Oregon Transforming Pediatrics for Early Childhood: 5th Learning Session

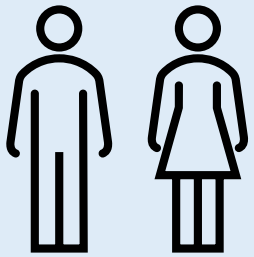
Enhancing Issue-Focused Interventions and Referrals to External ECD Experts & Addressing Social Determinants of Health

May 8th, 2025 8am-12pm

OREGON TPEC
Transforming Pediatrics and Early Childhood

WELCOME!

WE ENCOURAGE YOU TO TAKE CARE OF YOURSELF IN THIS SPACE



Restrooms out the door, to the left & around the corner

Water filling stations, coffee and breakfast are available

The room is yours, stretch and move about throughout as needed to stay connected

Learning Session #5 Agenda

- Welcome and Review of the Agenda
- Where We Are Now: Learnings from Qualitative and Quantitative Data
- Prioritizing Limited Remaining Time with TPEC Learning Curriculum and QI Supports to Enhance Issue-Focused Interventions and Connections to External ECD Experts: Key Area of Focus
- Small Group Action Planning: Part 1

Group Picture & BREAK

Social Determinants of Health/Social Influences of Health:

- Review of OR TPEC Sites' Current Processes
- Specific Strategies to Consider When Addressing Needs
- Increasing Issue-Focused Interventions and Connections to External ECD Experts: Role SDOH May Play and Strategies to Consider
- Small Group Action Planning: Part 2
- Close Out & Next Steps

This is our FIFTH!!! OR TPEC Learning Session!

Hillsboro Pediatric Clinic

Metropolitan Pediatrics

LEGACY HEALTH

Virginia Garcia Memorial HEALTH CENTER

Randall Children's Clinic

Acknowledgement of Funding

- Transforming Pediatrics for Early Childhood (TPEC) is supported by Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS).

- The contents of this learning sessions are those of the authors (OPIP staff) and do no necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the US Government.

OPIP Team Supporting the Learning Session

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OPIP Projects Coordinator

Guest Speakers from Health Share of Oregon & CareOregon

Maureen Seferovich, LCSW

Program Manager, Health Systems Integration at Health Share of Oregon

Kaely Summers (she/her)

Social Health Specialist at CareOregon

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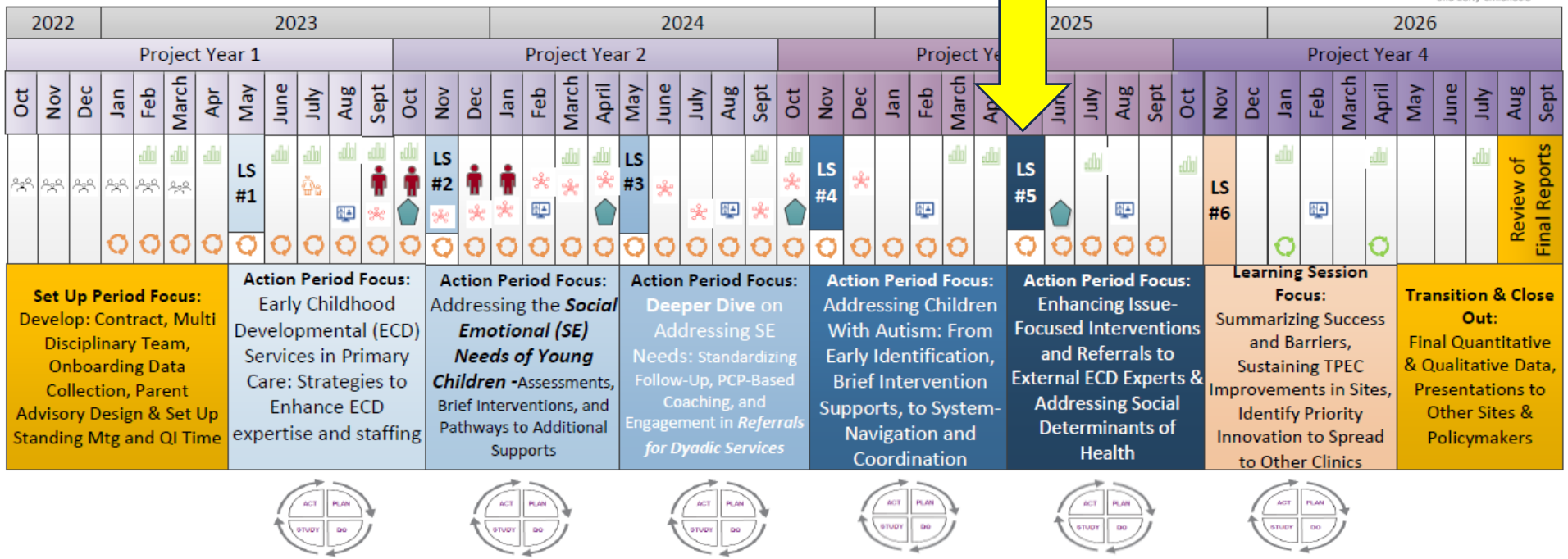
OR TPEC: We Are Nearing the Last Stretch

OREGON TPEC: Detailed Overview of the Oregon TPEC Learning Collaborative for the Four Patient-Centered Primary Care Home (PCPCH) Primary Care Sites, Six Learning Session (LS) Topics and Action Period Areas of Focus.

Tab 3



KEY:

- Onboarding, Engagement, Contract Development with Primary Care Site
- Evaluation Data Collection
- On-Site Practice Facilitation with Practice-Level Teams
- Check In with Sites, Qualitive ?s
- Across PCPCH Site: Webinar Supported Calls Supporting Action Plan Implementation (**Required**)
- Relevant PCPCH Site: Webinar Supported Calls Supporting ECD (Integrated Behavioral Health Staff)
- Relevant PCPCH Site: Webinar Supported Calls Supporting Continuum of ECD Services (Care Coordination, System Navigation)
- Action Periods Following Learning Session: QI approach to implementation of action plan created during Learning Session on topic area of focus and for priority population identified
- Hiring & Onboarding of Staff to Support Gaps in Early Childhood Developmental services (ECD) Functions in Practice and/or Existing Staff Training and Focus on Provision of Issue-Focused Services (Integrated Behavioral Health) and to Support System Navigation (Traditional Health Workers)

Overview of the Six Learning Sessions (LS) To Guide Action Periods:
Learning Sessions are in-person events with teams from all four sites and the Learning Session faculty (which includes subject matter experts), input obtained from parents, and where applicable advocacy groups. Didactic and peer interaction to support the application of principles of the continuum of ECD services, design implementation action plans, support learning from each, a parent-centered and parent forward approach driving and informing priority populations of focus. Post-Session evaluation data is also collected at each Learning Session.

Updated May 2025

National TPEC Objectives

1. Increase the **number of ECD experts** trained, equipped, and placed in pediatric settings serving Medicaid/CHIP-eligible or uninsured P–5 populations;

2. Increase the **number of pediatric practices** offering a **continuum of ECD services** that includes comprehensive early developmental health promotion/prevention, screening and surveillance, care coordination and linkage, and intervention;

3. Improve **ECD knowledge & competencies among pediatric primary care staff;**

4. **Identify and advance solutions to specific barriers to sustained and holistic ECD service** delivery in primary care, such as **policy and financing barriers**, ECD **workforce** needs, **care coordination**, and **service gaps**.

What Does the Quantitative & Qualitative Data Say About Oregon's Approach to TPEC Model & Requirements

- ✓Review data aligned with national TPEC objectives and the nationally required HRSA reporting metrics

Trivia Questions Throughout:

- ✓Write down your answers on the sheets provided for the 11 questions.
- ✓An OPIP team member will collect your answers at the end
- ✓Winner gets a prize!

OR TPEC Metrics: TPEC Objective #1

1. Increase the **number of ECD experts** trained, equipped, and placed in pediatric settings serving Medicaid/CHIP-eligible or uninsured P–5 populations;

- Main metric we report is the **number** of **behavioral health clinicians** given they provide the issue-focused interventions.
- We also report a broader count of staff trained on specific birth to five referrals and who play a specific role for birth to five along the ECD Continuum.

  Examples:

  ✓Care Coordinators

  ✓Referral Coordinators

  ✓Traditional Health Workers

  ✓Early Childhood Navigator

Interesting Fact:

- A majority of national TPEC grantees are implementing the Healthy Steps Model.
- Grant funding is used to hire **Healthy Steps Specialists**.
- Sites with these specialists are improving rapidly in child-level metrics, thanks to a full-time staff member funded through the cooperative agreement.

OR TPEC Learnings on Barriers Related TPEC Objective #1

1. Increase the **number of ECD experts** trained, equipped, and placed in pediatric settings serving Medicaid/CHIP-eligible or uninsured P–5 populations;

Barriers in Oregon TPEC Model & Learning Collaborative Relative to National TPEC Objective #1:

- We did not require grant funding to be tied to FTE of specific ECD expert staff that only work on birth to five or specific to certain functions.
- Each site has seen transitions in behavioral health staff/other staff that received training to focus on birth to five.
- Most sites don't have the recommended behavioral health staff to primary care provider staffing ratio, despite trying to hire.
- At this time, no site has a person that is dedicated to seeing only birth to five for issue-focused interventions

Trivia Game! Objective 1 – ECD Expert Activities

#1) Which site(s) modified their Circle of Security group therapy classes (led by an ECD expert) to consist of 4 classes and is offering gift cards to parents who attend?

a) Randall Children's Clinic
b) Virginia Garcia Memorial Health Clinic – Cornelius
c) Hillsboro Pediatric Clinic
d) Metropolitan Pediatrics – Johnson Creek

Trivia Game! Objective 1 – ECD Expert Activities

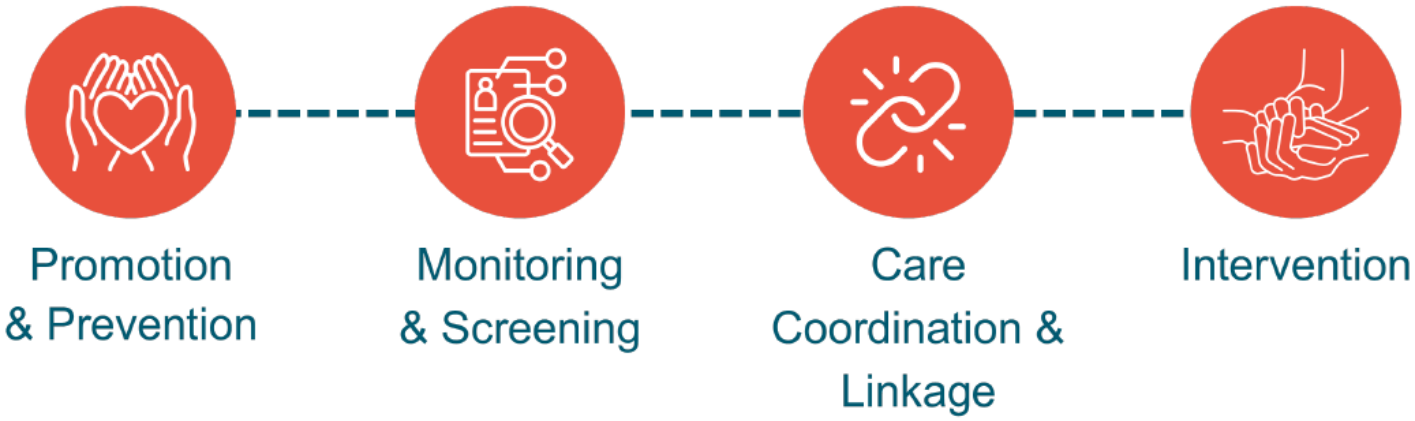
#2) Which site(s) had two of their behavioral health staff trained in birth to five transition out of the practice, and have since hired two new behavioral health staff that start this summer and fall?

a) Randall Children's Clinic
b) Virginia Garcia Memorial Health Clinic – Cornelius
c) Hillsboro Pediatric Clinic
d) Metropolitan Pediatrics – Johnson Creek

TPEC Objective #2:

Increase the **number of pediatric practices** offering a **<u>continuum of ECD services</u>** that includes comprehensive early developmental health promotion/prevention, screening and surveillance, care coordination and linkage, and intervention;

National TPEC Defined "Continuum of ECD Services"



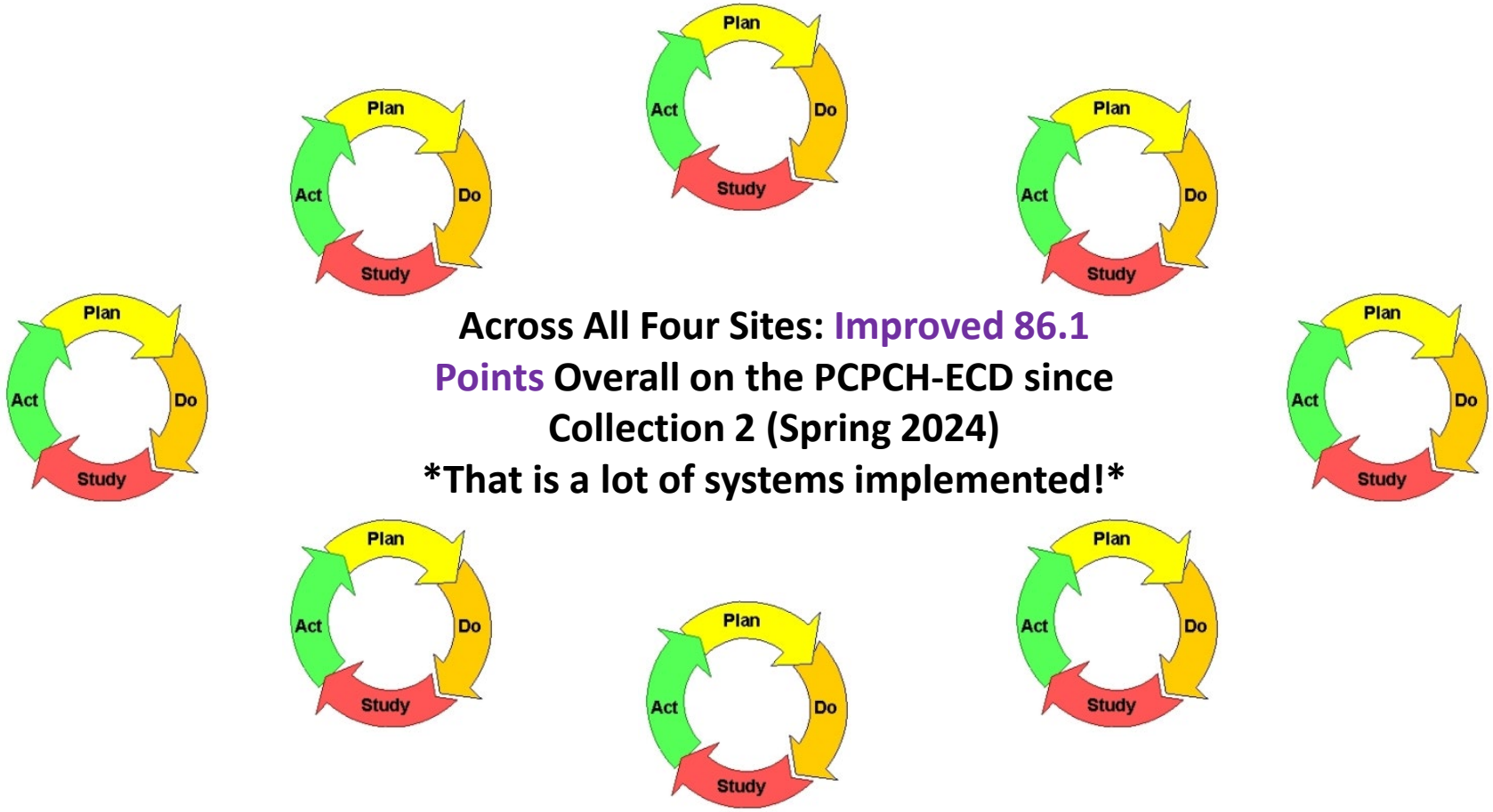
OR TPEC Metrics for Objective #2:

- PCPCH-ECD meant to measure office systems and processes related to the four parts of the ECD Continuum.
  - Used internally to inform QI within each site, & compared to PCPCH Standards
  - Current data is comparison to last year (Spring ‘25, Over Two Action Periods)
  - NOT an evaluation metric reported to HRSA

HRSA required four child-level metrics across TPEC sites that assess whether the number and proportion of children who have received these services has improved. Their goal is that within these practices, child-level services increase.

