serving members in the same region
2) **List 2: At least 2 partners providing services aligned with social complexity indicators, such as:**
   - Culturally-specific organizations serving children birth to age 5 and their families
   - Local department of human services programs, including offices of child welfare and self-sufficiency
   - Other behavioral health programs/providers serving children birth to age 5 and their families
   - Local criminal justice agencies
   - Other: please define
3) **List 3: At least 2 additional partners, such as:**
   - Early care and education programs, including preschool and child care programs
   - Local public health programs serving children birth to age 5 and their families (e.g., WIC, home visiting)
   - Regional health equity coalitions
   - Faith-based organizations
   - Other community-based organizations serving families with young children (e.g., Family Relief Nursery): please define

- **Otherwise, answer no**.

3.2 The CCO engaged communities experiencing historical and contemporary injustices to review and discuss Component 1 (the Social-Emotional Health Reach Metric data for the aggregate population and at least one population with historical inequitable outcomes) and Component 2 (Asset Maps of Social-Emotional Health Services), shared the CCO reflections, and obtained input about **barriers and opportunities** to improve Social- Emotional Health service capacity and access to inform the Action Plan. This engagement must address the partners in Lists 1, 2, and 3 above, include the content described below, and include one or more group-level meeting(s) with the proposed entities collectively to ensure shared understanding and input.

During the meeting(s), the CCO must display or provide copies of the findings from **Component 1.1, Component 1.2 and Component 2.1** in order to ensure that the community engagement to inform the Action Plan is anchored to a shared understanding of: 1) The current state of child-level **CCO-covered social emotional services** that are within scope of the metric, 2) An understanding of the current network of CCO-covered service providers identified in the Asset Maps (Component 2) and 3) Descriptive characteristics about the service providers that include the services that are available and factors that impact access, capacity, and degree to which the service modalities address the needs of children.

Answer yes if in the meeting(s), the CCO shared Component 1.1, 1.2, and Component 2.1 and discussed CCO reflections:

For Components 1.1 and 1.2, the CCO shared:

- The Social-Emotional Health Reach Metric data presented in the CCO aggregate report and CCO reflections about the implications of the findings for the Action Plan intended to increase access and capacity of CCO-covered Social-Emotional services (1.1).

- The Social-Emotional Reach Metric data findings for at least one population with historical inequitable outcomes (examples: social complexity factors, race, ethnicity, or geographic region) and CCO reflections about the implications of the findings for the Action Plan intended to increase access and capacity of CCO-covered Social-Emotional services (1.2).

For Component 2.1, the CCO shared:

- A summary of the information gathered in the CCO's Asset Maps, CCO reflections to Asset Maps and implications for the Action Plan as described in 3.1 (Page 7), with specific emphasis on the Asset Map findings specific to the population and the population needs.

Otherwise, answer no.

Note: When engaging with communities experiencing historical and contemporary injustices, CCOs and their partners must take steps to ensure that communities are not being engaged in a way that tokenizes their identities or perpetuates harm. Best practice principles[1] that CCOs should use for engaging communities include:

- *Seeking awareness of individual and systemic biases and building capacity for meaningful community engagement.*
- *Acknowledging historical traumas and inequities openly.*
- *Fostering a safe and engaging process that meets all access needs (e.g., interpretation, child care, transportation).*
- *Centering communities' expertise, resilience, and ownership of their stories and community solutions.*
- *Providing reciprocity and compensation (e.g., stipends, resources, information, etc.)*

3.3 Select the strategies the CCO implemented to obtain meaningful input from the communities experiencing historical and contemporary injustices engaged in 3.2.

- **Answer yes**, if you utilized one or more of the strategies below to obtain meaningful input from the communities experiencing historical and contemporary injustices engaged in 3.2.
- **Otherwise, answer no**

Strategies the CCO can use to obtain meaningful input from communities experiencing historical and contemporary injustices include:

- The CCO reviewed qualitative data from their region about families' experience accessing Social-Emotional health services to help contextualize and inform Component 1 and Component 2. (See **Appendix D** as a starting place.)
- The CCO partnered with and paid parent/family representatives from communities experiencing historical and contemporary injustices to engage on advisory councils or in meetings.
- The CCO included providers and/or advocacy groups that represent communities experiencing historical and contemporary injustices on advisory councils or in partner meetings.
- The CCO attended meetings hosted by families, providers, and/or advocacy groups that represent communities experiencing historical and contemporary injustices (e.g., Early Learning Hub Parent Advisory Council meetings) to hear family perspectives.
- The CCO partnered with families, providers, and/or advocacy groups that represent communities experiencing historical and contemporary injustices to collect new family data (e.g., via focus groups or listening sessions).
- Other: please define

3.4 Attach a written summary from conversations with cross-sector community partners and families.

[1] Best practice principles are adapted from Brink Communications community listening principles, Chicago Beyond's Why Am I Always Being Researched?, and Family Voices' Family Engagement in SystemsToolkit.

