



Oregon Transforming Pediatrics for Early Childhood (OR TPEC)
Presentation for the Health Share of Oregon
Children's Health Advisory Committee (CHAC)

- High-Level Overview of Oregon Transforming Pediatrics for Early Childhood

- Relative to Areas of Focus within CHAC – Key Learning

- What it takes to improve **social-emotional services** at the clinic level and implications for future work
 - Then, within these factors, payment Barriers to sustaining the services increased
 - Recent Overarching Barrier - Environmental factor

- Looking forward with hope and opportunity



Acknowledgement of Funding



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- The contents of this slide deck are those of the authors (OPIP staff) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the US Government.

Oregon TPEC Objectives, In Oregon Speak



- Increase the **number of trained early childhood development (ECD) experts** in primary care settings that can serve birth to five
 - Integrated behavioral health providing interventions (aligned with Young Children Receiving Issue-Focused Intervention metric)
 - In two sites, THW trained to provide interventions(aligned with Young Children intervention metric)
 - Care coordination/system navigation supporting birth to five patients accessing external behavioral health services, SDOH
- Increase the **number of pediatric practices** offering a **continuum of ECD services**, aligned with the EPSDT continuum, including screening, interventions and care coordination
 - Increase “EPS” aligned screenings
 - “D” and “T”: Internal interventions conducted integrated behavioral health
 - “T” - Connections to services, with priority on behavioral health, Early Intervention, Speech and SDOH
- **Identify and advance solutions** such as **policy and financing barriers, ECD workforce needs and service gaps.**
 - External services & network adequacy
 - FFS Payment
 - APM
 - VBPs