Since Last Year OR TPEC Sites Improved on Office Systems & Processes: PCPCH-ECD

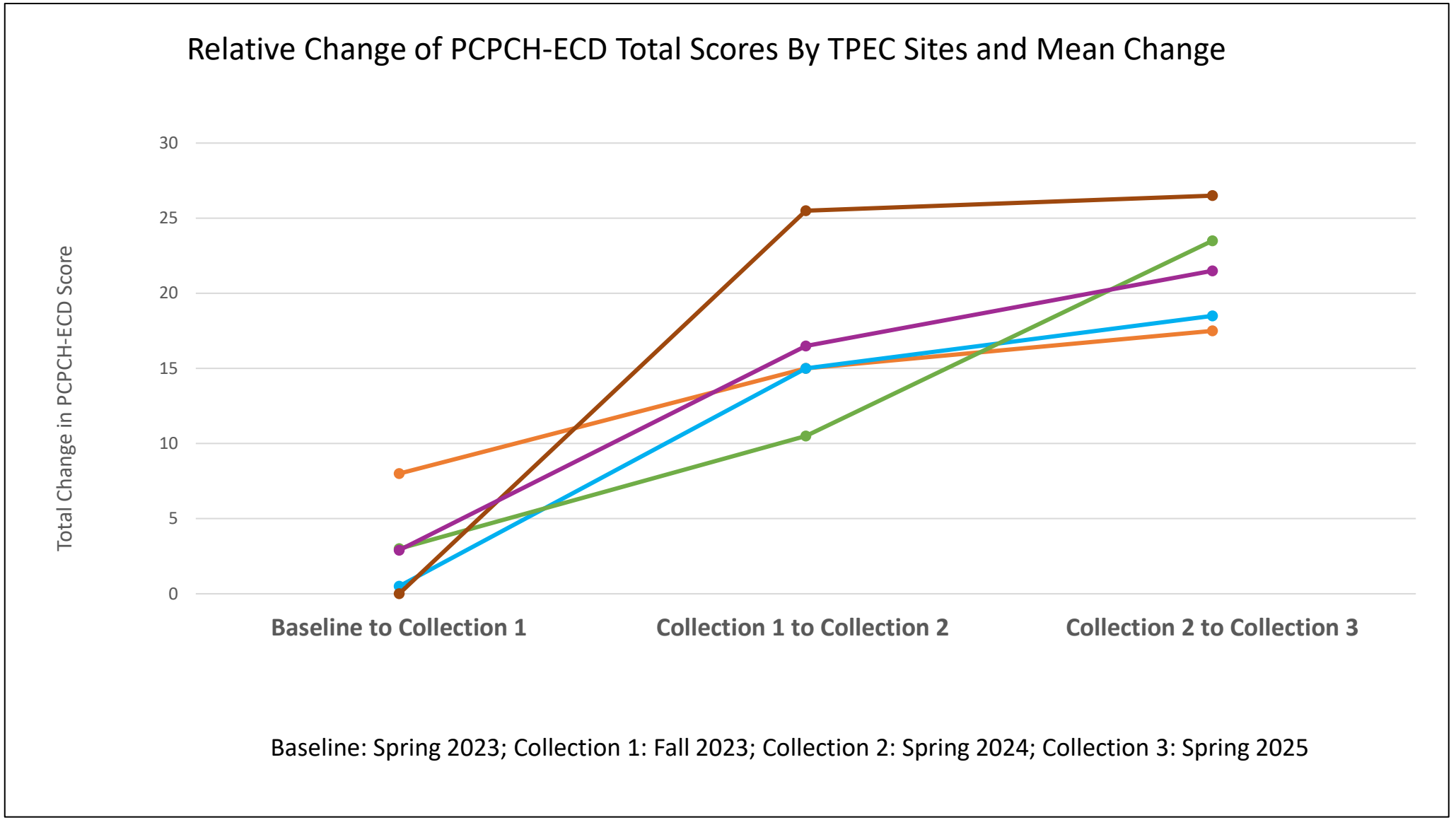
Tab 2



Across All Four Sites: Improved 86.1 Points Overall on the PCPCH-ECD since Collection 2 (Spring 2024)

That is a lot of systems implemented!

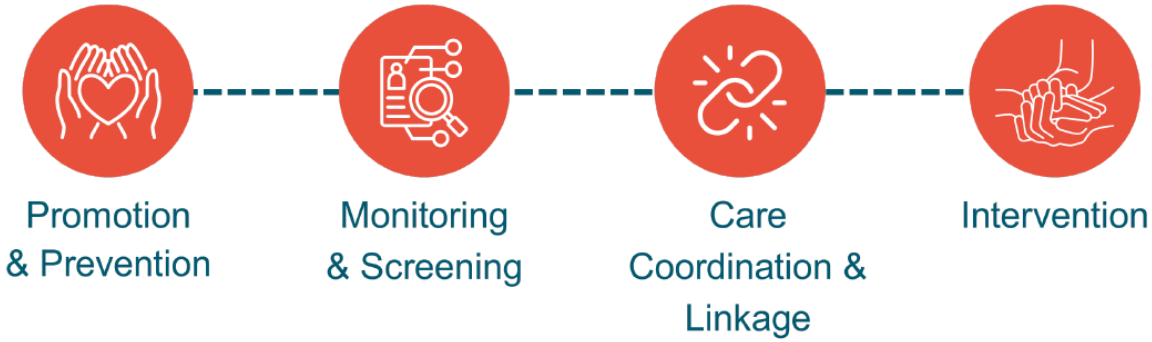
Total PCPCH-ECD Scores: Relative CHANGE Within Each Site



Tab 2

Data Source: PCPCH-ECD Tool Collected in Site Visits with Office Staff

Trivia Game! Objective 2 and PCPCH-ECD Data



#3) Which domain(s) measured in the PCPCH-ECD did all four sites improve on?

a) Promotion & Prevention
b) Monitoring & Screening
c) Care Coordination & Linkage
d) Intervention

OR TPEC Metrics for Objective #2:

HRSA required across TPEC sites four child-level metrics that assess whether the number and proportion of children who have received these services has improved. Their goal is that within these practices, child-level services increase.

Data is collected every six months, intended to measure if children are receiving the services that the PCPCH-ECD is capturing.

Tab 2

1. Well-Child Visits for Children Aged 3-6 (Source: Health Share of Oregon) ***Promotion & Prev.***

From Practice-Reported Child-Level Data

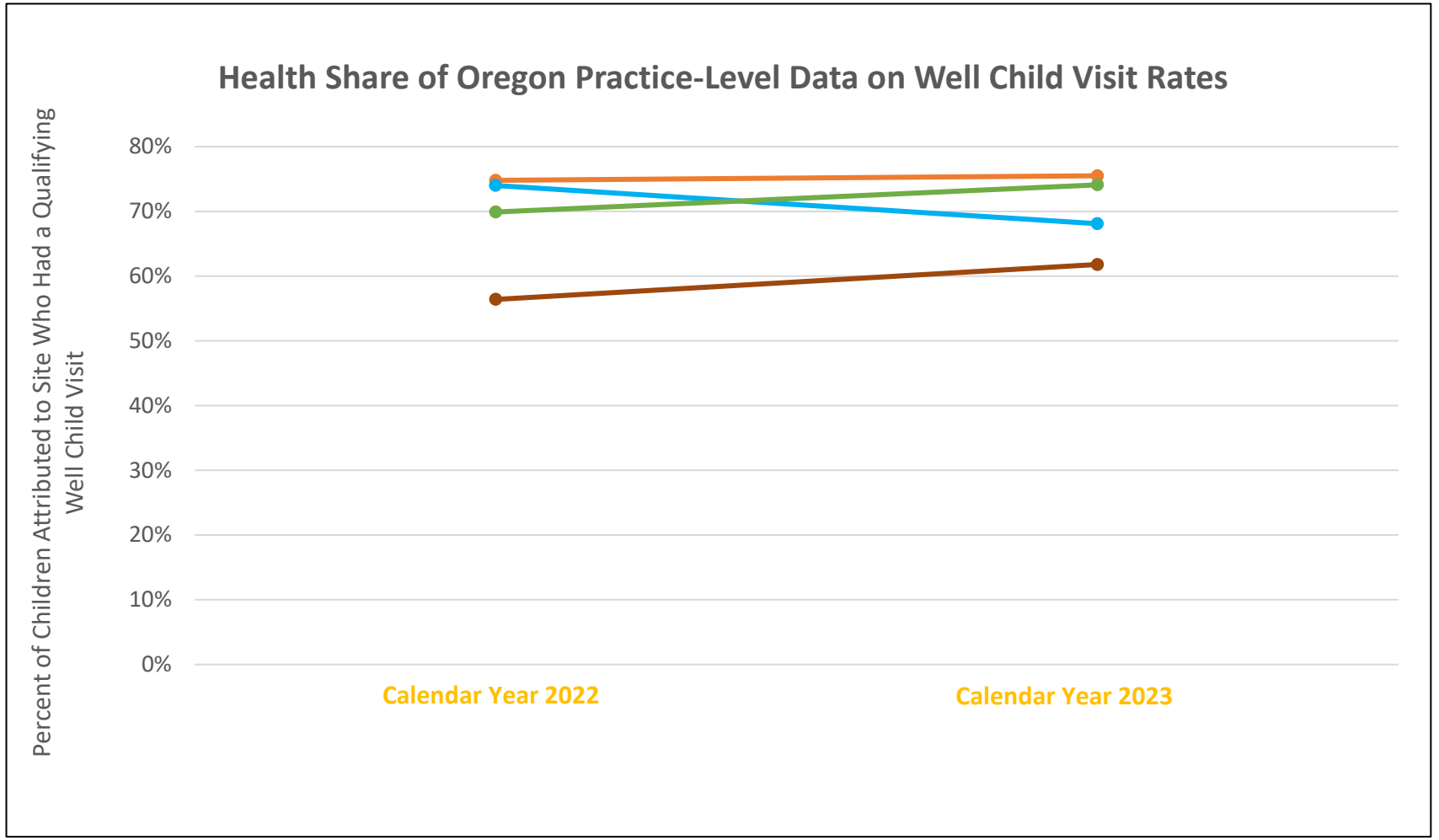
2. Social-Emotional Screening/Assessments (**1.3**) ***Monitoring & Screening***

3. Referrals to Specialty Behavioral Health (**2.3**) ***Care Coordination***

4. Children Receiving Issue-Focused Interventions (**3.1**) ***Issue-Focused Interventions***

Well Child Visit Data for Children 3-6 Years of Age

Promotion & Prevention



Tab 2

Source: Well Child Visit Ages 3-6 Rate by Site from Health Share of Oregon CY 2022 and CY 2023

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3. Referrals to Specialty Behavioral Health (**2.3**) ***Care Coordination***

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Trivia Game! Objective 2

Monitoring & Screening

#4) True or False:

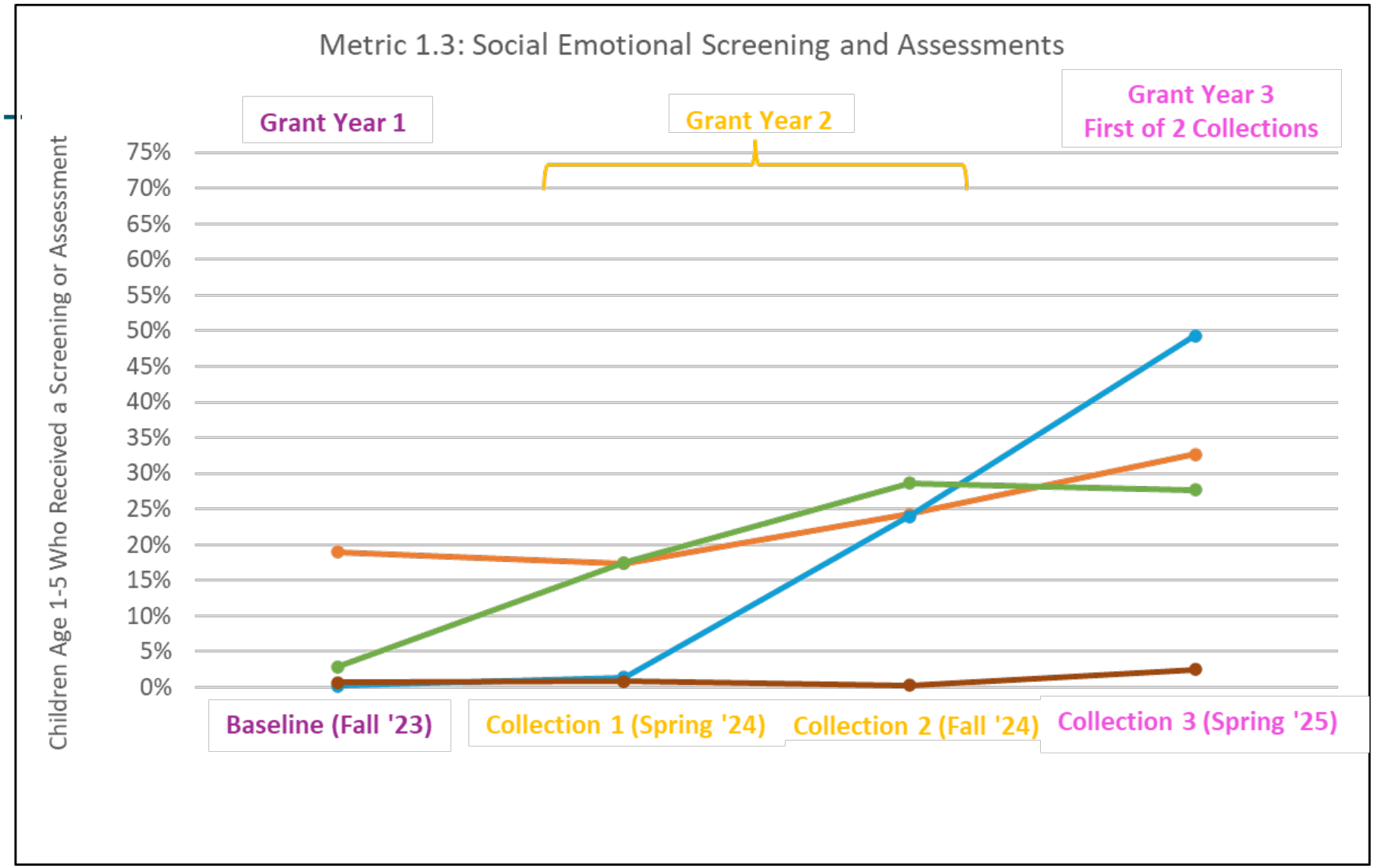
All four OR TPEC sites are implementing the Preschool Pediatric Symptom Checklist in at least one well child visit

a) True

b) False

Metric 1.3: Social-Emotional Health Screening/Assessments (1-5): Based on Claims Data

Monitoring & Screening



Tab 2 page 5

Measurement Periods: Baseline (7/1/22-6/30/23); Collection 1 (1/1/23-12/31/23); Collection 2 (7/1/23-6/30/24); Collection 3 (1/1/24-12/31/24).

Trivia Game! Objective 2

Monitoring & Screening

#5) Which site(s) doubled their social-emotional screening rate in the last year?

a) Randall Children's Clinic

b) Virginia Garcia Memorial Health Clinic – Cornelius

c) Hillsboro Pediatric Clinic

d) Metropolitan Pediatrics – Johnson Creek

OR TPEC Metrics for Objective #2

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From Practice-Reported Child-Level Data

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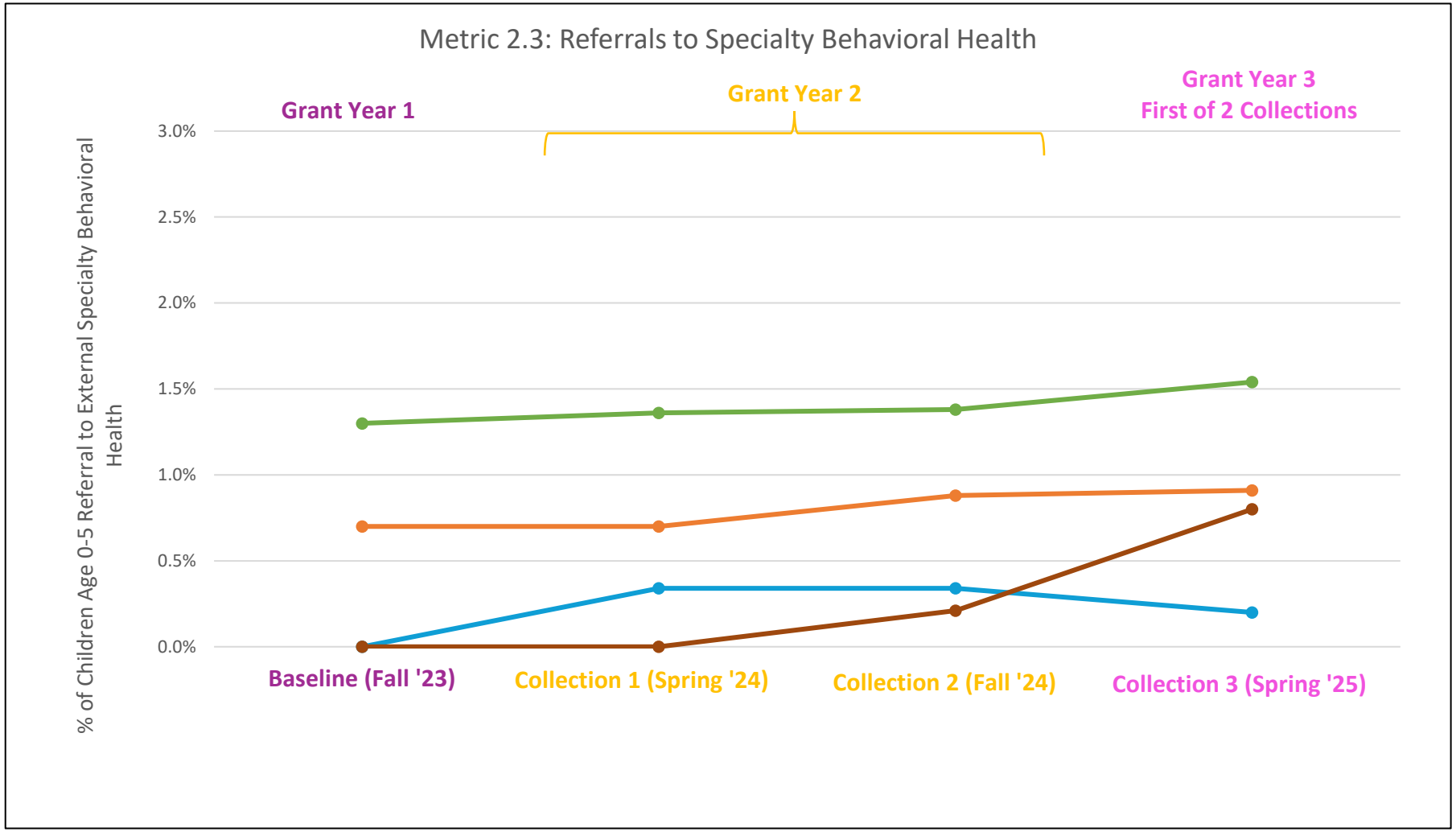
Metric 2.3: Referral Rates to Specialty Behavioral Health (External to Clinic)