Component 4: Action Plan to Improve Social-Emotional Health Service Capacity and Access

	MY 1 Requirements	MY 2 Requirements	MY 3 Requirements
4.1 The CCO has identified at least two target areas for improvement to be included in their Action Plan, informed by data review, asset mapping, and community conversations in Components 1-3.	Select at least 2 (Must Pass)		
4.2 The CCO has included input from communities experiencing historical and contemporary injustices in the development of the Action Plan.	Yes/No (Must Pass)		
4.3 The CCO has attached/uploaded their Action Plan, including: 1) Target areas selected 2) Improvement strategies and progress milestones for each target area	Yes/No (Must Pass)		
4.4 The CCO has assessed progress on their Action Plan.		Yes/No (Must Pass)	Yes/No (Must Pass)
4.5 The CCO has attached/uploaded a revised Action Plan, including: 1) At least 2 target areas of improvement informed by data review, asset mapping, and community conversations in Components 1-3 2) At least 1 target area focused on increasing issue-focused interventions/treatment services 3) Improvement strategies and progress milestones for each target area		Yes/No (Must Pass) Yes/No Yes/No (Must Pass)	Yes/No (Must Pass) Yes/No (Must Pass) Yes/No (Must Pass)

Relevant Materials:

Appendix E: Action Plan Template (all components in template are required for submission whether CCO submits the provided Action Plan Template or their own Action Plan document).

Required Item Details:

4.1 The CCO has identified at least two target areas to be included in their Action Plan, informed by data review, asset mapping, and community conversations in Components 1-3.

- **Answer yes** if your CCO has identified at least two target areas from the options below for improvement, informed by Components 1-3 of this measure.
- **Otherwise, answer no.**

Target areas for improving provision of Social-Emotional health services, informed by family input, improvement pilots, and stakeholder survey findings, include:

Issue-Focused Intervention/Treatment Services by CCO Contracted Providers

(At least 1 target area from this category is a Must Pass Requirement in 2024).

- Increase range of Social-Emotional health issue-focused intervention/treatment services by CCO contracted providers
- Workforce development to improve skills of available providers (e.g., training, support for credentialing, tool provision, quality improvement facilitation)
- Workforce development to increase provider diversity and availability (e.g., recruitment strategies, training, support for credentialing or other educational attainment)
- Enhancement of the types of intervention and/or therapy modalities offered (e.g. group, focused on trauma, etc.)
- Enhancement to how the issue-focused intervention/treatment services are provided to address barriers to access (provision in home, community-based settings, etc.)
- Pursue new contract and payment options for community-based providers to enhance provision of Social-Emotional health services.
- Other: please define

Screening & Assessment by CCO Contracted Providers

- Increase Social-Emotional health assessments provided to children in CCO covered settings.
- Increase Social-Emotional screening of young children in CCO covered settings.
- Workforce development to improve skills of available providers (e.g., training, support for credentialing, tool provision, quality improvement facilitation)
- Workforce development to increase provider diversity and availability (e.g., recruitment strategies, training, support for credentialing or other educational attainment)
- Workforce trainings/quality improvement support on flags of social-emotional delays based on current screenings conducted that could be used to identify children needing additional assessments.
- Workforce trainings/quality improvement support to implement population-based screening of children birth to five for social-emotional delays in primary care.
- Other: please define

Supporting Access – Referral Pathways

- Address access barriers for families (e.g., improve language access supports, provide child care supports, provide transportation supports, expand hours or offer flexible scheduling)
- Improve care coordination for families, including providing support navigating Social-Emotional health services and improving referral pathways
- Support Publicly Available Information about Providers to Inform Referrals**:** Materials about behavioral health providers identified in the asset made available in easy-to-use formats, including provider capacity and descriptive characteristics that inform referrals/access
- Pilot of “warm referrals,” feedback loops.
- Address barriers to accessing services through open time slots for evaluation.
- Other: please define

Environment

- Public health messaging efforts to increase awareness of Social-Emotional health services and/or reduce stigma.
- Other: please define

4.2 The CCO has included input from communities experiencing historical and contemporary injustices in the development of the Action Plan.

- **Answer yes** if feedback and input identified from conversations and/or meetings facilitated as part of Component 3 of this metric is included in the Action Plan uploaded in Component 4.3.
- **Otherwise, answer no.**

4.3 The CCO has attached/uploaded their Action Plan, including target areas selected, what type of social-emotional health service is targeted (if applicable) and improvement strategies and progress milestones for each target area. (**Appendix E** is an Action Plan Template to consider when drafting your Action Plan in a way that will allow the CCO to meaningfully attest to this component of the work.)

- **Answer yes** if your CCO has uploaded an Action Plan that includes target areas selected and improvement strategies and progress milestones for each target area.
- **Otherwise, answer no.**

4.4 *For MY 2 and 3:* The CCO has assessed progress on their Action Plan.

- **Answer yes** if your CCO assessed your action plan in all of the following ways:
    - The CCO assessed whether they achieved progress on their Action Plan, measured by meeting progress milestones the CCO set in the Action Plan.
    - The CCO involved communities experiencing historical and contemporary injustices to evaluate the success of improvement strategies in the CCO Action Plan and offer suggestions for revising the targets and strategies in the Action Plan.
    - MY 3: The CCO assessed whether their action plan resulted in improvements in the Social-Emotional Health Reach Metric data provided by OHA and/or based on internal and more updated calculations of the Social-Emotional Reach Metric data.

- **Otherwise, answer no.**

4.5 *For MY 2 and 3:* The CCO has attached/uploaded a revised Action Plan, including target areas selected and improvement strategies and progress milestones for each target area. It is **required** that at least one target area in (MY3) 2024's Action Plan addresses expansion of issue-focused intervention/treatment, which are services that address children with indications of social-emotional delay or risk for social-emotional delay and are services captures in Lists 3-5 of the Social-Emotional Reach Metric (Component 1) . (**Appendix E** is an Action Plan Template to consider when drafting your Action Plan in a way that will allow the CCO to meaningfully attest to this component of the work.)