Care Coordination & Linkage



Tab 2 page 3

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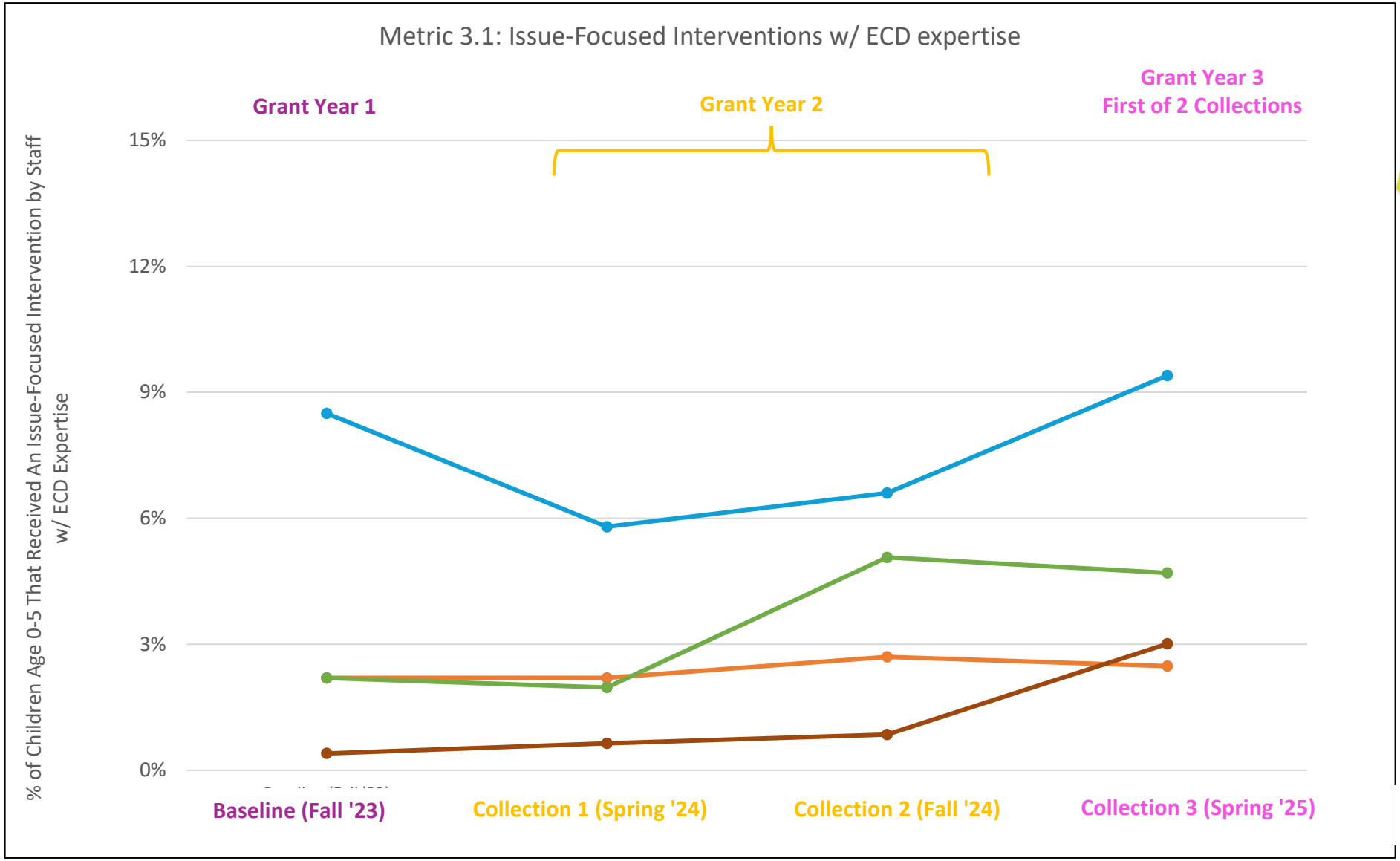
Tab 2

Metric 3.1: Children Who Received Issue-Focused Interventions from Staff with ECD expertise

Intervention



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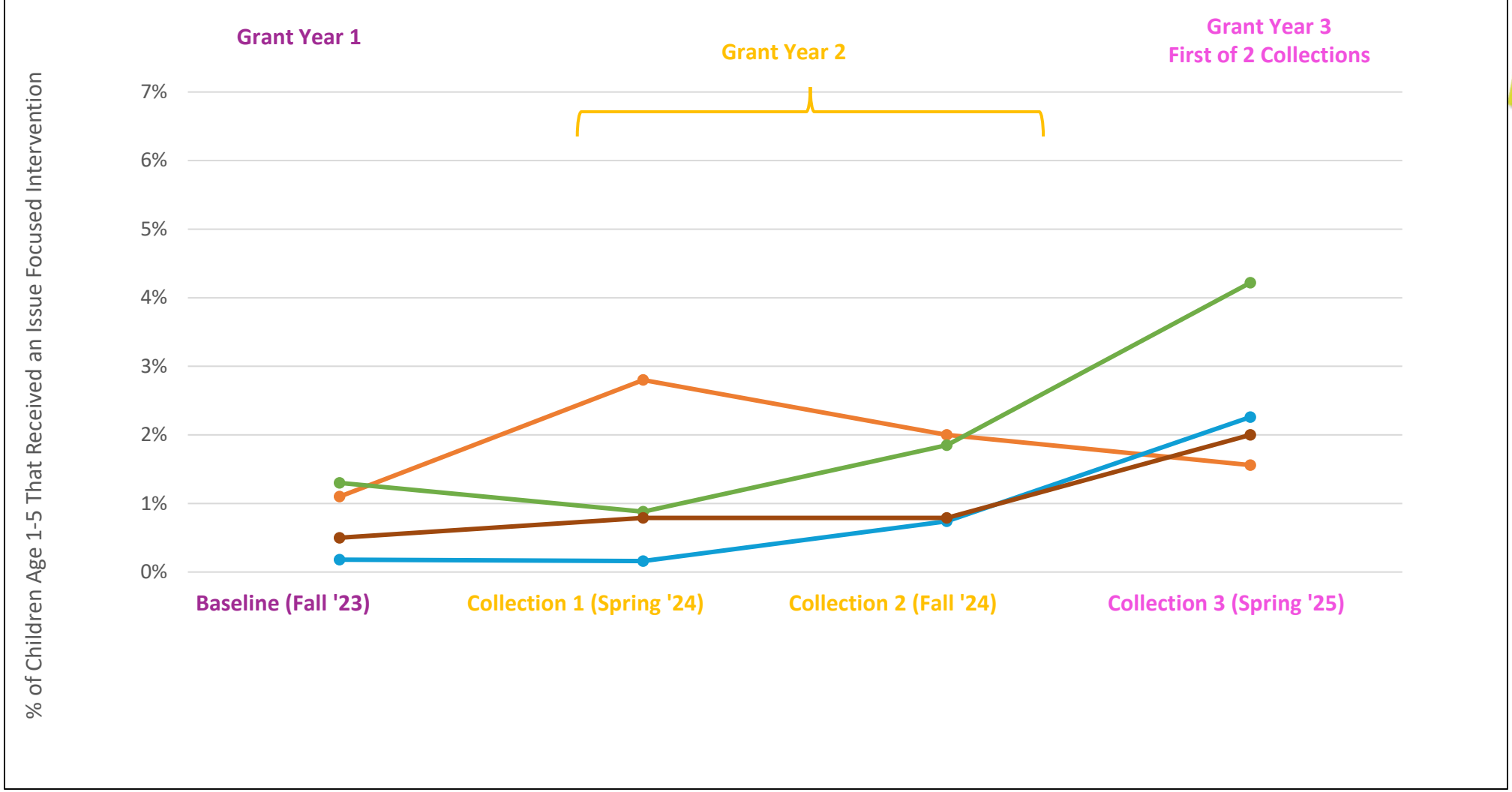
Metric 1.4: Social-Emotional Health Metric Specific to Primary Care: Therapy Services (Issue-Focused) (1-5-years)

Intervention



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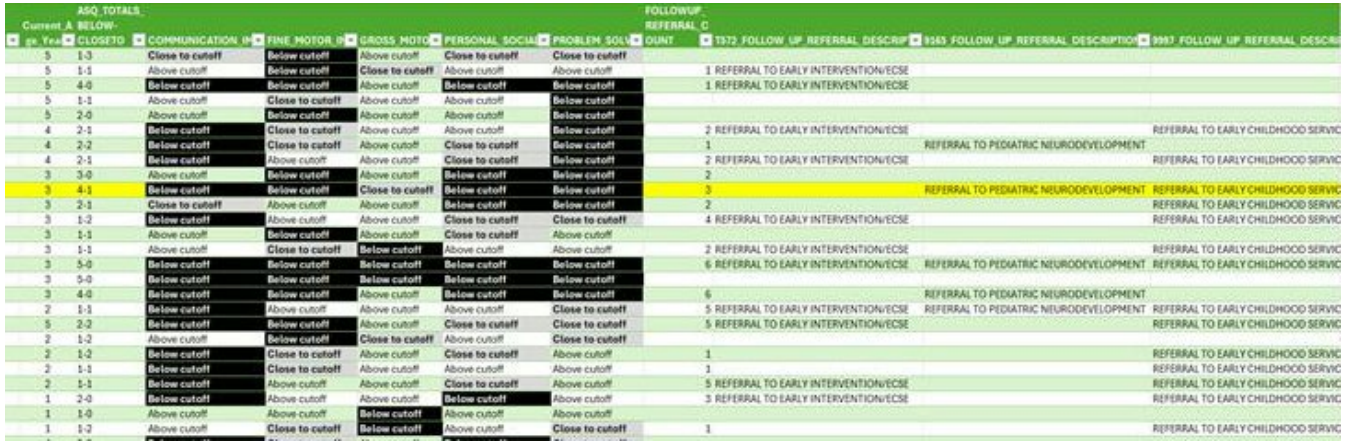
Trivia Game! Objective 2



Current_Age_Years	ASQ_TOTALS_BELOW-CLOSETO	COMMUNICATION_D	FINE_MOTOR_D	GROSS_MOTO	PERSONAL_SOCIAL	PROBLEM_SOLV	FOLLOWUP_REFERRAL_COUNT	T372_FOLLOW_UP_REFERRAL_DESCRIP	9365_FOLLOW_UP_REFERRAL_DESCRIPTION	9987_FOLLOW_UP_REFERRAL_DESCRI
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4	2-1	Below cutoff	Above cutoff	Above cutoff	Close to cutoff	Below cutoff	2	REFERRAL TO EARLY INTERVENTION/ECSE		REFERRAL TO EARLY CHILDHOOD SERVIC
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3	5-0	Below cutoff	Below cutoff	Below cutoff	Below cutoff	Below cutoff	6	REFERRAL TO EARLY INTERVENTION/ECSE	REFERRAL TO PEDIATRIC NEURODEVELOPMENT	REFERRAL TO EARLY CHILDHOOD SERVIC
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3	4-0	Below cutoff	Below cutoff	Above cutoff	Below cutoff	Below cutoff	6		REFERRAL TO PEDIATRIC NEURODEVELOPMENT	
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5	2-2	Below cutoff	Below cutoff	Above cutoff	Close to cutoff	Close to cutoff	5	REFERRAL TO EARLY INTERVENTION/ECSE		REFERRAL TO EARLY CHILDHOOD SERVIC
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2	1-1	Below cutoff	Close to cutoff	Above cutoff	Above cutoff	Above cutoff	1			REFERRAL TO EARLY CHILDHOOD SERVIC
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1	1-0	Above cutoff	Above cutoff	Below cutoff	Above cutoff	Above cutoff				
1	1-2	Above cutoff	Close to cutoff	Below cutoff	Above cutoff	Close to cutoff	1			REFERRAL TO EARLY CHILDHOOD SERVIC

Monitoring & Screening

Care Coordination Linkage

#6) Which site developed a data dashboard that tracks screening results and whether best match follow-up occurred, by provider, to target their QI work and increase referrals?

a) Randall Children's Clinic

b) Virginia Garcia Memorial Health Clinic – Cornelius

c) Hillsboro Pediatric Clinic

d) Metropolitan Pediatrics – Johnson Creek

Data Dashboard Example, Courtesy of Virginia Garcia Memorial Health Clinic – Cornelius

Current_A ge_Yea	ASQ_TOTALS_ BELOW-CLOSETO	COMMUNICATION_IN	FINE_MOTOR_D	GROSS_MOTO	PERSONAL_SOCIA	PROBLEM_SOLV	FOLLOWUP_ REFERRAL_C OUNT	T372_FOLLOW_UP_REFERRAL_DESCRIP	9365_FOLLOW_UP_REFERRAL_DESCRIPTION	9997_FOLLOW_UP_REFERRAL_DESCRI
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5	1-1	Above cutoff	Close to cutoff	Above cutoff	Above cutoff	Below cutoff				
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4	2-1	Below cutoff	Close to cutoff	Above cutoff	Above cutoff	Below cutoff	2	REFERRAL TO EARLY INTERVENTION/ECSE		REFERRAL TO EARLY CHILDHOOD SERVIC
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4	2-1	Below cutoff	Above cutoff	Above cutoff	Close to cutoff	Below cutoff	2	REFERRAL TO EARLY INTERVENTION/ECSE		REFERRAL TO EARLY CHILDHOOD SERVIC
3	3-0	Above cutoff	Below cutoff	Above cutoff	Below cutoff	Below cutoff	2			
3	4-1	Below cutoff	Below cutoff	Close to cutoff	Below cutoff	Below cutoff	3		REFERRAL TO PEDIATRIC NEURODEVELOPMENT	REFERRAL TO EARLY CHILDHOOD SERVIC
3	2-1	Close to cutoff	Above cutoff	Above cutoff	Below cutoff	Below cutoff	2			REFERRAL TO EARLY CHILDHOOD SERVIC
3	1-2	Below cutoff	Above cutoff	Above cutoff	Close to cutoff	Close to cutoff	4	REFERRAL TO EARLY INTERVENTION/ECSE		REFERRAL TO EARLY CHILDHOOD SERVIC
3	1-1	Above cutoff	Below cutoff	Above cutoff	Close to cutoff	Above cutoff				
3	1-1	Above cutoff	Close to cutoff	Below cutoff	Above cutoff	Above cutoff	2	REFERRAL TO EARLY INTERVENTION/ECSE		REFERRAL TO EARLY CHILDHOOD SERVIC
3	5-0	Below cutoff	Below cutoff	Below cutoff	Below cutoff	Below cutoff	6	REFERRAL TO EARLY INTERVENTION/ECSE	REFERRAL TO PEDIATRIC NEURODEVELOPMENT	REFERRAL TO EARLY CHILDHOOD SERVIC
3	5-0	Below cutoff	Below cutoff	Below cutoff	Below cutoff	Below cutoff				
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1	1-2	Above cutoff	Close to cutoff	Below cutoff	Above cutoff	Close to cutoff	1			REFERRAL TO EARLY CHILDHOOD SERVIC

Trivia Game! Objective 2

Monitoring & Screening

Care Coordination & Linkage

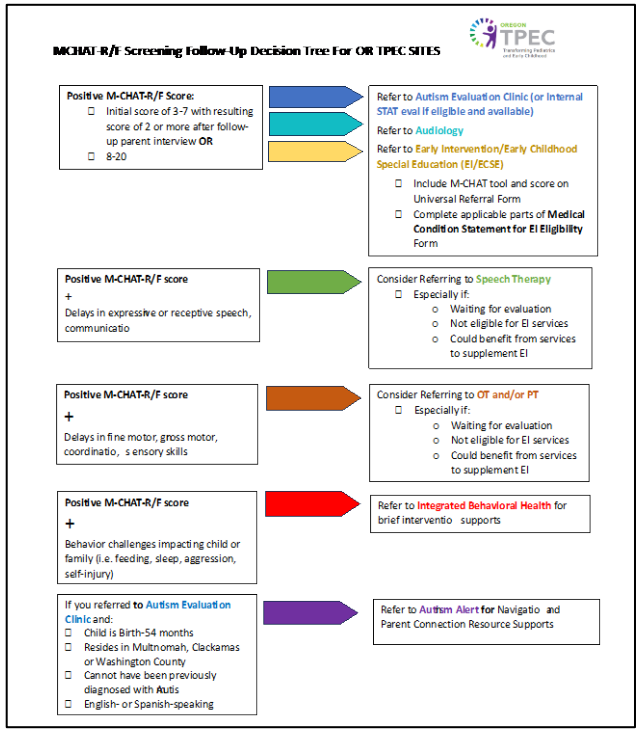
#7) Which site(s) developed standardized MCHAT Follow-Up Decision Trees and Autism Follow-Up Education Sheets?