- **Answer yes** if your CCO has uploaded a revised Action Plan that includes:
    - At least two target areas of improvement, informed by Components 1-3 of this measure
    - In MY3, at least 1 target area on issue-focused intervention/treatment services
    - Improvement strategies and progress milestones for each target area
- **Otherwise, answer no.**

Measure Scoring

Summary of System-Level Social-Emotional Health Metric Scoring

Component within CCO Attestation Tool	MY 1	MY 2-3
Component 1: CCO reviews and interprets the provided Social-Emotional Health Reach Metric data Required Items: 1.1-1.3 Optional Items: 1.4	**1.1** 1 point **1.2** 1 point **1.3** 1 point	**1.1** 1 point **1.2** 1 point **1.3** 1 point
Component 2: CCO develops Asset Map(s) of existing Social- Emotional Health Services and Providers Required Items: 2.1 Optional Items: 2.2	**2.1** 1 point	**2.1** 1 point
Component 3: CCO leads Cross-Sector Community Engagement Required Items 3.1-3.4 3.4 Reflection: No Points Assigned	**3.1** 1 point **3.2** 1 point **3.3** 1 point **3.4** 0 point	**3.1** 1 point **3.2** 1 point **3.3** 1 point **3.4** 0 point
Component 4: CCO develops Action Plan to improve provision of Social-Emotional Health Services MY 1 Required Items: 4.1-4.3 MY 2-3 Required Items: 4.4-4.5	**4.1** 1 point **4.2** 1 point **4.3** 1 point	**4.4** 1 point **4.5** 1 point* * In MY 3, Action Plan must include at least one target area focused on increasing access to and capacity of issue-focused intervention/treatment services
Total Count of Required Attestation Items	**10 points**	**9 points**
Proposed Scoring Threshold for CCO Meeting the Metric	**10/10 Required Items Completed**	**9/9 Required Items Completed**

Measure Reference Materials

This section includes information compiled by the Oregon Pediatric Improvement Partnership and Children's Institute to meaningfully complete and attest to measure requirements.

While CCOs do not have to use the example asset map or action plan templates in these specifications or the fillable versions provided by OHA, CCO submissions must, at a miniumum, include the elements of each component noted in the Appendices below and provided on pages 5-6 and pages 11-13 of these specifications.

Appendix A: Example Social-Emotional Health Reach Metric Report Based on Statewide Data (CCOs will receive reports specific to their member population)
Appendix B: Compendium of Codes for the Child-Level Social-Emotional Health Reach Metric Data
Appendix C: Asset Map Form Describing Required Elements to be Provided in the Asset Map(s)
Appendix D: Inventory of Recent Family and Community Engagement Efforts on Social-Emotional Health Developed by the Children's Institute
Appendix E: Action Plan Template
Appendix F: Summary of Four Components of System-Level Social-Emotional Health Metric

Appendix A: Example Social-Emotional Health Reach Metric Report Based on Statewide Data (CCOs will receive reports specific to their member population)

Title: CCO Child-Level Reach Metric of Social Emotional Health (Assessments & Services)
Date: 2/22/2021
Summary: As part of the piloting activities for the child-level social emotional health reach metric, the Oregon Health Authority (OHA) is providing data to each CCO to guide and inform efforts and to assess the sensitivity and specificity of the metric.

OHA will provide two data findings:

1) **A child-level data file,** and an
2) **Aggregate report** of the most recent metric findings to each CCO. As part of this report, and to provide information that could guide community level engagement, OHA matched the social emotional health services reach child-level data to the Child Health Complexity data and prepared results of the reach metric by the social complexity indicators.

It is important to note that the **reference periods for the data vary**, thus the reach metric findings in the report may not be consistent. Please see the table below:

Output	Data Reference Period	Notes
Child-Level Data File Child-level data file of reach metric findings – latest rolling period.	**Claims Data** October 2019 – September 2020 **Enrollment Data** Members attributed to CCOs based on 12/31/2020 enrollment snapshot.	• File includes the most recent rolling period of claims for the metric. • Findingsincludecontinuousenrollment criterion. • Findings are not available for all CCOs participating in pilot.
Aggregate Report: Social Emotional Health Reach Metric Findings over Four Year Span 2016-2019 reach metric findings	**Claims Data** January – December 2016 January – December 2017 January – December 2018 January – December 2019 **Enrollment Data** Members attributed to CCOs based on continuous enrollment and enrollment in CCO as of last day of year.	• Findingsincludecontinuousenrollment criterion (no more than one gap in enrollment of less than 45 days). • Findings are not available for all CCOs participating in pilot given some CCOs were not operating in the regions at the time.
Aggregate Report: Social Emotional Health Reach Metric Findings by Child Health Complexity Data Reach metric findings matched to child health complexity file.	**Social Emotional Health Reach Metric** • **Claims Data:** January 2019 – December 2019 **Child Health Complexity** • **Claims Data:** Medical Complexity determined using All Payer All Claims (APAC) data from January 2017 through December 2019 • **Enrollment Data:** Cohort includes all children enrolled in Medicaid/CHIP as of 5/31/2020. CCO member attribution is based on a 5/31/2020 enrollment snapshot.	• CY2019 reach metric findings were used to be more closely aligned with the child health complexity reference period. • Findings do not include continuous enrollment criterion.

Contact: Please email metrics.questions@dhsoha.state.or.us with questions about this metric.