a) Randall Children's Clinic

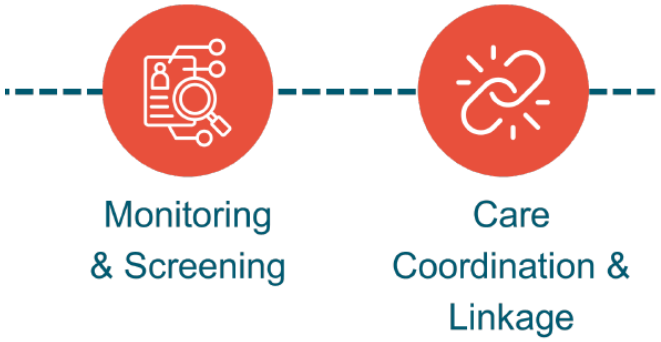
b) Virginia Garcia Memorial Health Clinic – Cornelius

c) Hillsboro Pediatric Clinic

d) Metropolitan Pediatrics – Johnson Creek



Trivia Game! Objective 2



#8) Which site(s) are referring to Autism Alert?

a) Randall Children's Clinic

b) Virginia Garcia Memorial Health Clinic – Cornelius

c) Hillsboro Pediatric Clinic

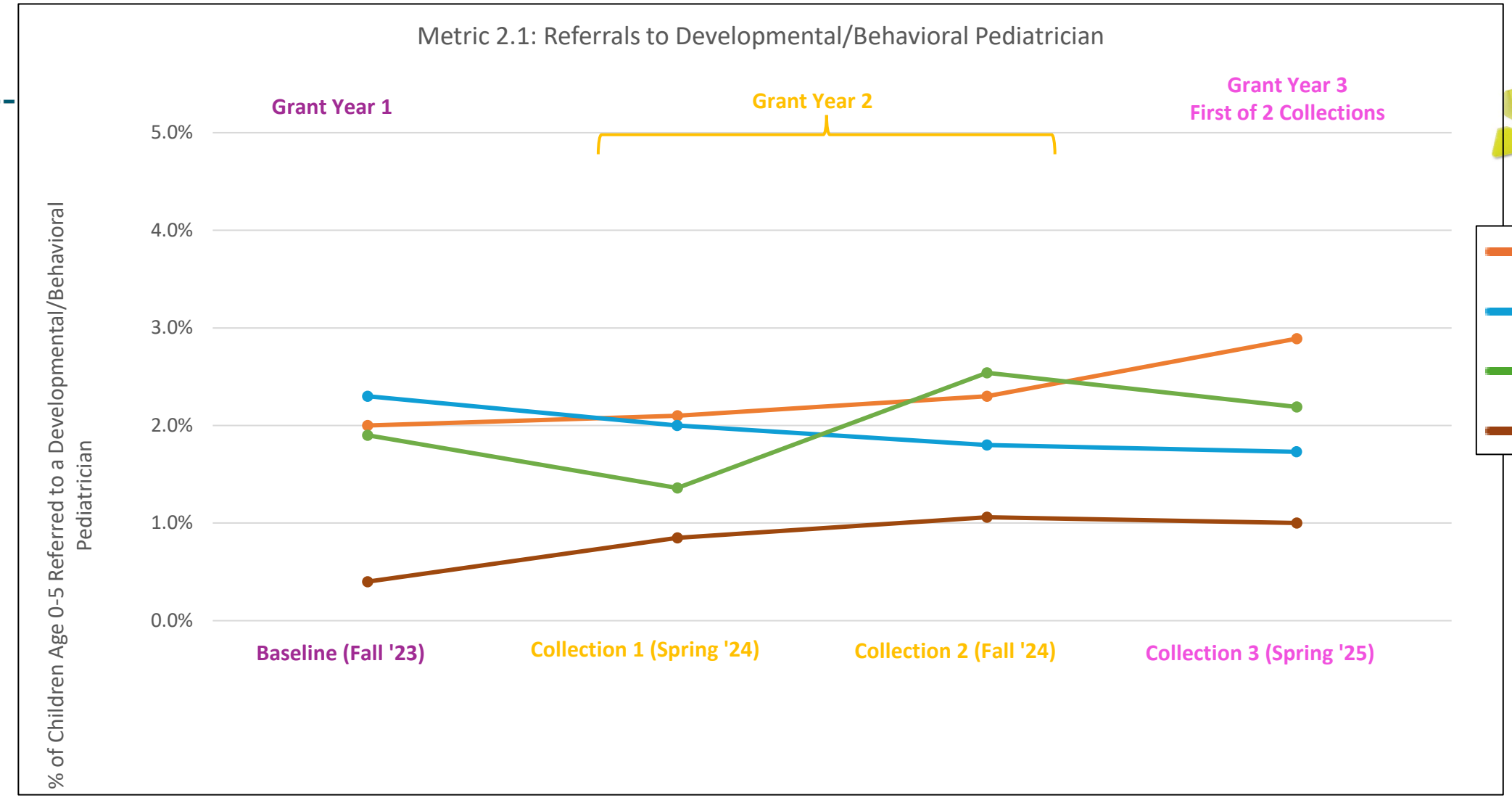
d) Metropolitan Pediatrics – Johnson Creek

e) All four sites

Additional Metrics:
Evaluation Metrics of Subaward Funds Provided to Support Increasing Referrals to External ECD Experts

Metric 2.1: Referral Rates to Developmental/Behavioral Pediatrician

Care Coordination & Linkage

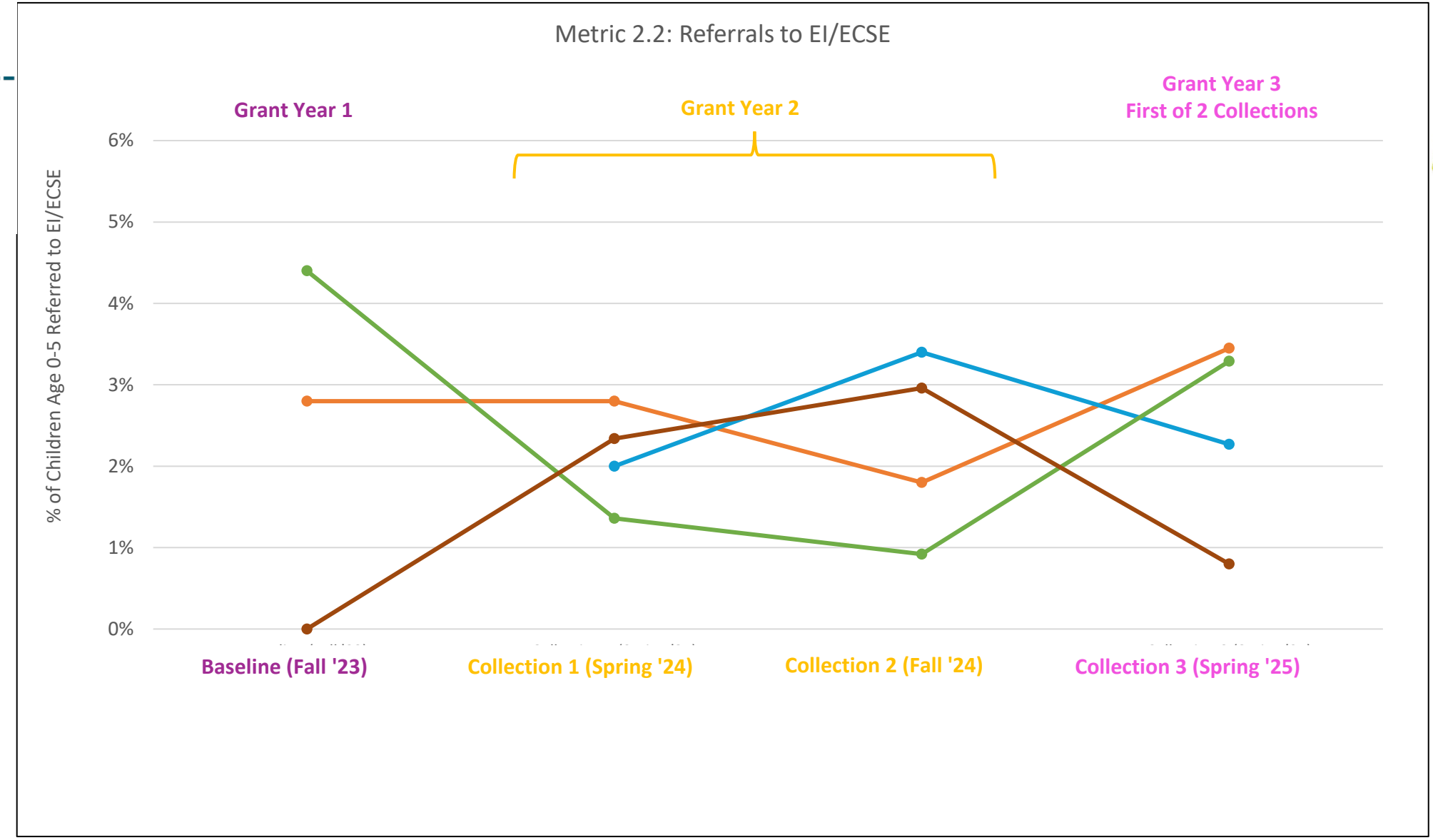


Tab 2 page 2

Measurement Periods: Baseline (1/1/23-6/30/23); Collection 1 (7/1/23-12/31/23); Collection 2 (1/1/24-6/30/24); Collection 3 (7/1/24-12/31/24).

Metric 2.2: Referral Rates to Early Intervention (EI)/Early Childhood Special Education (ECSE)

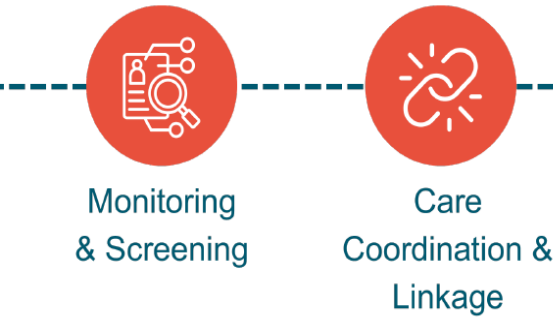
Care Coordination & Linkage



Tab 2 page 2

Measurement Periods: Baseline (1/1/23-6/30/23); Collection 1 (7/1/23-12/31/23); Collection 2 (1/1/24-6/30/24); Collection 3 (7/1/24-12/31/24).

Trivia Game! Objective 2



#9) Which sites trained their providers on a standardized follow-up decision tree to ASQ and saw an increase in best match referrals in the next six-month period?

a) Randall Children's Clinic

b) Virginia Garcia Memorial Health Clinic – Cornelius

c) Hillsboro Pediatric Clinic

d) Metropolitan Pediatrics – Johnson Creek

Trivia Game! Objective 2

#10) Which site increased the proportion of their population receiving care coordination/system navigation supports by 7% in a six-month period?

a) Randall Children's Clinic
b) Virginia Garcia Memorial Health Clinic – Cornelius
c) Hillsboro Pediatric Clinic
d) Metropolitan Pediatrics – Johnson Creek

TPEC Objective #3:

#3: Improve **ECD knowledge and competencies among pediatric primary care staff**

- We report elements of PCPCH-ECD relative to office systems and processes (already shared data with you)
- This is why we collect evaluation data after every Learning Session and IBH Webinar.
- This is why we also track trainings you within your site and of your staff.
  - A key area OPIP is open to supporting you during this last leg is on providing trainings on tools and strategies developed.

TPEC Objective #4

Objective #4: Identify and advance solutions to specific barriers to sustained and holistic ECD service delivery in primary care, such as **policy and financing barriers**, ECD **workforce** needs, **care coordination**, and **service gaps**.

- This is a routine section of monthly facilitator reports.
- Required section in your qualitative reports. This will be a big focus of the November 2025 Learning Session
- Specific areas OPIP has been working on:
  - **Work with EI/ECSE contractors on Universal Referral Form and Summary of Services**
  - **Health Share of Oregon Health Plans** payment to primary care
    - Sustainable Rates – IBH services, Well-Child Visit Rates
    - PMPMs
    - VBPs
  - **2025 Child-level CCO Incentive Metric** – Will create focus on policy and financing related to issue-focused interventions
  - **OHA/Early Learning**
    - EPSDT Coverage
    - Payment Parity
    - Primary Care Payment Reform
    - Addressing Lack of Network Adequacy in Behavioral Health; Developmental Peds
    - Addressing Gaps in EI/ECSE

Trivia Question! Objective 4

#11) Which site(s) provided public comment to OHA on the proposed 2026 Social determinants of health (SDOH) social needs screening measure specifications?

a) Randall Children's Clinic
b) Virginia Garcia Memorial Health Clinic – Cornelius
c) Hillsboro Pediatric Clinic
d) Metropolitan Pediatrics – Johnson Creek

Trivia Game: Turn In Your Answer

- An OPIP team member will pick up the sheets at the end.
- Winner will get a prize!

Photo Credit: Getty Prize 12,124

Learning Session #5 Agenda

- Welcome and Review of the Agenda
- Where We Are Now: Learnings from Qualitative and Quantitative Data
- Prioritizing Limited Remaining Time with TPEC Learning Curriculum and QI Supports to Enhance Issue-Focused Interventions and Connections to External ECD Experts: Key Area of Focus
- Small Group Action Planning: Part 1

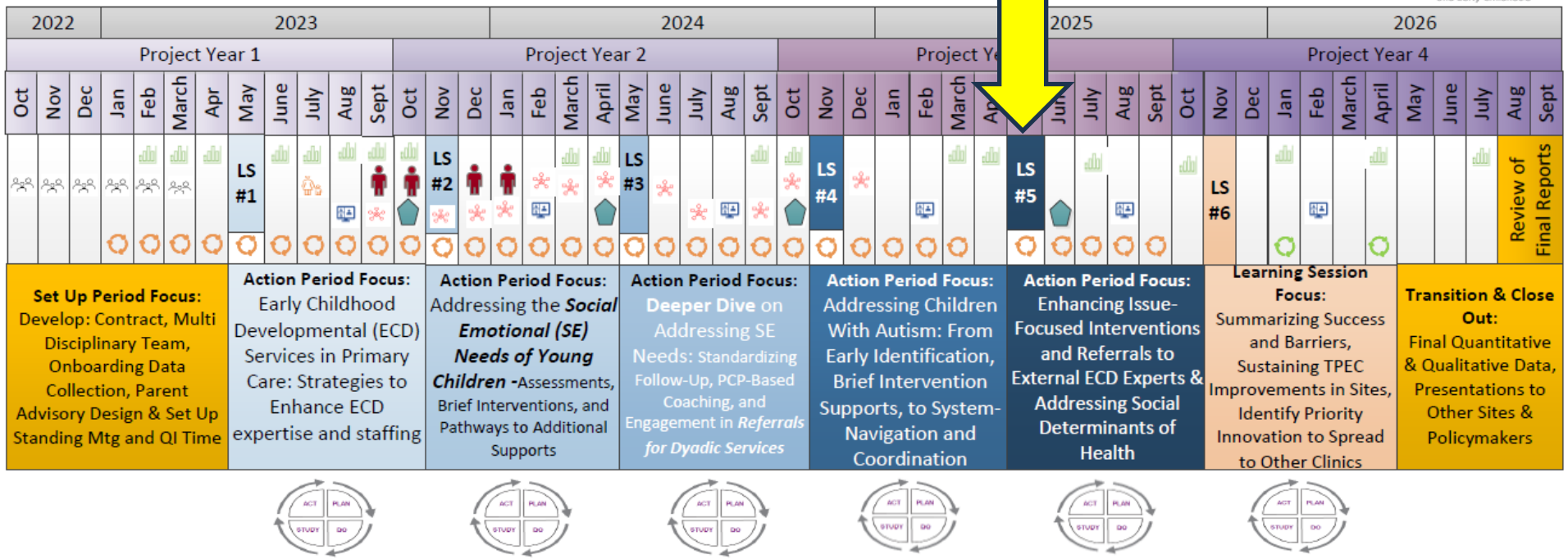
Group Picture & BREAK

Social Determinants of Health/Social Influences of Health:

- Review of OR TPEC Sites' Current Processes
- Specific Strategies to Consider When Addressing Needs
- Increasing Issue-Focused Interventions and Connections to External ECD Experts: Role SDOH May Play and Strategies to Consider
- Small Group Action Planning: Part 2
- Close Out & Next Steps

OR TPEC: We Are Nearing the Last Stretch

OREGON TPEC: Detailed Overview of the Oregon TPEC Learning Collaborative for the Four Patient-Centered Primary Care Home (PCPCH) Primary Care Sites, Six Learning Session (LS) Topics and Action Period Areas of Focus.



KEY:

- Onboarding, Engagement, Contract Development with Primary Care Site
- Evaluation Data Collection
- On-Site Practice Facilitation with Practice-Level Teams
- Check In with Sites, Qualitive ?s
- Across PCPCH Site: Webinar Supported Calls Supporting Action Plan Implementation (**Required**)
- Relevant PCPCH Site: Webinar Supported Calls Supporting ECD (Integrated Behavioral Health Staff)
- Relevant PCPCH Site: Webinar Supported Calls Supporting Continuum of ECD Services (Care Coordination, System Navigation)
- Action Periods Following Learning Session: QI approach to implementation of action plan created during Learning Session on topic area of focus and for priority population identified
- Hiring & Onboarding of Staff to Support Gaps in Early Childhood Developmental services (ECD) Functions in Practice and/or Existing Staff Training and Focus on Provision of Issue-Focused Services (Integrated Behavioral Health) and to Support System Navigation (Traditional Health Workers)

Overview of the Six Learning Sessions (LS) To Guide Action Periods:
Learning Sessions are in-person events with teams from all four sites and the Learning Session faculty (which includes subject matter experts), input obtained from parents, and where applicable advocacy groups. Didactic and peer interaction to support the application of principles of the continuum of ECD services, design implementation action plans, support learning from each, a parent-centered and parent forward approach driving and informing priority populations of focus. Post-Session evaluation data is also collected at each Learning Session.

Tab 3

Updated May 2025

Focusing Efforts & Remaining Time on North Star Metrics

Part 1: Issue-Focused Interventions

- ✓ Interventions for children with identified issues
- ✓ Conducted by persons with expertise in addressing those issues outside context of well child visits.
- ✓ For most sites, this is integrated behavioral health
- ✓ Some sites exploring role of other staff (THW, Navigator)
- Aligned with the CCO Incentive Metric: Young children receiving social-emotional issue-focused intervention/treatment services

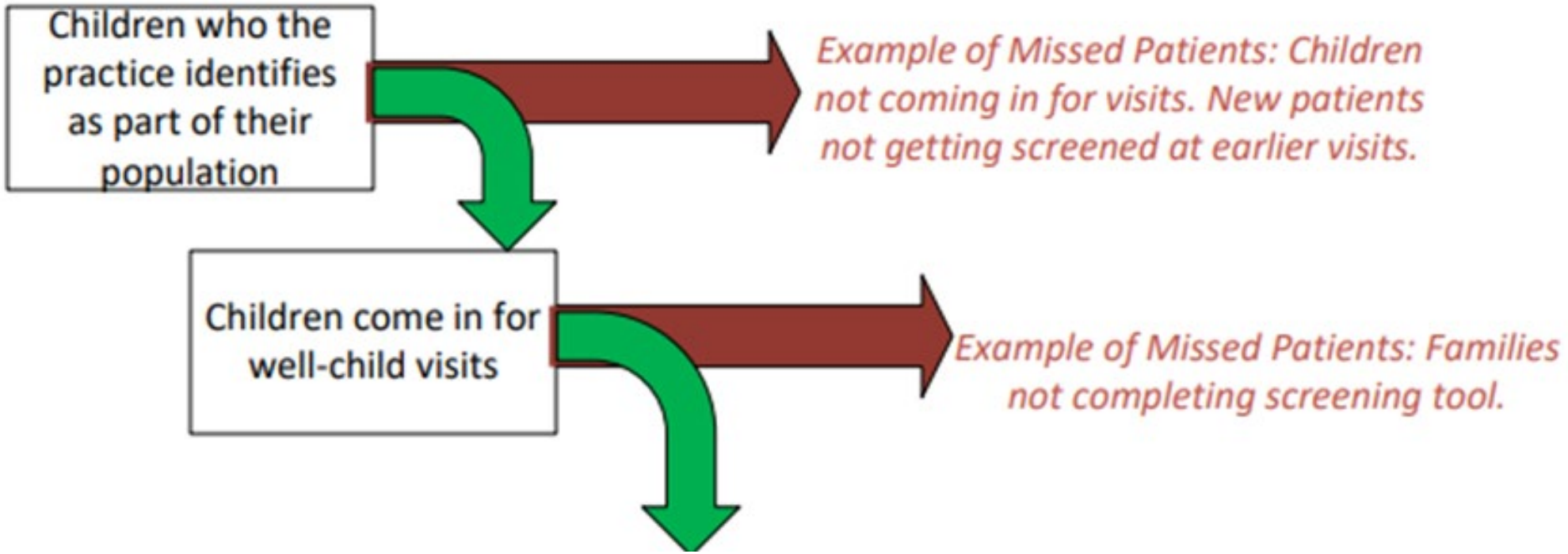
- Children (Birth to Five) that received **issue-focused interventions** from staff with ECD expertise *(Based on various data sources. Metric 3.1)*
- Children 1-5 that Received Brief Intervention/Treatment Services (*Based on Claims Data, Metric 1.4*)

Part 2: Referrals and System Navigation Supports to External ECD Experts

- ✓ Specific to priority external referrals
- ✓ Improvement efforts should focus on standardizing how to IDENTIFY people who should receive referrals

Increased Referrals To:

- **Specialty** Behavioral Health* *(Metric 2.3, *Federal evaluation metric of OR TPEC)*
- Early Intervention/Early Childhood Special Education *(Metric 2.2)*
- Medical Therapies: OT, PT, Speech *(Metrics 2.4-2.6)*


Children who the practice identifies as part of their population
Example of Missed Patients: Children not coming in for visits. New patients not getting screened at earlier visits.
Children come in for well-child visits
Example of Missed Patients: Families not completing screening tool.

Aim: Increase Well Child Visit Attendance So Services Can Be Offered

- ❑ Schedule the next well visit before families leave the office - require it as part of check out (recognizing VGMHC open access policy)
- ❑ Education for parents about recommended well visit schedule
  - After visit summary provided at each visit with schedule (i.e. table with dates)
  - Posters or flyers in waiting area with recommended schedule
- ❑ Health Maintenance Panel coordinator prioritization of the 12 months-4 years old time period
  - Call those who have not come in
  - Call “no shows” to reschedule
- ❑ EHR Modifications and enhancements
  - Automatic notifications to families
  - Flag on chart for those behind on well visits (so staff can leverage sick visits, phone calls, portal messages to encourage scheduling and address barriers)
- ❑ Scheduling
  - Offer evening or weekend hours for well visits
  - Ensure cancelled appts are rescheduled on the spot or schedule future appts
- ❑ Appointment reminders
  - Identify preferred way to get reminders – text, phone & language spoken

Aim: Increasing Children Receiving Issue-Focused Interventions

Children (Birth to Five) that received **issue-focused interventions** from staff with ECD expertise *(Based on various data sources. Metric 3.1)*

Children 1-5 that Received Brief Intervention/Treatment Services (*Based on Claims Data, Metric 1.4*)

Aim: Increase Children Receiving Issue-Focused Interventions

- ❑ Hire and retain behavioral health staff that have expertise in birth to five or can free up caseload of your current staff with this expertise
  - Ensure IBH staffing ratio aligned with standards
- ❑ Enhance appointment slots available with behavioral health for children birth to five
  - Prioritize space and appointments for birth to five
- ❑ Offer group therapy classes
- ❑ Train Traditional Health Workers (THW)/Community Health Workers (CHW) on specific issue-focused interventions
- ❑ Address children being screened, but not receiving referrals to issue-focused interventions offered within practice
  - Standardized decision trees
  - Use data to guide and target training and improvement efforts: Examine follow-up to screening
- ❑ Address families who decline services being offered
  - Shared decision-making sheet for family, parent education; THW/CHW support
- ❑ Identify targeted strategies for families where SDOH/SIOH factors create barriers to access

Aim: Increase Children Who Receive Referrals to External ECD Experts and System Navigation Supports

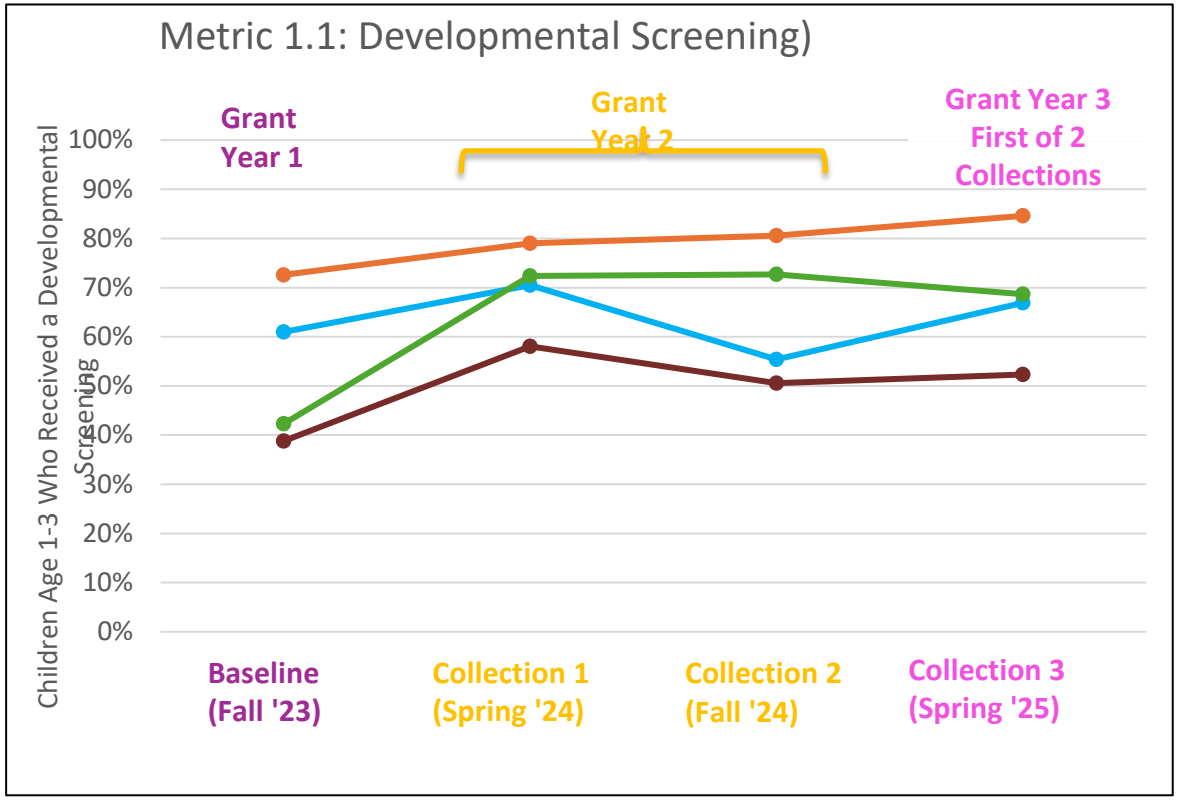
Increase Referrals To:

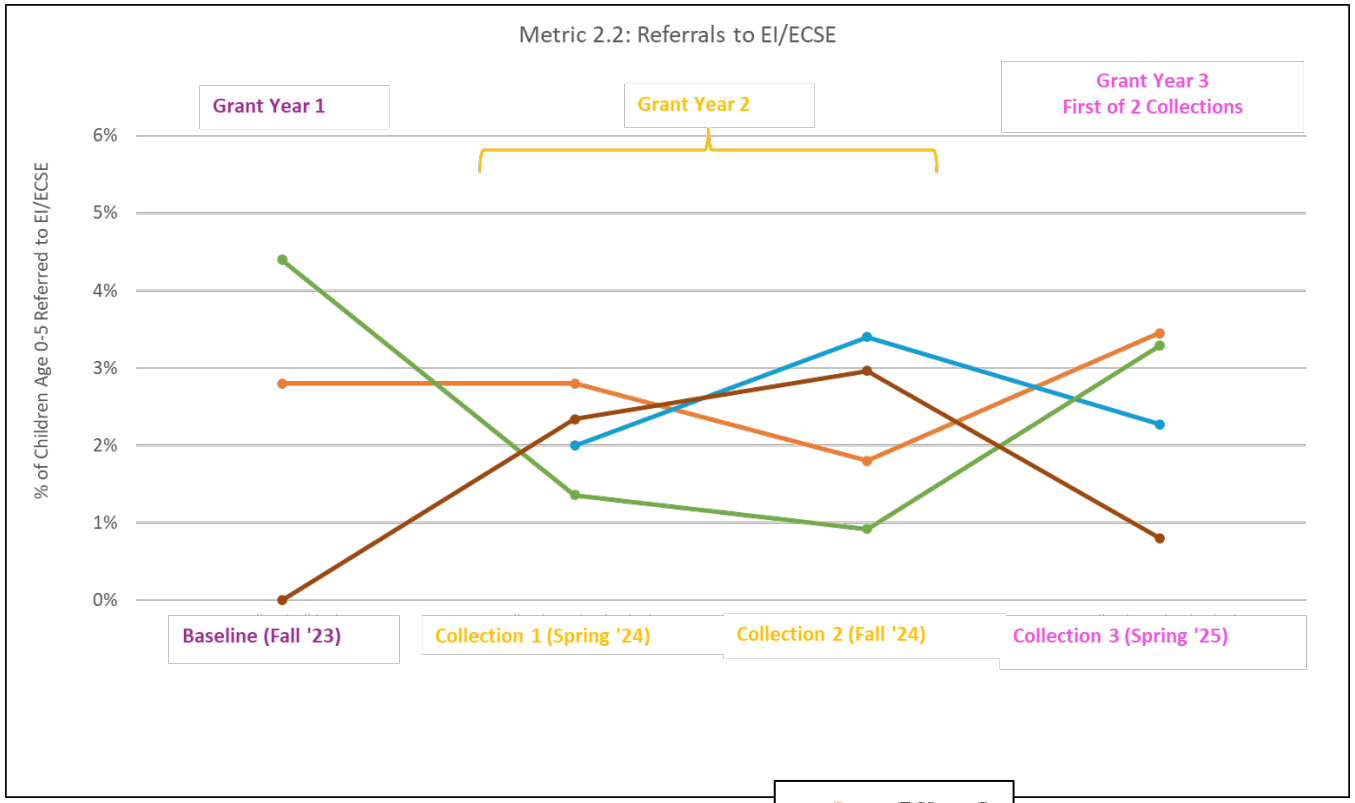
- **Specialty** Behavioral Health* *(Metric 2.3, * Federal evaluation metric of OR)*

- Early Intervention/Early Childhood Special Education *(Metric 2.2)*
- Medical Therapies: OT, PT, Speech *(Metrics 2.4-2.6)*

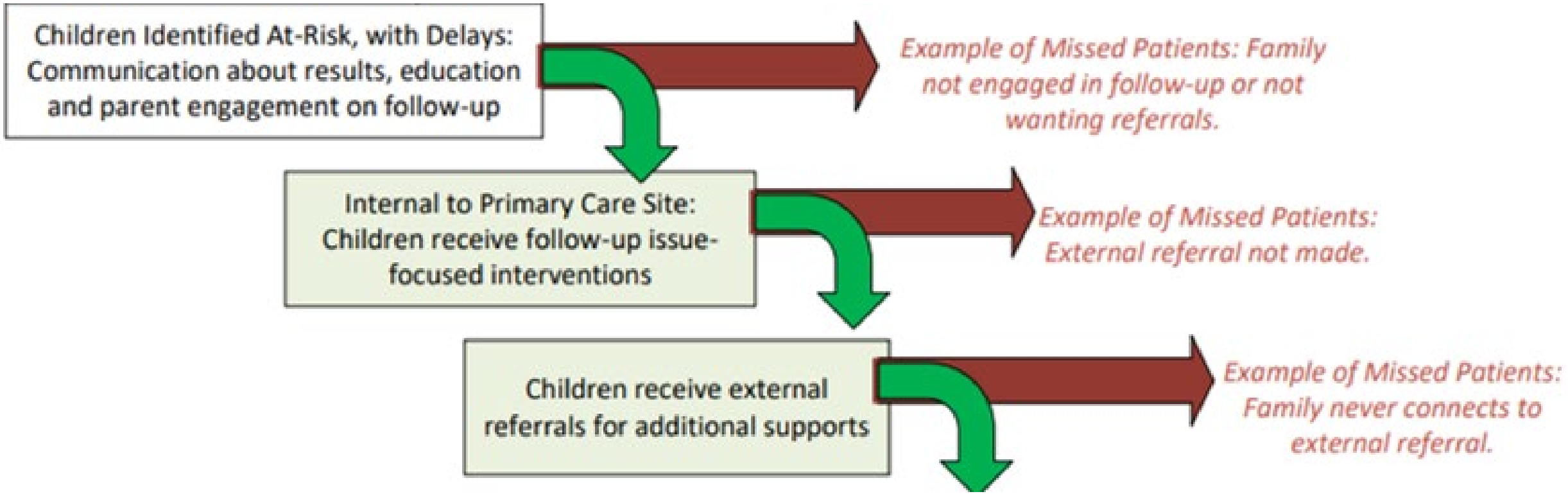
Learning from Data: Developmental Screening & EI/ECSE Referrals

Increases in <u>Screening or HIGH SCREENING Rates Alone</u> Have Not Equaled Increases in Clinically Recommended Referrals





<u>Measurement Periods</u>: Baseline (7/1/22-6/30/23); Collection 1 (1/1/23-12/31/23); Collection 2 (7/1/23-6/30/24); Collection 3 (1/1/24-12/31/24).


Children Identified At-Risk, with Delays: Communication about results, education and parent engagement on follow-up
Example of Missed Patients: Family not engaged in follow-up or not wanting referrals.
Internal to Primary Care Site: Children receive follow-up issue-focused interventions
Example of Missed Patients: External referral not made.
Children receive external referrals for additional supports
Example of Missed Patients: Family never connects to external referral.