Appendix B: Compendium of Codes for the Child-Level Social- Emotional Health Reach Metric Data

The reach measure numerator logic is below (SEM=social-emotional health measure):

1. Any proc code in SEM1_PROC, or
2. Any proc code in SEM2_PROC + Any diagnosis in SEM245_DIAG + Any provider taxonomy in SEM25_TAX, or
3. Any proc code in SEM3_PROC, or
4. Any proc code in SEM4_PROC + Any diagnosis in SEM245_DIAG, or
5. Any proc code in SEM5_PROC + Any diagnosis in SEM245_DIAG + Any provider taxonomy in SEM25_TAX

The full code set is available here: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/SEM-VSD-MY2023-CCO-use_20230912_20231228.xlsx

A more descriptive version of the code lists that may be helpful to providers is available here: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Social-Emotional-Health-Reach-Metric-Descriptive-Code-Lists_2024%2012.7.24_final.xlsx

Appendix C: Asset Map Forms Describing Required Elements to be Provided in the Asset Map(s)

THESE FORMS WILL SUPPORT CCOs IN COMPLETING AND ATTESTING TO THIS COMPONENT OF THE WORK

While CCOs do not have to use these asset map forms or the fillable versions provided by OHA, CCO submissions must, at a miniumum, include the elements of each component (i.e. each row) noted in the Asset Map Forms below and provided on pages 5 and 6 of these specifications.

Year 1-3: Required to complete table for all **behavioral health providers contracted** with CCO.

- Focused on assets and services specific to children birth to age five who the CCO contracts with to provide mental and behavioral health services. These are providers that specifically serve publicly insured (Medicaid/CHIP) children birth-to-five in need of mental and behavioral health services.
- This should include contracted providers that PCPCH clinics note being "co-located" within PCPCH 3.C.1.
- Modalities listed in the asset map below are clinically indicated as an evidence-based treatment resource for children birth to five. Each CCO may have additional modalities provided within their network, but the asset map should not include programs not rated for young children by **https://www.cebc4cw.org**

Year 2-3: Required to complete table for contracted **Patient Centered Primary Care Homes** who have attested to PCPCH Standard 3.C.3 to indicate that they provide **integrated behavioral health services,** including population-based, same-day consultations by behavioral health providers.

- https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2020-PCPCH-TA-Guide.pdf
- To Include only **Clinicians aligned with PCPCH Standard 3.C.3 (*PsyD, PMHNP, LCSW, LPC, LMFT, Clinical trainee under the supervision of a licensed clinician*)**

Year 3: Required to complete table for **Early learning providers** and **other community-based Social-Emotional services** identified in Attestation Component 3 in Years 1 and 2 **that the CCO contracts with or is exploring a CCO contract with.**

- In years 1-2 the CCO convened Early Learning, Family Support Services, and Other Community-Based Services as part of the required Component 3 activities (Community Engagement).
- This is important because these organizations have experience with providing social-emotional services in non-health care settings (e.g. conduct screenings or provide classes in their non-health care sectors) and can provide input on priority needs young children in their care have for CCO covered social-emotional services.
- Through these discussions, CCOs may have identified opportunities to expand their network of CCO contracted providers to include these community-based providers. If so, this may be a component of their Action Plan for MY3 (Component 4)**This enhanced Asset Mapping of providers should only be completed for community-based providers that the CCO is exploring becoming part of their contracted network of providers to provide billable services that would be captured in the current reach metric and future child-level metric (Aim for this CCO Incentive metric).**
    - **If the CCO is NOT exploring addition of these agencies as a CCO Contracted provider, then they can answer that this section is not applicable and is not required to complete this asset map.**
- A template of the Year 3 community-based providers asset map is provided for example purposes and includes Social-Emotional services identified in previous quality improvement proof pilots. That said, these services will be highly individualized to each community and the community settings and to areas in which the intended community-level engagement identifies a need and opportunity to build or leverage supports and services in the community.

Behavioral Health Therapy Service Modalities for Children Birth to Five

Selected Parent-Child Programs for Children Birth to 5 (B-5) with a Scientific Rating of 1-3 Focused on (1) Positive parenting, (2) Effective limit setting and safe discipline, and (3) Child-parent relationship building

Therapy/ Program Name	B-5 Delivery Method[1]	Age of Child	Scientific Rating	Regions Available (if more than 1 county)	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			
Generation-PMTO	Dyadic, Family	2-18	1			
Triple P Positive Parenting Program	Level 3 - Dyadic	0-12	2			
	Level 4 - Group		1			
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3						
Collaborative Problem Solving	Family	3-21	3			
Play Therapy	Family, Individual (5 an up)	3-12	N/A			
SERVICES TARGETED TO CHILDREN BEHAVIORS AS A RESULT OF TRAUMA HISTORY						
Attachment Regulation and Competency (ARC)	Dyadic, Family	0-21	NR			
Child Parent Psychotherapy	Dyadic	0-5	2			
SERVICES VALID ONLY FOR CHILDREN OLDER THAN 3						
Trauma Focused Cognitive Behavioral Therapy	Dyadic	3-18	1			
Eye Movement Desensitization & Reprocessing	Individual	4-17	1[2]			
SERVICES TARGETED TO CHILDREN WITH AT-RISK FOR BEHAVIOR PROBLEMS						
Promoting First Relationships	Dyadic	0-3	3			
Family Check-Up	Dyadic	2-17	1			
Attachment and Biobehavioral Catch-Up (ABC)	Dyadic	0-2	1			
Incredible Years (Also for Children with Challenging Behaviors)	Dyadic or Group	4-8	1			

**Additional organizations who provide evidence-based services to young children may not be represented above, if couldn't be reached for asset mapping.*

1 Dyadic therapies are those done with the parent and the child together. Group therapies can be delivered caregivers without children present, or delivered to a group of families with both children and caregivers present. 2 None of the evidence used to rate EMDR was conducted on children under 4.