Bridge of Supports Learning from OR TPEC Sites and Others: Sites that Support Clinical Decision Making, EHR Supports, Parent Education, and Data Tracking DO Improve

Part 2: Referrals and System Navigation Supports to External ECD Experts

Overarching Strategies:

- ❑ Address children being screened, but not receiving referrals to **external ECD** experts
  Standardized decision trees
  - Examination of follow-up data by provider
  - Provider trainings
- ❑ Standardized enhancements to the Electronic Health Record to support standardized processes for referrals to ***external*** **ECD** experts
- ❑ Address families who decline referrals being offered
  - Shared decision-making sheet with family, parent education
  - Traditional Health Worker (THW) support
- ❑ Identify targeted strategies for families where SDOH/SIOH create barriers to accept referral offered

Referrals to Specialty Behavioral Health

Metric 2.3  

- ❑ 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
  - For your region
  - For your patient demographic
- ❑ **Train providers** on external behavioral health services, what services exist externally, and how to engage families
- ❑ Develop a **standardized process** for rounding back and re-engaging families who may decline referrals

Example of a Parent Education Sheet:
OPIP developed in a project on supporting parents referred by primary care and EI to access a specialty behavioral health provider.

As part of the TPEC Supports:
OPIP staff could help to create OR TPEC site-specific versions of these if you are interested.

OREGON TPEC Transforming Pediatrics and Early Childhood

Tab 3

Parenting young children can be hard, but there are resources that can help!

Steps your Healthcare Providers will take:

1. Assess – National recommendations call for specific tools to be used to assess a child's development – such as the one you completed.

2. Talk with parents about different ways to support young children's development and services that can support parents through challenging stages.
Goals of services include:
- Improved behavior, self-control and self esteem for children
- Better relationships and reduced stress for families
- Help young children and families thrive

3. Once Referred – A scheduler will call you:
- You will be asked a few questions about your child and health care insurance
- You will book a 1.5-2 hour in-person assessment with you and your child
- If you *do not hear* from the scheduler please let your doctor know

4. Follow up with the family during and after referral process to confirm progress

What Parents Can Expect

With the support of behavioral health providers, parents can learn skills to help improve their child's behavior, leading to improved functioning at home,school and in relationships.

Parents typically attend 8 or more sessions with a therapist. Sessions may involve groups or individual families. Learning and practicing behavior therapy requires time and effort, but it has lasting benefits for the child.

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 therapy ends, 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

Positive Communication | Positive Reinforcement | Structure

Behavior therapy, given by parents, teaches children to better control their own behavior, leading to improved functioning at school, home and in relationships. Learning and practicing behavior therapy 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

Version 1.0 12/19

OPIP Edited and distributed by the Oregon Pediatric Improvement Partnership

Insights from Parent Input Sessions: Frequently Asked Questions

Questions Addressed:

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 therapist doesn’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?
9. What is the difference between a Psychiatrist, Psychologist, Social Worker, Counselor, etc?
10. Will my child be medicated?

OPIP

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.

Tab 3

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 children 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 years of age often look like play time for the child, allowing the therapist to observe their interactions with people and objects. A therapist will spend time with you and your child to learn about 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 to your child’s daily life.

Early Intervention/Early Childhood Special Education (Metric 2.2)

- ❑ Develop a parent education sheet about referrals to EI/ECSE, what to expect, and who to call if they don't get evaluated **or** are not eligible
- ❑ Develop a standardized process for children NOT evaluated with follow-up steps
- ❑ Develop a standardized process for children evaluated and NOT eligible with follow-up steps
- ❑ Develop a standardized process for children evaluated and eligible with review of the one-page summary of provided services to **determine if additional referral(s)** (e.g. supplemental medical therapies) or follow-up is needed

Referrals to Medical Therapies

Occupational Therapy (Metric 2.4), Physical Therapy (Metric 2.5), Speech Therapy (Metric 2.6)

- ❑ Identify children who have been referred for a Dev Peds evaluation and could benefit from medical therapies while they wait
- ❑ Identify children who were referred to EI/ECSE but were NOT eligible, and determine if they could benefit from medical therapies
- ❑ Develop a curated list of providers that serve specific needs

  E.g. Speech therapists that speak languages other than English

Small Group Action Planning to Prioritize Remaining Time

Note about Timing, Metric time periods and Due Dates

- Practice child-level metrics will be collected for Jan ‘25-June ’25 period, and then July-’25-December ‘25 period (Final data collection for cooperative agreement)
- Report is due in September ‘25 for review for Year 4 funds: Sites have option to present updated data for July-September ‘25

Tab 3

Action Plan Document:

- OPIP has customized this for each site.
- Use your time wisely to think about what you will do in these **six months** to increase numbers of children receiving the priority services of focus.

✓Identify supports, QI tools, Provider training supports, etc that OPIP can provide to help you be successful.

✓We will ask each site to share out key areas you plan to focus on.

Learning Session #5 Agenda

- Welcome and Review of the Agenda
- Where We Are Now: Learnings from Qualitative and Quantitative Data
- Prioritizing Limited Remaining Time with TPEC Learning Curriculum and QI Supports to Enhance Issue-Focused Interventions and Connections to External ECD Experts: Key Area of Focus
- Small Group Action Planning: Part 1

Group Picture & BREAK

Social Determinants of Health/Social Influences of Health:

- Review of OR TPEC Sites' Current Processes
- Specific Strategies to Consider When Addressing Needs
- Increasing Issue-Focused Interventions and Connections to External ECD Experts: Role SDOH May Play and Strategies to Consider
- Small Group Action Planning: Part 2
- Close Out & Next Steps

Oregon Transforming Pediatrics for Early Childhood

Learning Session #5 Agenda

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Social Determinants of Health/Social Influences of Health

As defined by the World Health Organization:

Tab 4

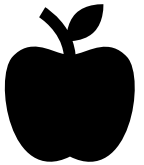
- The non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Health-related social needs are the specific social and economic needs that affect the ability to maintain health and well-being.

Social Determinants of Health/Social Influences of Health

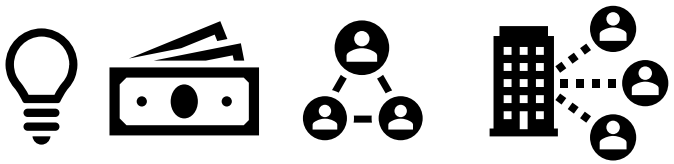
All 4 OR TPEC sites are screening for social determinants of health (SDOH)/social influences of health (SIOH) and the three domains related to Oregon Health Authority's CCO Incentive Metric on SDOH Screening and Referral:

1. Housing insecurity
2. Food insecurity
3. Transportation insecurity



Other domains asked about include:

- Utilities
- Financial hardship
- Safety
- Social connections
- Employment



OR TPEC Sites SDOH/SIOH Screening Tools: Table 1.0

Overview of SDOH/SIOH Screening Tools Used in OR TPEC Sites: Summary Table

Each OR TPEC Site is screening for Social Determinants of Health (SDOH)/Social Influences of Health (SIOH) at routine periods, and the screening tools used are included in the binder. The table below and on the following pages provides a summary of the similarities and differences in approaches used (as of March 2025).

Table 1.0: Summary of SDOH/SIOH Screening Tools Used in the OR-TPEC Sites

SDOH Screening	Randall Children's Clinic (RCC)	Hillsboro Pediatric Clinic (HPC)	Metropolitan Pediatrics: Johnson Creek (MP-JC)	Virginia Garcia Memorial Health Center (VGMHC): Cornelius
Periodicity	Form given out at 2-week visit, 1 yr, annually at well visit.	Screen at every well-visit.	Sent to families @ child's birthday (annually).	Annually, any in-person visit.
Wording at the Top of the Tool to Contextualize Why Questions are Being Asked	These questions are about needs that can affect your health. We have resources that may be of help to you. Please answer the following.	We are asking all of our patients to complete this form because having access to food, transportation, and other resources affect a person's health. Please complete this form to help us find the things that make it hard for you to take care of your/your child's health and connect you with the resources you need.	To ensure we offer the most relevant resources for your family's health, we'd appreciate it if you could answer a few questions. The following questions are related to your housing, transportation, and food availability, as problems in these areas can affect your health. The information you share here will be kept in the patient's medical record. The screening results may not be discussed at this visit, but if you indicate you'd like assistance, our Community Health Worker is available and will reach out to you to offer personalized guidance. The State of Oregon requires we provide this screening once per year, however you may choose to decline to answer.	Part of an annual verification form that includes other questions. SDOH section header: Access to food, transportation, and other basic supports affect your health. The questions below focus on this. Your answers may help us provide better medical care and we may be able to connect you with more services.
Specific Items in Tool				
Food insecurity	• Within the past 12 months, you worried that your food would run out before you got the money to buy more. (Never true, sometimes true, often true)	• Within the last 12 months, we worried whether our food would run out before we got money to buy more. (Y/N) • Within the last 12 months, the food we bought just didn't last and we didn't have money to get more. (Y/N)	• Within the past 12 months, you worried that your food would run out before you got the money to buy more. (Never true, sometimes true, often true, decline) • Within the last 12 months, the food you bought just didn't last and you didn't have money to get more. (Never true, sometimes true, often true, decline)	• Within the last 12 months, you worried that your food would run out before you got money to buy more. (often true, sometimes true, never true)

Tab 4

Screening Tools from each OR TPEC site included in binder

OR TPEC Sites' SDOH/SIOH Screening Process

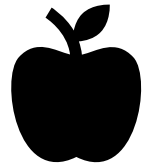
OR TPEC Site Highlights around SDOH/SIOH Screening:

- Hillsboro Pediatric Clinic, VGMHC-Cornelius, and Randall Children's Clinic ask questions around need for Utilities support (part of HRSN housing benefit and utility assistance agencies)
- Metropolitan Pediatrics-Johnson Creek asks about other family members who are Metro Peds patients to enter results into sibling charts
- Randall Children's Clinic asks questions related to safety
- VGMHC-Cornelius asks questions related to social connections

OR TPEC Sites Follow Up To SDOH/SIOH Screening

All 4 OR TPEC sites have dedicated staff to address results of SDOH/SIOH screens and help families access resources (Community Health Worker, Social Worker, Navigator, Care Coordinator)

OPIP team interviewed each OR TPEC site to understand their systems and processes related to follow-up of SDOH/SIOH screening results – **THANK YOU!!!**



- Hillsboro Peds: Shella, Marc
- Metro Peds-Johnson Creek: Heather, Tori, Carmen
- Randall Children's Clinic: Jeanette, Cat, Kendall, Christian
- VGMHC-Cornelius: Dan, Laura, Selenne, Juan

Created high-level summary of key, standardized follow-up steps based on these calls and reviewed by each site

- Each family is different and there is a lot of individualized support provided
- Process is evolving, which is exciting!

SDOH/SIOH Follow Up Steps: Table 2.0

Overview of Follow Up Summary Tables

OPIP staff interviewed each OR TPEC Site to understand their systems and processes related to follow-up to the Social Determinants of Health (SDOH)/Social Influences of Health (SIOH) screening results. Below is a high-level summary of key, standardized follow-up steps as noted by the sites based on these phone calls (as of March 2025).

Table 2.0. High-Level Summary of Data Entered into the EHR Related to SDOH/SIOH Screening and General Follow-Up Steps

High-Level Summary of Follow-Up Process	Randall Children's Clinic (RCC)	Hillsboro Pediatric Clinic (HPC)	Metropolitan Pediatrics: Johnson Creek (MP-JC)	Virginia Garcia Memorial Health Center (VGMHC): Cornelius
EHR Entry of Results and Primary Care Provider (PCP) Access of Information	MA enters SDOH screen results into EPIC flowsheet, also viewable in EHR Snapshot and Synopsis views. Therefore, multiple ways for provider to access & see in EPIC.	Provider receives paper SIOH screener to discuss during the visit with the family. MAs then input SIOH results into EHR for reference.	MA enters SDOH screen results into EPIC flowsheet, which populates flowsheet & pops up in sidebar as part of story board for provider to see.	Front desk staff enter SDOH screen results in EPIC flowsheet. Providers can see icons related to SDOH in EHR.
If families don't want to be contacted based on their SDOH Screening (if asked on the form):				
Follow Up Steps for Patients Not Wanting Contact	Paper form goes into bin that CHW picks up in the clinic.	No outreach done.	All positive screens go to CHW, who closes task if no contact desired by family. No outreach done.	Outreach to all families with positive screens given there is a not question asked about whether they want to be contacted.
	Still send resources (handouts) by text, email or MyChart			
If families DO want to be contacted based on SDOH Screening (or question not asked):				
Follow Up Steps for Patients Who DO want to be contacted	Form is given directly to Kendall/Cat. They try to meet with families during visit (warm handoff). If not possible, they follow up with families after via phone.	Provider creates referral for patient navigator.	CHW receives all positive SDOH screens then reaches out if desired.	Patients are sometimes given resource lists from front desk if positive screen received while they're still in clinic. Otherwise, MA or provider refers to patient navigator for follow-up steps.
				If a referral is received, Navigator (Dan) calls patients to schedule appointment (in-clinic, home, or phone call). Meet w/ patient to understand needs and situation.
Number of Attempts Made to Follow-Up	Call 2 times, chart in EPIC whether contact made.	Calls 3+ times & sends email.	Reaches out to families 3 times – call, text, or MyHealth.	Reaches out to family multiple times – up to 2x in a row without contact before closing.

Tab 4

SDOH/SIOH Follow Up Steps: Table 3.0

Overview of Follow Up Summary Tables

Below is a high-level summary of each sites' follow-up steps specific to the three domains of SDOH/SIOH screening that are required as part of the CCO incentive metric.

Table 3.0: Summary of follow-up related to three domains of SDOH/SIOH screening

	RCC	HPC	MP-JC	VGMHC: Cornelius
Housing insecurity follow-up				
Follow Up Steps (in order of process)	Provide list with county-specific resources and nonprofits. Support families with navigating applying for affordable housing, temporary shelters, and/or accessing housing lawyers.	N/A	N/A	Provide list of local resources (*Ex. If eviction-Community Action. If homeless–Shelters. If need short term stay–Hotels*)
	If eligible, help family fill out Health Related Social Needs (HRSN) app on Unite Us platform or apply through 211.	N/A	N/A	If community resource isn't working, support families to apply for flex funds available internally.
	If HRSN denied and eligible, support families to apply for Flex Funds. RCC has internal funding for some cases.	If eligible, helps family fill out HRSN app and apply through 211 on Unite Us platform.	If eligible, refers families to 211 on Unite Us platform to apply for HRSN.	If eligible, helps family fill out HRSN app. Has family call 211 to apply.
	Sometimes will refer to 211 for other resources (rare).	Refer to 211 broadly and to apply for HRSN for those eligible.	Refers all families to 211 even if not eligible for HRSN.	If the family is instructed to call 211, pt navigator offers to call with them, especially if there is language barrier.
Closed Loop Tracking	211/Unite Us only indicates contact with parent re HRSN app. Difficult to follow up with families to ensure services with agencies.	211/Unite Us only indicates contact with parent. Pt navigator calls family to assess if services received.	CHW tracks in Unite Us if HRSN referral has been picked up, then calls CareOregon to follow up. Calls family to confirm if resource has been provided.	Navigator calls the family to understand services received and any barriers encountered.
Food insecurity follow-up				
Follow Up Steps (in order of process)	Help families apply to SNAP & WIC if eligible.	Refer to 211 on Unite Us platform	Refer to 211 on Unite Us platform for SNAP/WIC.	Help families apply to SNAP & WIC if eligible.
	Provides curated list of local food banks/resources.	Provide Oregon Food Bank website information.	Provides list of local food banks.	Provides list of local food banks/resources & info on food pantry next door to clinic.
	Food bags and monthly free food market offered at RCC.			Deliver food if transportation is a barrier or use internal flex funds.
Closed Loop Tracking	None.	Call 211 to see if they've connected a pt or calls families directly.	Can see on Unite Us when SNAP/WIC applications have been accepted. Calls family to confirm if resource has been provided.	Talk with families.

Tab 4

OR TPEC Sites SDOH/SIOH Screening & Follow Up Processes

OR TPEC Site Learnings around **Housing** Follow Up Process:

- Housing agencies have variable requirements, funding availability, and waitlists
- Homeless shelters have limited capacity, regulations, and waitlists
- 211 Info is a good resource, but there are barriers:
  - Resource lists are limited
  - Often don't know nuances of individual agencies
  - Not as familiar with each family's needs

Strategies Implemented **by Randall Children's Clinic** and **VGMHC-Cornelius**:

- Created detailed lists of local, county-specific housing resources most often able to provide support for their patient population
  - Guide families throughout process to specific agencies depending on time of month, individual circumstances, urgency
  - Include info about affordable housing, rent assistance, legal support, shelters
- Assist in applying for CCO Flex Funds, and have internal flex funds available as well

Example of Housing Resource Sheets: Randall Children's Clinic

HOUSING

Affordable Housing

Catholic Charities
503-231-4866 | catholiccharitiesoregon.org
Offers information and referral services, short-term intervention, housing assistance, employment information, parent classes, youth groups, and mental health counseling; also provides immigration legal services.

Central City Concern
503-200-3893 | centralcityconcern.org
Provides housing, healthcare, peer support, and employment.

Home Forward
503-802-8300 | homefoward.org
Provides affordable housing and some subsidized housing in Multnomah County. Visit their website to sign up for their newsletter to be alerted when the Section 8 Housing Choice Voucher wait list opens.

Our Just Future
503-548-0200 | ourjustfuture.org
Helps families in Multnomah County gain self-sufficiency by providing affordable housing, shelter connection, utility assistance, career development, and family support services.

Relay Resources
503-261-1266 | relayresources.org
Provides affordable housing and subsidized housing in Multnomah County.

Hacienda CDC
(503) 961-6432 | haciendacdc.org/residential
Provides affordable housing, subsidized housing, home ownership support, small business services, and youth and family services.