Version: Updated December 2023

Developed by the Oregon Pediatric Improvement Partnership (OPIP) based on information derived from https://www.cebc4cw.org.

Contracted Behavioral Health Providers – Social Emotional Services for Birth to Five: *Asset Map* *(MY 1-3)*	**Behavioral Health Organizations Contracted with CCO That Have Providers Who Serve Children Birth to Five**				
	Organization # 1	**Organization #2**	**Organization # 3**	**Organization # 4**	**Organization # 5**
Location of Clinic Sites (City)					
County(ies) Served by the Clinic Site					
Number of Providers Who Currently Serve Birth to Five and Have Applicable Skill Sets ***(Drop down that will customize form)***					
Provider's Average Capacity for New Referrals Specific to Birth to Five. Please note this will need to calculated for each provider within each organization in order to understand capacity. ***Measurement Options:*** **Numerator:** # of open (available for booking) appt slots in the next 2 months for new referrals 0-5 **Denominator:** # of total appt slots in the next 2 months					
Provider(s) Identified Race, Ethnicity ***(Drop down of REAL-D Categories)***					
Languages the Provider(s) are able to Use to Provide Services ***(Drop down of languages)***					
Therapy Modalities the Provider(s) Offer ***(Drop down of evidence-based modalities*, addition of an "other". See Previous Page for full list.)***					

Contracted Behavioral Health Providers: ***Key considerations and reflection questions for asset mapping and community engagement*** Use the Social-Emotional Reach Metric findings and data showing the findings by specific social complexity factors for children birth to five to consider how many children would potentially benefit from these services but are not getting them, compared with the number of available new referrals.

- Each "row" of the map reflects an area where there may be a gap in access and availability as compared to theneed.
    - For each characteristic (geography, provider availability for new referrals, provider race or ethnicity, languages spoken by the provider, modalities offered) consider where there are opportunities for discussion and reflection in Attestation Component #3 when engaging community-based providers.
    - Consider community-based organizations and advocacy groups that represent children and families in your community and consider community-based educational opportunities for enhanced understanding of what services do exist and how they can address the factors in the data. Engage these communities potentially impacted by gaps and consider how they can be engaged on solutions.

Social Emotional Services within Contracted Patient Centered Primary Care Homes who Attested to PCPCH Standard 3.C.3 as Having Integrated Behavioral Health (IBH): Asset Map (MY 2-3)	**Patient Centered Primary Care Homes** To Which CCO Members Birth to Five Are Attributed and Who Attested to PCPCH Standard 3.C.3 to indicate that they provide **integrated behavioral health (IBH) services**.		
	# 1	**# 2**	**# 3**
Location of Clinic Site (City)			
Number of IBH Providers Who Currently Serve Birth to Five and Have Applicable Skill Sets ***(Drop down that will customize form for individual providers*** - Include only **Clinicians aligned with PCPCH Standard 3.C.3** ***PsyD, PMHNP, LCSW, LPC, LMFT, Clinical trainee under the supervision of a licensed clinician*** **)**			
Average Capacity Serving Birth to Five. Look back on historical data to understand the capacity of services. Note: This will need to be completed for each provider in the practice to obtain a summary of capacity in the site. **Numerator:** # of open (available for booking) appt slots in the LAST 2 months that were filled by patients age birth-5 ; **Denominator:** # of total appt slots in the LAST 2 months			
Provider(s) Identified Race, Ethnicity - ***(Drop down of REAL-D Categories)***			
Languages the Provider(s) are able to Use to Provide Services ***(Drop down of languages aligned with CLAS metric)***			
Assessments (Which Can Include Screening Tools): Does this provider currently conduct applicable social emotional assessments and screenings for birth to five (*Drop down of tools in compendium*)**			
Issue Focused Brief Intervention Services Provider(s) Offer: What brief interventions addressing social-emotional health for patients birth to five does this provider offer that are, or could be, submitted through claims? (*Drop down anchored to claims and codes aligned with reach metric*			
Issue-Focused Intervention/Treatment Services and Modalities the Provider(s) Offer: What behavioral health services does this provider offer? (*Drop down anchored to specific therapy modalities listed in MY1 Template*			
Other Social Emotional Services Provided Not Captured Above: (Open Field Text)			

****Assessments and Screenings: *Drop down Options***

Examples of Additional Assessment and Screening Tools Documented to Support Other Claims (Please reference the Social-Emotional Reach Metric Specifications for an Exhaustive List):

- 96130/96131 (Psychological testing evaluation by psychologist)
- 96132 (Neuropsychological testing evaluation services by qualified healthcare professional)
- 96136/96137 (Psychological or neuropsychological testing administration and scoring by qualified professional)

***Examples of Screening and Assessment Tools that an Integrated Behavioral Health may use as part of their assessment that are allowable under code* 96127:**

- Ages and Stages Questionnaire-Social-emotional (ASQ-SE)
- Survey of Well-being of Young Children (SWYC)
- Devereux Early Childhood Assessment- (DECA)
- Pediatric Symptom of Checklist (PSC)
- Behavioral Assessment System for Children (BASC)
- Child Behavior Checklist (CBCL)
- Devereux Early Childhood Assessment for Infants (1-18 months) Record Form (DECA)
- DECA for Toddlers (18-36 months) Record Form
- Strengths and Difficulties Questionnaire (SDQ)
- Thinking Skills Inventory
- Eyberg Child Behavior Inventory (ECBI)
- McMaster Family Assessment Device
- SCAS Anxiety Scale for Preschool
- Beck's Depression Inventory
- Multidimensional Assessment of Parenting Scale (MAPS) Parenting Scale
- Other Screens (provide name)

Contracted PCPCH Sites with Integrated Behavioral Health: Key considerations and reflection questions for asset mapping and community engagement

- How many of the PCPCHs you contract with that serve children do **not** have Integrated Behavioral Health (IBH)?
    - Are there any gaps in services by region?
- How many PCPCH sites attested to PCPCH Standard 3.C.3 and have Integrated Behavioral Health staff, but those IBH providers don't serve children birth to five?
- Examine each of the rows describing the integrated behavioral health services:
    - For each characteristic (geography, provider availability for new referrals, provider race or ethnicity, languages spoken by the provider, assessments, interventions and treatment modalities offered), consider where there are opportunities for discussion and reflection in Attestation Component #3 when engaging community-based providers.
    - Consider opportunities for training and coaching of integrated behavioral health staff

Year 3: Asset Map Template of Contracted **Early learning providers** and **other community-based Social- Emotional services** identified in Attestation Component #3 in Years 1 and 2 that the CCO contracts with or is exploring a CCO contract.

- *In years 1-2 the CCO convened Early Learning, Family Support Services, and Other Community-Based Services as part of the required Component 3 activities (Community Engagement).*
- *This is important because these organizations have experience with providing social-emotional services in non-health care settings (e.g. conduct screenings or provide classes in their non-health care sectors) and can provide input on priority needs young children in their care have for CCO covered social-emotional services*
- *Through these discussions, CCOs may have identified opportunities to expand their network of*

CCO contracted providers to include these community-based providers. If so, this may be a component of their Action Plan (Component 4)

- *This enhanced Asset Mapping of providers should only be completed for community-based providers that the CCO is exploring becoming part of their contracted network of providers to provide billable services that would be captured in the current reach metric and future child-level metric (Aim for this CCO Incentive metric).*

If the CCO is NOT exploring addition of these agencies as a CCO Contracted provider, then they can identify that this section is not applicable and is not required to complete this asset map

Contracted** Early learning providers **and** other community-based Social- Emotional services **: Key considerations and reflection questions for asset mapping and community engagement

- Where applicable, what opportunities are you exploring to address policies and payment that would allow for these services to be reimbursed by the CCO given their direct alignment with needed social emotional supports? What are specifics strategies to enhance education and information about these services at a community-level?
- If applicable, is there a way to address areas where you may have identified limited capacity within these issue-focused intervention/treatment services to see more children birth to five?
- If applicable, is there a way to address areas where you may have identified limited capacity within these issue-focused intervention/treatment services to see more children birth to five?

***CCO Contracted Early Learning, Family Support Services, and Other Community-Based Services* for issue focused intervention/treatment services: Asset Map (MY 3)**	Community-Based Social Emotional Services the CCO is Exploring to Become a CCO Contracted Provider: Descriptive Information							
	What social emotional services are provided that the CCO is exploring contracting with to expand the network of CCO covered services?	**Are there eligibility requirements impacting access for publicly insured children?**	**Do they have openings for more children birth-to-five to be served by the program?**	**Counties in which these services are available ?**	**Is there a focus on populations with historical inequitable outcomes?**	**Can this provider perform Issue-focused intervention/ treatment services addressing Social-Emotional health?**	**Can this provider submit a claim for these services?**	**Does the CCO provide supports or investments to the program?**
Not Applicable: The CCO is not exploring contracts with any community-based programs to become a CCO Contracted provider for social-emotional services at this time.	☐ NA							
Example of Providers the CCO May Explore as Part of the CCO Contracted Services.								
Home visiting providers								
Early Head Start/Head Start								
Early Intervention/Early Childhood Special Education staff								
Evidence-based/ evidence informed parenting classes with a specific focus on attachment and Social- Emotional health								
Children's Relief Nurseries								
Other Services Identified								

Appendix D: Inventory of Family and Community Engagement Efforts Focused on Children's Social-Emotional Health Developed by the Children's Institute

Commitment to Centering the Voices of Families and Communities Experiencing Historical and Contemporary Injustices

Throughout work to improve capacity of and access to social-emotional health services for children ages 0-5 and their families, it is crucial to center the experience, needs, and assets of children and families experiencing historical and contemporary injustices and therefore experience the greatest health and learning disparities.

Communities experiencing historical and contemporary injustices include but are not limited to:

- Families who identify as Black, Indigenous, and people of color (BIPOC)
- Families experiencing social challenges including poverty, substance use disorder, mental illness, child welfare involvement, parental incarceration, parental disability, parental death, or language access barriers
- Other groups, depending on the community history and context (e.g., families living in a geographically isolated area of the region)

One strategy for learning about the experiences, needs, and assets of children and families is to review existing data that has been collected across Oregon about families' social-emotional health needs and health care access barriers. Using this information as a starting place ensures we are valuing the time and energy that communities have already committed to sharing their experiences and priorities and may help CCOs and their partners identify and prioritize future engagement.

Family Engagement on Social-Emotional Health and Access Needs to Date

Below are specific efforts over the last few years to engage families and communities, including those experiencing historical and contemporary injustices, on the topic of children's social-emotional health needs and health care access barriers. Links to reports are provided.