Northwest Housing Alternatives
503-655-8575 | nwhousing.org
Connects families in Clackamas County to an array of housing services such as the Annie Ross Housing Service, Pathways Housing, and affordable housing properties.

Community Partners for Affordable Housing
503-293-4038 | cpahoregon.org
Offers affordable subsidized housing programs throughout Washington County as well as housing stabilization.

Rent Assistance

Catholic Charities
503-231-4866

Community Action
503-615-0770
For Washington County residents

Impact NW
503-294-7400

SEI
503-713-5590

St. Vincent de Paul, Portland Council
503-235-8431

El Programa Hispano Catalico
503-489-6809

Urban League
503-280-2600

NAYA
503-288-8177

Bienestar
503-988-3509

IRCO
503-234-2048

HRSN Housing Benefit
503-468-5375 | healthshareoregon.org/members/my-health-plan/hrsn-benefits
This benefit through your health insurance CCO can provide rental assistance, utility assistance, storage assistance and home modifications for health and safety needs. *Must have a clinical health need related to the request* and meet requirements as stated on application website above.
If requesting rental assistance, you will need a copy of your rental agreement/lease and if requesting utility assistance, you will need a copy of your utility bill to submit with the application.

HOUSING

Housing Legal Support

If you have received a court date for an eviction, there are sometimes organizations outside of the courthouse who provide emergency rental assistance. Go early and ask around.

ResolutionsNW
503-595-4890 | resolutionsnorthwest.org
Provides landlord/tenant mediation to help resolve conflict outside of court for issues like past-due rent, housing discrimination, infestation, mold remediation, etc.

Legal Aid Services of Portland
503-224-4086
Free legal representation for eviction court. Serving Clackamas, Hood River, Multnomah, Sherman, and Wasco counties.

Oregon Renter's Rights
oregonrentersrights.org/handbooks
Provides information, guidance, and letter templates for your rights as a renter. Can help with repair requests, infestation requests, and mold remediation.

Shelters

Coordinated Access
2-1-1 | 211.org
Helps place people and families into shelters and/or supportive housing programs if you are currently unhoused. To be placed on the Coordinated Access Family Housing Wait List or the Family Shelter Wait List you must complete a phone assessment by calling 2-1-1. Each County has their own wait list, and families are prioritized in order of need.

Bybee Lakes
971-333-5070
helpinghandsreentry.org/bybee-lakes-hope-center
This individual and family shelter offers emergency shelter for up to 30 days. You can submit a referral with a partner agency by calling the number above. Families are accepted as beds are available.

Family Promise of Metro East
503-753-3960
familypromisemetroeast.org
This shelter serves families with dependent children under the age of 18 and moves to a different church each week. You can fill out a wait list application at the website above.

American Red Cross
503-528-5947 | redcross.org/cascades
3131 N Vancouver Avenue | Portland, OR 97227
Provides shelter for families who must leave their home due to a disaster or emergency.

Community Action
503-648-6646 | caowash.org
1001 SW Baseline Street | Hillsboro, OR 97123
Provides emergency shelter and short-term rent assistance. Other services include childcare resources and referrals, parenting education, and food/energy assistance. Available to all residents of Washington County.

My Father's House
503-492-3046 | familyshelter.org
5003 W Powell Blvd | Portland, OR 97030
Provides shelter for up to 28 families. Aims to reclaim at-risk homeless families from street life by providing them with the life skills necessary to become permanently independent. Also provides food and clothing to residents.

Sustainability of SDOH/SIOH Screening and Supports

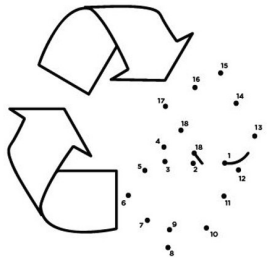
Each site has processes supporting families with health-related social needs and supporting social factors

Financial sustainability of this time-intensive work could come from:

- Billing of services
  - Screening
  - Services to connect
- Alternative Payments
- Value based payments tied to metrics:
  - Example: Oregon Health Authority (OHA) Incentive Metric

SDOH/SIOH Billing and EHR Documentation: Table 4.0

To help connect the dots on sustainability, OPIP created this table:



Tab 4

Table 4.0: Billing and EHR Documentation

Below is a summary of whether each OR TPEC site is billing for Social Determinants of Health (SDOH)/Social Influences of Health (SIOH) screening and follow-up services and then if there is searchable documentation in Electronic Health Record (EHR) to indicate positive screen results. (Updated April 2025)

Table 4.0 Summary of OR TPEC Sites Billing and Electronic Health Record Documentation Related to SDOH/SIOH				
	Randall Children's Clinic	Hillsboro Pediatric Clinic	Metropolitan Pediatrics: Johnson Creek	Virginia Garcia Memorial Health Center Cornelius
Submitting Claims for SDOH/SIOH Screening				
Are claims submitted for SDOH/SIOH screening?	Yes (CPT code 96160)	No	No	No
Are screening claims reimbursed?	RCC is examining if paid.	N/A	N/A	N/A
Documentation of positive screens in EHR				
Are positive results put on the problem list? What are the diagnoses put on list?	No	"SIoH Screening" added under diagnosis.	No	No
Are positive results otherwise searchable in EHR?	Yes, positive results are entered into flowsheet and viewable in Snapshot and Synopsis, which is searchable.	Yes, under Social History, results (both negative and positive) are posted.	Yes, entered into flowsheet, populates story board.	Yes, entered into flowsheet, visible as an "icon".
If you are billing when you meet with family for SDOH/SIOH needs and services, what diagnostic code is used?	• Primarily use the diagnosis code: "Encounter for screening involving social determinants of health [Z13.9]" when meeting with a family regarding a positive SDOH screen. • Use more specific diagnosis codes such as "housing instability [Z59.819]", "food insecurity [Z59.41]" and "transportation insecurity [Z59.82]" if ongoing support to family.	N/A	N/A	N/A
Are these services reimbursed?	Yes, but not at full rate billed.	N/A	N/A	N/A
Payment policies				
Is SDOH/SIOH screening currently included as a VBP in contracts? (Meaning you are incentivized to meet a screening rate threshold)	No requirement specific to screening or rate. Global area within CHW PMPM is demonstrating a process for addressing health-related social needs.	General expectation, reporting, but no VBP tied to a rate.* (HPC is checking contract language)	Yes, however payment is reporting and not meeting a screening threshold.	Yes
Is use of Connect Oregon/Unite Us included in your contract? (Meaning you are incentivized to use Connect Oregon/Unite Us)	No	HPC is checking contract language.	Yes	No

Learning Session #5 Agenda

- Welcome and Review of the Agenda
- Where We Are Now: Learnings from Qualitative and Quantitative Data
- Prioritizing Limited Remaining Time with TPEC Learning Curriculum and QI Supports to Enhance Issue-Focused Interventions and Connections to External ECD Experts: Key Area of Focus
- Small Group Action Planning: Part 1

Group Picture & BREAK

Social Determinants of Health/Social Influences of Health:

- Review of OR TPEC Sites' Current Processes
- Specific Strategies to Consider When Addressing Needs
- Increasing Issue-Focused Interventions and Connections to External ECD Experts: Role SDOH May Play and Strategies to Consider
- Small Group Action Planning: Part 2
- Close Out & Next Steps

Health Related Social Needs Benefit

Oregon Transforming Pediatrics in Early Childhood Learning Collaborative

May 8, 2025

Introductions

Maureen Seferovich – Program Manager, Health Systems Integration, Health Share of Oregon

Kaely Summers— Social Health Specialist, CareOregon

Learning Objectives for Today

- Define the new Health Related Social Needs housing and nutrition benefits
- Understand who might qualify for the benefits
- Learn about the referral flow for these benefits

HRSN Housing Benefits

Eligibility & Scope

Housing Benefit Eligibility

OHP

Is a current OHP Member

Life Transition

- Individuals involved with the **child welfare system**
- People experiencing **homelessness**
- People who are **at risk of homelessness**
- Adults and youth released from **incarceration** within the past 12 months
- Adults and youth discharged from an HRSN eligible **behavioral health facility** within the past 12 months
- Individuals transitioning to dual status (**both Medicaid and Medicare coverage**)
- Young adults ages **19-26 with special health care needs**

For Housing Stability eligibility

Social and Clinical Health Need

Has a social health need
(food, housing, climate)

&

Has a clinical health need

Examples:

- Age (under 6, over 65)
- Complex physical health needs
- Complex behavioral health needs
- Developmental disability
- Pregnancy
- Needs assistance with ADLs

OREGON TPEC Transforming Pediatrics and Early Childhood

Tab 5

Housing Stability Benefits

Supports	Eligibility Requirements
• Rent assistance for up to 6 months (past due or future due) • Utility assistance for up to 6 months (past due or future due) • Utility set up fees • Storage fees for up to 6 months • Tenancy support	✓ Currently housed ✓ Needs support staying in current housing ✓ Is a renter and has a written rental agreement ✓ Has an income that is 30% or less than the area median income where the individual resides ✓ Lacks resources to prevent homelessness ✓ Has a qualifying clinical health need

health share
Health Share of Oregon

CareOregon

Home Safety & Health Benefits

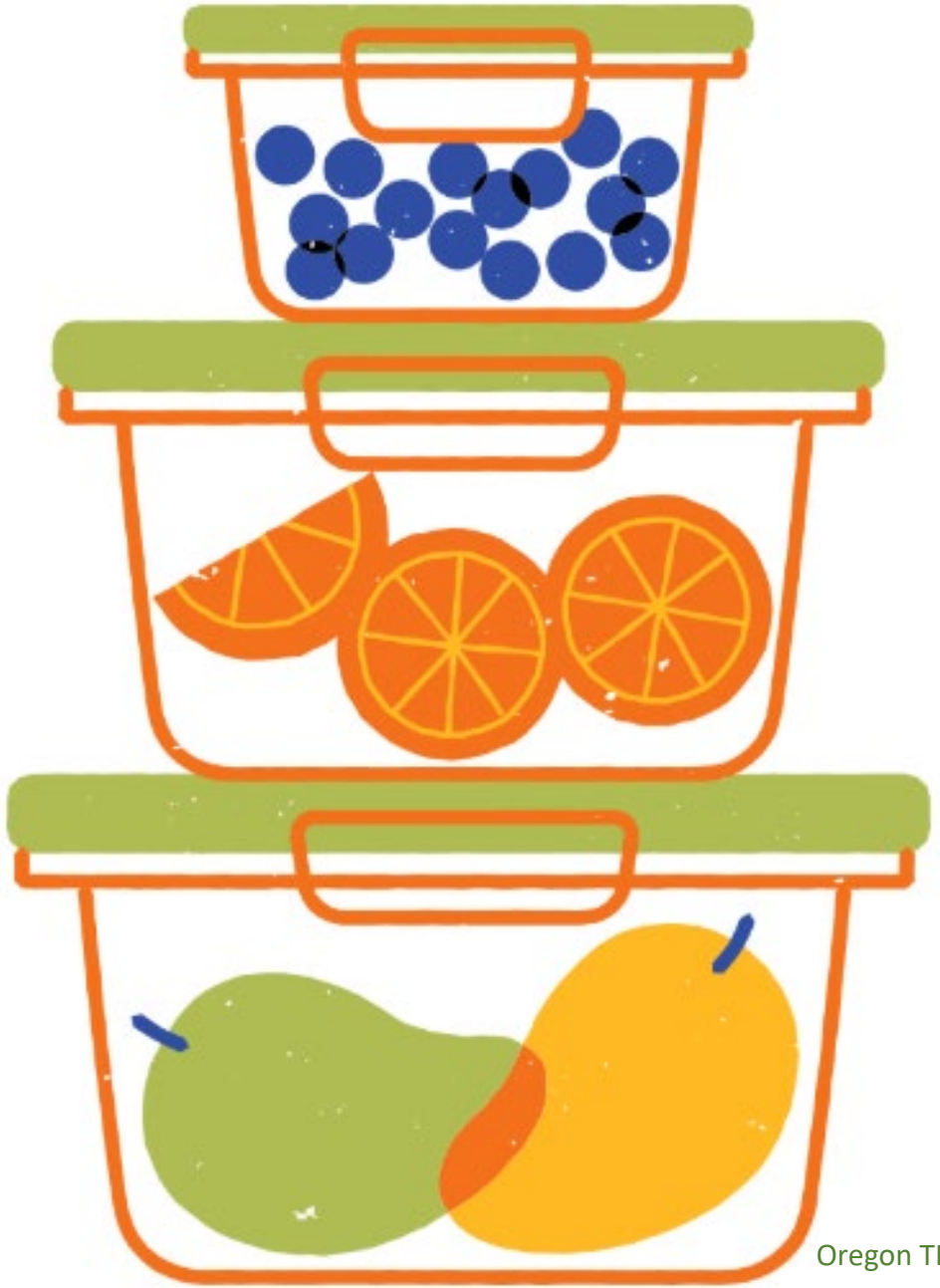
Supports	Eligibility Requirements
• Wheelchair ramps • Grab bars • Drawer pulls • Deep cleaning • Pest eradication • Installing window blinds • Hotel/motel stays **if** relocation is needed during home modifications	✓ Currently housed ✓ Experiencing an eligible life transition ✓ Has a qualifying clinical health need that requires changes to current housing for safety ✓ For renters, landlord approval is required

health share
Health Share of Oregon

CareOregon

HRSN Nutrition Benefits

Eligibility & Scope



Nutrition Benefit Eligibility

OHP + Life Transition + Social & Clinical Health Need

Is a current OHP Member

Life Transition

- Individuals involved with the **child welfare system**
- People experiencing **homelessness**
- People who are **at risk of homelessness**
- Adults and youth released from **incarceration** within the past 12 months
- Adults and youth discharged from an HRSN eligible **behavioral health facility** within the past 12 months
- Individuals transitioning to dual status (**both Medicaid and Medicare coverage**)
- Young adults ages **19-26 with special health care needs**

Social & Clinical Health Need

Be experiencing low or very low food security

&

Has a clinical health need

- Age (under 6, over 65)
- Complex physical health needs
- Complex behavioral health needs
- Developmental disability
- Pregnancy
- Needs assistance with ADLs

Medically Tailored Meal

- Health condition identified in the OHP Prioritized List, for which Medical Nutrition Therapy (MNT) is an indicated treatment

health share
Health Share of Oregon

CareOregon

Qualifying Health Conditions for Birth-to-5

Examples of diagnoses from the OHP prioritized list, for which Medical Nutrition Therapy (MNT) is an indicated treatment:

- Low birth weight; prematurity
- Galactosemia
- Phenylketonuria (PKU)
- Epilepsy and febrile convulsions
- Metabolic disorders
- Neurologic dysfunction in eating, swallowing
- Nutritional deficiencies
- Cleft palate and/or cleft lip
- Feeding/eating disorders of infancy or childhood
- Type 1 diabetes mellitus
- Intestinal malabsorption
- Obesity in children
- Chronic kidney disease
- Liver transplant
- Cardiomyopathy, Myocarditis

Current Nutrition Benefits

Assessment for Medically Tailored Meals

- Conducted with a PCP or RD
- Develop a nutrition care plan highlighting the need for MTMs

Prerequisite for MTM

Medically Tailored Meals

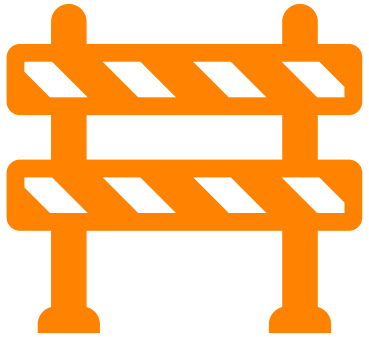
- Meals tailored to support a member's health condition and overall well being
- Includes up to 3 meals/day
- Meals are prepared and delivered either fresh or frozen

Nutrition Education

- 1:1 nutritional counseling or group education class
- Meal preparation education is also included
- May be provided one-time or on a recurring basis

Members cannot receive medically tailored meals and nutrition education at the same time

Fruit and Vegetable (FV) + Pantry Stocking TBD



- F&V Benefit could be launched anytime between Oct. 2025 and July of 2026
- Anticipated volume of requests: ~250,000 Members may utilize the benefit across the state for the duration of the waiver (thru Sept. 2027)
- Members can request support at anytime during the year, not limited to the growing season
- Rate includes the provision of fruits & vegetables, delivery, and packaging
- Pantry Stocking, expected to launch in 2026, will be administered by OHA through an EBT Card

Request Process

Requests can be submitted independently by the member or with the assistance of a provider

Request submitted with member information

Requests accepted through:

- Digital form
- PDF form
- Via 211
- Unite Us referral
  - *if being assisted by provider who has access*

Initial eligibility reviewed by 211info

- 211info collects required documentation and ensures it is represented in Unite Us

CareOregon reviews criteria and makes authorization decision

- Clinical Operations and Navigation team review and follow up with members as needed

If authorized, info is shared with member/provider to initiate service

- Respond to referral within 3 days
- If accepted, begin services <30 days

Receiving Referrals & Initiating Services

Once authorized, a member's request is sent to the HRSN provider as a referral

HRSN provider closes the referral loop by responding to the referral (must respond within 3 business days)

If accepted, HRSN provider begins providing services as quickly as possible (must begin services within 30 days)

HRSN provider updates case status once member begins engaging in services

After service is completed, HRSN provider updates case outcome

Benefit Timeline Expectations

Current situation: We have received a high volume of requests since benefit launch. This is causing delays in turnaround times for initial review.