Project	Communities engaged	Research questions	Findings
CI and PSU Kindergarten Readiness Family Focus Groups (2017-2018)	- Black and Latino families - Families with limited English proficiency/DLL	- What does school readiness mean to families? - How do early learning programs support school readiness?	Social-emotional health and development is a top priority for families. Families identified several health system barriers: - Not enough time with health care providers to build trust, voice concerns - Lack of culturally and linguistically responsive services - Children are not identified and referred early enough

	- Families of children with special health care needs - Families in rural communities	- How do health care services support school readiness? - How do families want early learning programs and health services to improve?	- Lack of locally accessible services - Confusing coverage policies for specialty services - Lack of access to BH services for parents/caregivers - Lack of resources to address SDOH Summary report Summary slides
Racism in Oregon's Health Care System: Experiences of Families of Black and Latino Children and Youth with Special Health Care Needs (2020)	- Black and Latino immigrant families of children with special health care needs	- What are the experiences of racism for Black and Latino immigrant families of children with special health care needs?	Families' experiences of racism include: - Lack of cultural understanding, respect, and assumptions about Black people - Culturally insensitive and discriminatory comments that invalidate families' concerns about their child's health and create hostile environments for families - Language barriers Summary report
Oregon Early Learning Hub Family Focus Groups and Surveys for Sector Plans (2019)	- Black, Latino, Asian/Pacific Islander/Native Hawaiian, and Native American families - Families with limited English proficiency/DLL - Families involved in child welfare - Families of children with developmental delays/disabilities - Families in rural communities	- What are family priorities for early care and education programs? - What are barriers to access to early care and education programs? - What supports are needed?	Findings relevant to supporting social-emotional health and development: - Families seek programs and providers skilled in supporting social-emotional development - Providers need training and support on trauma - Families need support accessing BH services Findings about barriers to accessing early care and education programs, which may also be relevant for accessing social-emotional health services: - Transportation - Language access - Honoring family culture and values - Lack of trust in systems Early Learning Hub Sector Plans

Oregon's Preschool Development Grant Needs Assessment Family Surveys and Listening Sessions (2019-2020)	- Latino, Native American, and East African refugee/immigrant families - Families with limited English proficiency/DLL - Families of children with developmental delays/disabilities or special health care needs - Incarcerated mothers (potential child welfare involvement)	- What are families' experiences, satisfaction, and challenges with early care and education? - What are families' experiences with suspension and expulsion? - How do families support children's healthy development at home?	Findings relevant to supporting social-emotional health and development: - Families prioritize social-emotional development opportunities when choosing early care and education programs - Families value early identification and referrals for developmental delays and disabilities - Providers need more training and support for children with developmental delays, disabilities and BH needs - Behavior challenges and social-emotional health needs are the top reason children are "asked to leave care" (suspended or expelled) Findings about barriers to accessing early care and education programs, which may also be relevant for accessing social-emotional health services: - Lack of trust in public programs and systems - Transportation needs Oregon PDG Needs Assessment reports
CCO Community Health Improvement Plans	- Consumers and community partners	- What are the health needs in our community? - What are the priorities for improving community health in our region?	Some findings may illuminate broad needs and priorities around barriers accessing health care services, and some may be specific to the needs of young children, their social-emotional development and behavioral health, and early learning and kindergarten readiness. CCO Community Health Improvement Plans
Coalition of Communities of Color Research Justice Institute Report on Investing in Culturally and Linguistically	- Respondents from diverse geographies including Eastern and Central Oregon, the Gorge, the Coast, the Portland metro area, Salem,	- What are sources of stress, anxiety, frustration, and worry, including for children and elders? - What are the barriers to seeking behavioral health care?	Key findings: - Majority of BIPOC people receive behavioral health care from religious figures, traditional healers, community-based organizations, and clinics. - Awareness about behavioral health services is a major barrier and translation is insufficient for communicating culturally relevant information.

Responsive Behavioral Health Care in Oregon (2022)	Eugene, and Medford - Respondents who identify as Black/African American and Latino/a/x were the majority of participants - Representation of Native/Indigenous, Asian, and Pacific Islander communities	- What are experiences of discrimination by and distrust of health care professionals? - What are experiences of local and culturally specific resources for behavioral health support?	- Rates of behavioral health care utilization are low among BIPOC people largely due to a lack of multilingual and multicultural providers. - BIPOC people have low rates of enrollment in CCOs, especially outside of the Portland metro area. - BIPOC people experience high rates of racism, discrimination, and bias in medical settings. - BIPOC needs and experiences cannot be understood without collecting disaggregated, community-informed, actionable data. - Western and Anglo-centric assumptions aboutbehavioral health alienate and harm BIPOC communities. **Full report**, including actionable recommendations

Appendix E: Action Plan Template

Target Area 1 Identified for Improvement (Aligned with Issue-Focused Interventions for Social-Emotional Health – Required in MY3)							
Aim Statement/Desired Outcome (Ensure that is a SMART Aim)							
Improvement Strategies or Action Steps	***Target area for improvement: Issue-Focused Interventions/Treatment (Required in MY3)***	***Responsible Person/Party***	***Community-Level Partners Engaged***	***Deadline***	***Resources Needed***	***Methods that will be used to track progress and impact***	***Status/Update***
1.							
2.							
3.							
Target Area 2 Identified for Improvement: (Aligned with 4 Target Areas)							
Aim Statement/Desired Outcome (Ensure that is a SMART Aim, List the Specific Social Emotional Service or Target Areas of Focus**):**							
Improvement Strategies or Action Steps	***Target area for improvement: Intervention, Screening/Assessment, Referral Pathway or Environment***	***Responsible Person/Party***	***Community-Level Partners Engaged***	***Deadline***	***Resources Needed***	***Methods that will be used to track progress and impact***	***Status/Update***
1.							
2.							
3.							