Please keep in mind:

- It can take several weeks to review, process, and deliver HRSN benefits.
- These benefits are not designed to respond to emergency needs.
- The approval timeline might not meet the needs of members who have an urgent need.

Required Documents

Tab 5

Housing (Rent)

- *Complete HRSN request form
- *Signed rental agreement or lease
- *Proof of amount owed for past due rent, if applicable
- W9 from landlord, if available at time of request
- Eviction notice, if applicable

Housing (Utilities)

- *Complete HRSN request form
- *Utilities bill(s) with member's name listed or submit proof of address if name is not included, ideally itemized bills with clear service dates*
- Utilities shut off notice, if applicable

Nutrition

- *Complete HRSN request form
- *Medically Tailored Meal Assessment, if requesting this service

Items with an * are required to process an HRSN request

Unite Us/Connect Oregon

The Connect Oregon/Unite Us platform is being used to process HRSN Requests

Purpose:

- Support initial housing requests
- Share information between 211info and CareOregon
- Send referrals to HRSN providers

Benefits:

- Better protection of members' health information while sharing across organizations

For Users with a Unite Us Login:

- Can send request within the platform
- Allows for visibility into the member’s HRSN services journey

For Users without a Unite Us Login:

- Submit HRSN requests to 211info using the digital request form or PDF form

Housing and Nutrition Referral Pathways

- Health Share is partnering with CareOregon to administer the HRSN Housing and Nutrition Benefit on behalf of all Health Share plan partners.
- Health Share members will complete an initial eligibility form to request the benefit. Details can be found here.
- Members can submit this form themselves or can work with 211info, their provider, Customer Service or a community-based organization for support.
    - Methods for submitting an eligibility form include:
        - **Digital form:** Members can make a request using the digital form (embedded in Unite Us)
        - **PDF form:** Members, providers, or community-based organizations can complete the fillable PDF form and submit it to 211info for processing through email at hrsn@211info.org or fax at 503-214-8909. **Housing request form posted here**
        - **Over the phone:** Members can call 211info at 866-698-6155 for help with completing the HRSN request.

Referrals through Unite Us

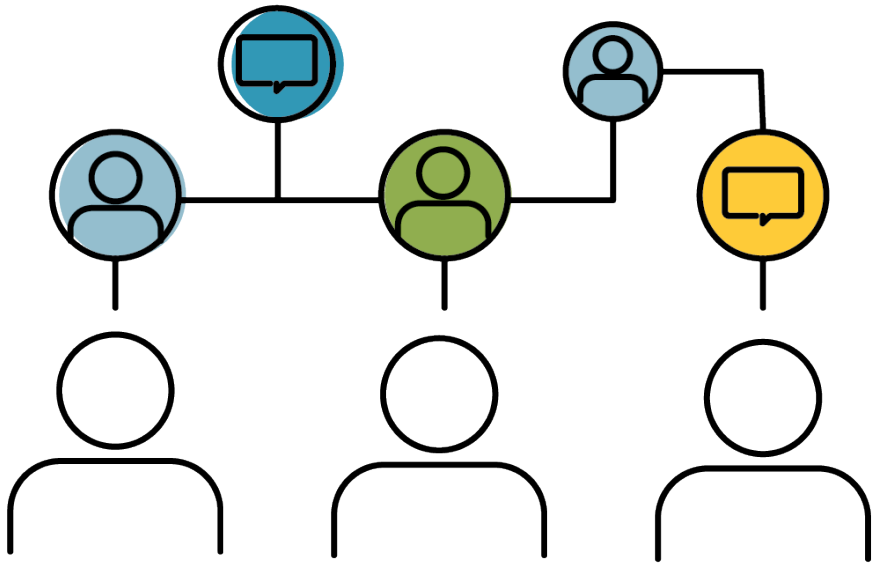
Once logged into Unite Us:

1. Click **Browse Resources for Client** from the Client Face Sheet.
2. Select the service type:
    i. Select **Benefits Navigation - Benefits Eligibility Screening.**
3. Search for **211info Coordination Center - HRSN Requests**
    i. Select the program: **HRSN Services Benefits Eligibility Screening**
4. Complete the referral description and indicate any relevant information based on the member's request.
    i. Upload applicable documentation.
5. Complete the **HRSN Request Form: Climate/Housing/Nutrition**.
6. Review referral information and click **Confirm and Submit.**
7. To check on the status of the request afterwards, navigate to the "referrals" tab on the client's face sheet.

Helpful Website Links

- OHA's HRSN Guidance Document
- OHA's HRSN Provider webpage
- Connect with Health Share at:

  socialhealth@healthshareoregon.org



Questions?

Thank you

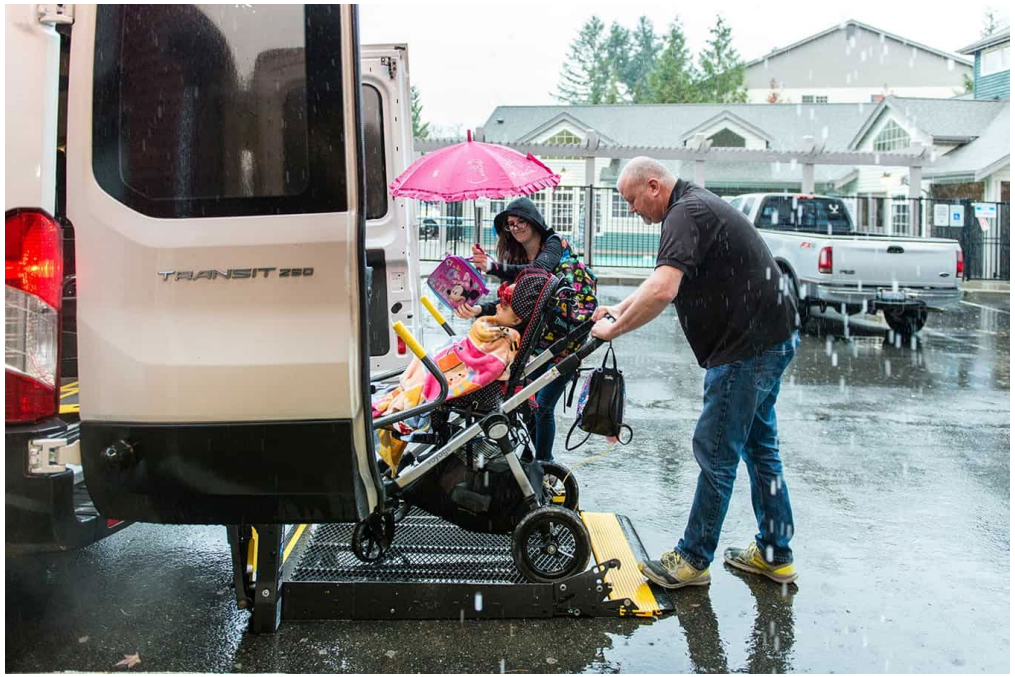
Non-Emergent Medical Transportation

Travel paid by Oregon Health Plan to get members to and from healthcare services.

Specific service provider depends on CCO and region

Transportation services include:

1. Public transit
2. Vehicle-provided rides
3. Mileage reimbursement



Non-Emergent Medical Transportation

Ride to Care is the local ride service through Health Share of Oregon

- All 4 OR TPEC sites guide families to Ride to Care when there are transportation needs for Health Share of Oregon members
- Requires screening process by Ride to Care Customer Service
- Some barriers noted by each TPEC team, will share back in June webinar call

Ride to Care provides free non-emergent (not for an emergency) medical transportation, or NEMT. NEMT is a benefit for eligible Health Share of Oregon members. NEMT gets you to health care visits that Health Share pays for. The visits could be to a doctor, dentist, mental health counselor or other provider. Our service area is Clackamas, Multnomah and Washington counties.

Mileage Reimbursement – Share Out from Randall Children's

- **The mileage reimbursement programs that we refer our families to are through their OHP CCO transportation benefit**
  - Each CCOs' programs vary slightly:
    - OHP Health Share members use Ride To Care who pays $0.70/mile
    - OHP Trillium members in Multnomah, Washington and Clackamas county use Medical Transportation Management (MTM) who pays $0.44/mile
    - All other OHP members (Open Card) in Multnomah, Washington and Clackamas County use TriCounty MedLink who pays $0.46/mile

- For each company, families call their specific medical transportation line to set up an account and receive a debit card

Mileage Reimbursement – Share Out from Randall Children's

- Families call same number to report and get approval for all the medical trips in advance (if possible), providing information about the appointment, locations, purpose of visit
- Member is reimbursed within 14 days by money being loaded onto debit card
- Can drive self or have someone else drive to services
- Can reimburse travel expenses for eligible healthcare services outside tri-county area (mileage, meals, lodging)

**This benefit can be used to attend medical, dental, mental health, pharmacy, and WIC appointments.

Helpful Link: Health Share of Oregon Ride to Care Reimbursement Guide

June Webinar with OR TPEC Staff Working on SDOH/SIOH

- Date and Time: June 11th, 11:00 am

Agenda

- Share information provided today to the larger group of staff in your office
- Time for questions
- Space for OR TPEC sites to share learnings on barriers related to Ride to Care (NEMT)

Learning Session #5 Agenda

- Welcome and Review of the Agenda
- Where We Are Now: Learnings from Qualitative and Quantitative Data
- Prioritizing Limited Remaining Time with TPEC Learning Curriculum and QI Supports to Enhance Issue-Focused Interventions and Connections to External ECD Experts: Key Area of Focus
- Small Group Action Planning: Part 1

Group Picture & BREAK

Social Determinants of Health/Social Influences of Health:

- Review of OR TPEC Sites' Current Processes
- Specific Strategies to Consider When Addressing Needs
- Increasing Issue-Focused Interventions and Connections to External ECD Experts: Role SDOH May Play and Strategies to Consider
- Small Group Action Planning: Part 2
- Close Out & Next Steps

Role SDOH/SIOH May Play in North Star Metrics

- Increase Well Child Visit Attendance So Services Can Be Offered

- **Part 1: Issue-Focused Interventions**

Children (Birth to Five) that received **issue-focused interventions** from staff with ECD expertise *(Based on various data sources. Metric 3.1)*

Children 1-5 that Received Brief Intervention/Treatment Services (*Based on Claims Data, Metric 1.4*)

- **Part 2: Referrals and System Navigation Supports to External ECD Experts**

Increased Referrals To:

Specialty Behavioral Health* *(Metric 2.3, *Federal evaluation metric of OR)*

Early Intervention/Early Childhood Special Education *(Metric 2.2)*

Medical Therapies: OT, PT, Speech *(Metrics 2.4-2.6)*

Considering SDOH/SIOH and Impact on **Well Child Visits**

- ❑ Flag charts of children with SDOH/SIOH needs to reach out a month before scheduled well child visit to confirm availability and offer supports (i.e. with transportation)
- ❑ Health Maintenance Panel Coordinator prioritization of children with SDOH/SIOH needs identified in past
  - Call those who have not come in to schedule and connect them with CHW/navigator if family needs and desires SDOH/SIOH support
  - Call “no shows” to reschedule and connect them with CHW/navigator if family needs and desires SDOH/SIOH supports
- ❑ Scheduling considerations for children with SDOH/SIOH needs
  - Offer evening or weekend hours for well visits
  - Ensure cancelled appts are rescheduled on the spot or schedule future appts
  - Incorporate scheduling needs based on transportation or other barriers
- ❑ Other (Your Idea)

Considering Role SDOH/SIOH May Play in Children Receiving Issue-Focused Interventions OR Accepting Referrals from External ECD Experts

- ☐ Add to standardized decision trees a flag to review whether an SDOH/SIOH need was identified. *Example: If child identified at-risk on ASQ, additive factors of SDOH/SIOH need and the impact it can have on development should be indicator for EI/ECSE referral*
- ☐ Round back to parents of children identified with delays who decline referrals two months later to check in about their interest and offer supports
- ☐ Consider huddles including providers and CHW/navigators to discuss specific patients with SDOH/SIOH needs and to strategize how to help families access issue-focused interventions and referrals
- ☐ Consider provision of food box/coupon/other resources at time of brief intervention visit to add value to visit
- ☐ Consider group classes that also offer food for parents
- ☐ Other (Your Idea)

Part 2 of Small Group Action Planning to Prioritize Your Time

Action Plan Document: Tab 3

- Any process updates based on information provided today?
- Factors to consider in providing Issue-Focused Interventions
- Factors to consider with referrals to External ECD Experts

Learning Session #5 Agenda

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Group Picture & BREAK

Social Determinants of Health/Social Influences of Health:

- Review of OR TPEC Sites' Current Processes
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The Next Six Months!

Oregon TPEC Action Period #5: Enhancing Issue-Focused Interventions & Referrals to External Early Childhood Development (ECD) Experts & Addressing Social Determinants/Influences of Health

Virginia Garcia Memorial Health Center - Cornelius - Activities: May 2025 – November 2025

Tab 6

2025						
Project Year 3					Project Year 4	
May	June	July	August	September	October	November
Learning Session #5 **May 8th** **8-12 PM PST** **Site Visit:** 5/13/25 1:00-2:00PM	**Action Period:** QI Implementation **Site Visit:** 6/17/25 1:00-2:00PM **On Zoom** **Webinar on HRSN Benefits, Feedback to Ride to Care** 6/11/25 11-12PM	**Action Period:** QI Implementation **Site Visit:** 7/8/25 1:00-2:00PM **Practice-level, Child-level Data (Claims, EHR Counts)**	**Action Period:** QI Implementation **Site Visit:** 8/12/25 1:00-2:00PM **Across TPEC Sites Webinar** 8/6/25 12:30-2PM (Required)	**Action Period:** QI Implementation **Site Visit:** 9/9/25 1:00-2:00PM **Deliverables Due for Both Subawards (9/30)** If approved, Invoices Due	**PCPCH-ECD Data Collection at Site:** 10/14/25 1:00-2:30 PM	**FINAL Learning Session #6** **November 6th** **8-12 PM PST**

KEY:

- Action Period: QI Implementation
- On-Site Practice Facilitation with Practice-Level Teams: **Site Visit**
- Across Sites TPEC Webinar: August 6th Webinar: 12:30-2PM PST
- Community Health Worker (CHW)/ Patient Navigator/Care Coordinator Call on HRSN Benefits, Feedback to Ride to Care
  - 6/11/25 Webinar 11-12PM
- Evaluation Data Collection
- Deliverables Due for Two Subawards (*Example for Subaward Supporting Issue Focused Interventions/Referrals: Qualitative Report of Activities/Learning Barriers, Summary of Quantitative Changes in Required Metrics, Updated Staffing & Resource Plan*); If Deliverables Approved, Invoices Submitted.

Action #5 Period Focus:
Enhancing Issue-Focused Interventions and Referrals to External ECD Experts & Addressing Social Determinants/Influences of Health

Virginia Garcia Memorial Health Center - Cornelius

Upcoming OR TPEC Learning Collaborative Activities

- **June**
  - ✓ OPIP applies for the Continuation of the Cooperative Agreement to Year 4 (October 25-September 26)
  - ✓ **June 11th** Webinar: Members of the Health Share of Oregon/CareOregon HRSN Benefits team and Community Health Workers/Patient Navigators from your site.

- **August 6th**
  - **All OR TPEC Sites Check in Call** (Halfway Through Action Period)

Subaward Deadlines for Each Site

- **September 2025 (End of Cooperative Grant Year 3): Reports and Invoices Due**

1. Subaward Supporting Enhancing Issue-Focused Interventions by ECD Experts & Connections to External ECD Experts:

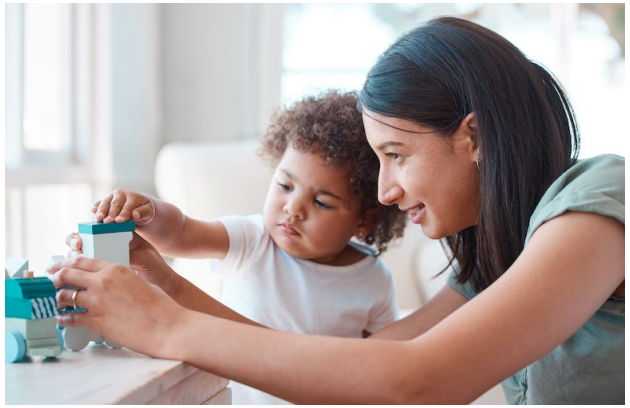
- **Reports and Invoices DUE**. (Each Site Responsible for Developing Reports)
  - ✓ **Summary of Quantitative Changes** in Required Metrics & Learnings. (Spring 2025 and Summer 2025 Metrics). Stratification for Required Metrics by feasible race, ethnicity and language variables.
  - ✓ **Qualitative Report** for Grant Year 3 Activities that Includes: 1) Implementation Successes and Barriers to the Staffing and Resource plan, 2) Overview of Increases in Staffing (either New Staffing, FTE of Existing New Staff Focused on Birth to Five). Report **must include the required elements** described in the Scope of Work.
  - ✓ Updated **Staffing and Resource Plan** that Includes Remaining Plan for Enhancement.

2. Subaward on Learning Collaborative Participation

- **Report and Invoice Due**: OPIP will draft

Our Last OR TPEC Learning Session: Save the Date!

- Date: **November 6th, 8am-12pm**
- Location: Location TBD (See Survey Poll)
- Current Proposed Topics:
  1. Summarizing Successes and Barriers
  2. **Sustaining** TPEC Improvements in Sites
  3. Identifying **Priority Innovations** to Spread to Other Clinics



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Transforming Pediatrics and Early Childhood