Improvement Strategies within **target areas for improving provision of Social-Emotional health services, informed by family input, improvement pilots, and stakeholder survey findings, include:**

Issue-Focused Intervention/Treatment Services **(within CCO Contracted Specialty Behavioral Health, Integrated Behavioral Health, and/or Applicable Community Based Organizations)**

- Increase range of Social-Emotional health issue-focused intervention/treatment services by CCO contracted providers
- Workforce development to improve skills of available providers (e.g., training, support for credentialing, tool provision, quality improvement facilitation)
- Workforce development to increase provider diversity and availability (e.g., recruitment strategies, training, support for credentialing or other educational attainment)
- Workforce development to increase provider diversity and availability (e.g., recruitment strategies, training, support for credentialing or other educational attainment)
- Enhancement of the types of intervention/therapy modalities offered (e.g. group, focused on trauma, etc.)
- Enhancement to how the issue-focused intervention/treatment services are provided to address barriers to access (provision in home, community-based settings, etc.)
- Pursue new contract and payment options for community-based providers to enhance provision of issue-focused intervention/treatment services.
- Other: please define

Screening & Assessment by CCO Contracted Providers

- Increase Social-Emotional health assessments provided to children in CCO covered settings.
- Increase Social-Emotional screening of young children in CCO covered settings.
- Workforce development to improve skills of available providers (e.g., training, support for credentialing, tool provision, quality improvement facilitation)
- Workforce development to increase provider diversity and availability (e.g., recruitment strategies, training, support for credentialing or other educational attainment)
- Workforce development to increase provider diversity and availability (e.g., recruitment strategies, training, support for credentialing or other educational attainment)
- Workforce trainings/quality improvement support on flags of social-emotional delays based on current screenings conducted that could be used to identify children needing additional assessments.
- Workforce trainings/quality improvement support to implement population-based screening of children birth to five for social-emotional delays in primary care. .
- Other: please define

Supporting Access - Referral Pathways

- Address access barriers for families (e.g., improve language access supports, provide child care supports, provide transportation supports, expand hours or offer flexible scheduling)
- Improve care coordination for families, including providing support navigating Social-Emotional health services and improving referral pathways
- Supporting Publicly Available Information about Providers**:** Materials about behavioral health providers available in region for children birth-to-five that are easy to access and use, including provider capacity and descriptive characteristics that inform referrals/access
- Pilot of "warm referrals", feedback loops.
- Address barriers to accessing services through open time slots for evaluation.
- Other: please define

Environment

- Public health messaging

Appendix F: Summary of Four Components of System-Level Social-Emotional Health Metric

	Must Pass Items	Optional Items to Enhance Measure
Component 1		
CCO has reviewed and interpreted the provided Social-Emotional Health Reach Metric data	**The CCO will attest to:** **1.1** The CCO has reviewed the 1) aggregate reports and 2) child-level data file provided in the Social-Emotional Health Reach Metric Report for children ages 1 –5 years. **1.2** The CCO has examined the Social-Emotional Health Reach Metric data for at least one population with historical inequitable outcomes, using CCO data available. (Examples: race, ethnicity, use of translator, geographic region) **1.3** The CCO has assessed payment policies and contracts for the claims and services included in the Social-Emotional Health Reach Metric to ensure there is a continuum of services that address Social- Emotional health from prevention to treatment, includingcommunity options and arrangements.	**1.4** The CCO has identified missing assessment or service claims and intends to submit additional data capturing children accessing services not yet reflected in the reach metric results.
Component 2		
CCO develops Asset Map(s) of Existing Social-Emotional Health Services and Resources	**The CCO will attest to:** **2.1** Submit the Asset Map(s) that summarizes capacity for: ***Year 1***: Contracted Behavioral Health Services ***Year 2: Year 1 Updated +*** Social-Emotional health services provided within integrated behavioral health ***Year 3: Year 1 & 2 Updated + Other*** Contracted Early learning providers and other community-based Social- Emotional services	**2.2** The CCO has submitted reflections about asset mapping and key learnings to share with community partners in Component 3.
Component 3		
CCO led Cross-Sector Community Engagement activities	**The CCO will attest to:** **3.1** The CCO engaged cross-sector community partners to review and discuss Social-Emotional Health Reach Metric data, Asset Map(s), and barriers and opportunities to improve service capacity and access. **3.2** The CCO engaged communities experiencing historical and contemporary injustices such as racism and other systemic bias* to review and discuss Social-Emotional Health Reach Metric data, Asset Map(s), and barriers and opportunities to improve service capacity and access. **3.3** Select the strategies the CCO implemented to obtainmeaningful input from the communities experiencing historical and contemporary injustices engaged in 3.2 above. **3.4** The CCO has submitted a summary of reflections from conversations with cross-sector community partners and families.	
Component 4		
CCO develops Action Plan to Improve Provision of Social-Emotional Health Services	**The CCO will attest to:** **4.1** The CCO has identified at least two target areas for improvement in their Action Plan informed by data review, asset mapping, and community conversations in Components 1-3 (MY1) **4.2** The CCO has included input from communities experiencing historical and contemporary injustices in Action Plandevelopment. (MY1) **4.3** The CCO has attached/uploaded their Action Plan, including: (MY1) 1) Target areas selected 2) Improvement strategies and progress milestones for target areas **4.4** The CCO has assessed progress on their Action Plan. (MY2-3) **4.5** The CCO has attached/uploaded a revised Action Plan, including at least 1 target area that includes issue-focused intervention/treatment services (required for MY 3). (MY 3_	