OR TPEC Early Childhood Continuum Aligns with EPSDT Continuum

Within primary care,
evidence-based
interventions



Promotion
& Prevention



Monitoring
& Screening



Intervention



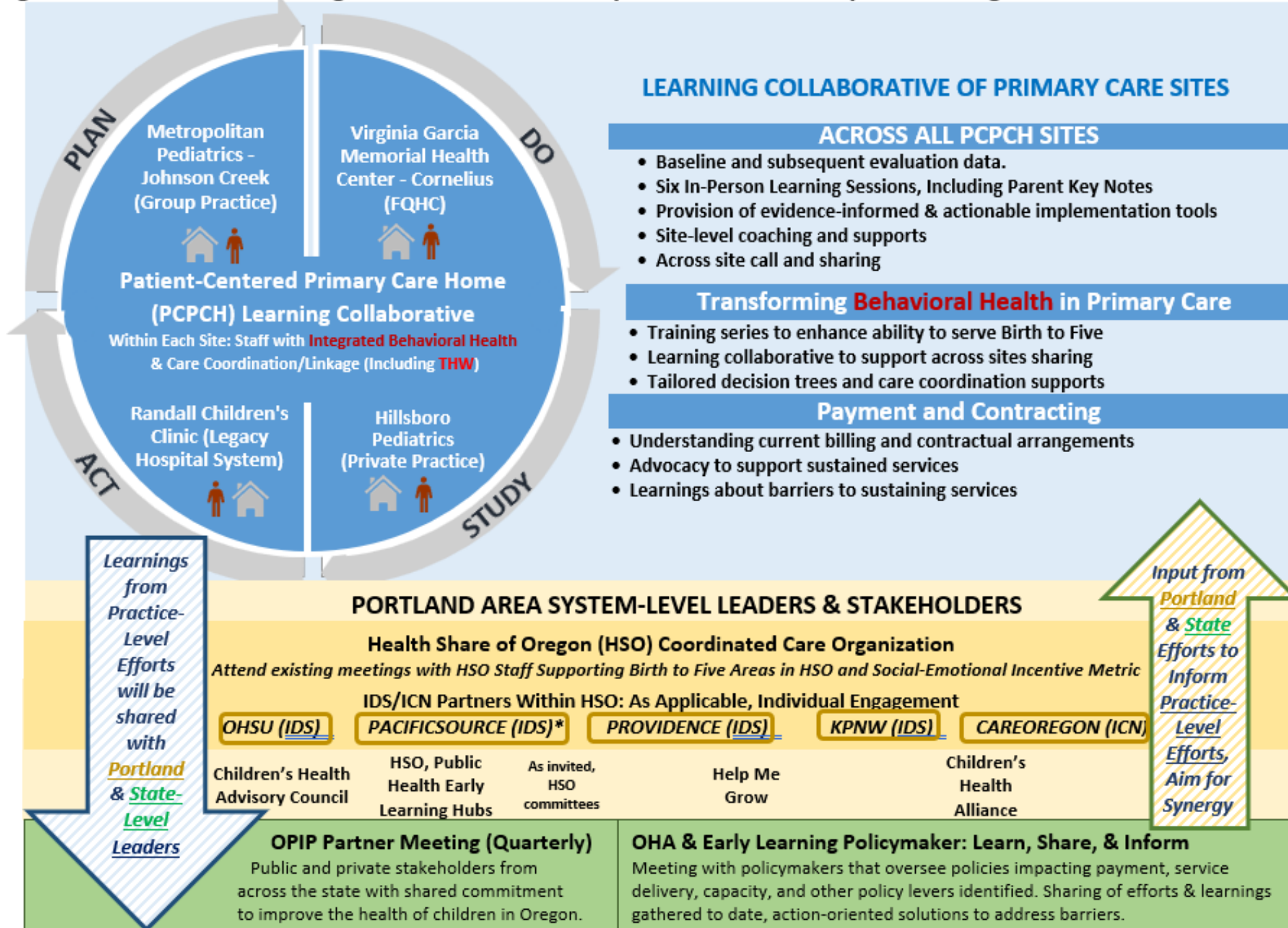
Care
Coordination &
Linkage



Intervention

- **Social-emotional screening**
- **Follow-up to Developmental Screening**
- **Follow-up to SDOH screening.**
- **Behavioral Health trained in birth to five**
- **Engaging families in services internally.**
- **Standardized referral pathways to internal services.**
- **Asset map of services.**
- **Training on how to engage.**
- **Specific strategies for non-medical referrals.**
- **System navigation supports and family engagement.**

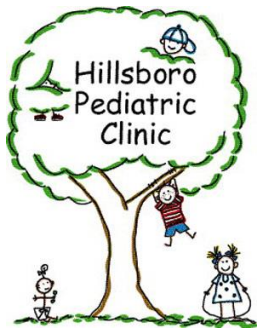
Figure 1: Overview of Learning Collaborative of Primary Care Sites Guided by & Informing Inform Local & State Leaders



Six Action Plans: Area of Focus



1. Strategies to Enhance **Staffing** with Expertise in Development that can Provide **Issue-Focused Interventions**
2. Addressing the ***Social Emotional (SE) Needs of Young Children*** - Assessments, Brief Interventions, and Pathways to External Behavioral Health
3. **Deeper Dive** on Addressing SE Needs: Standardizing Follow-Up, PCP-Based Guidance & Education, and Engagement in ***Referrals to External Behavioral Health***
4. Addressing Children With **Autism**: From Early Identification, Brief Intervention Supports, to System-Navigation and Coordination
5. Enhancing Issue-Focused Interventions and Referrals to External ECD Experts & **Addressing Social Determinants of Health**
6. Summarizing **Success** and **Barriers**, Sustaining TPEC Improvements, Identify Priority Innovation to Spread to Other Clinics



Randall Children's Clinic



Cornelius Site

OPIP Use of a Learning Collaborative Model: Why It Matters if Improved Child-Level Outcomes Desired

1. Studies show that one-time trainings of providers **does NOT** result in implementation of services in a busy clinical setting
2. Secret Sauce – Training followed by at-the-elbow support by people with expertise on the topic
 - QI skills and ability to tailoring to office systems, EHRs, and staff within.
3. Value in learning and being inspired by each other
4. **Evaluation data: Motivates, informs, and drive systems changes**
5. Addressing Carrots and Sticks- Especially for beleaguered primary care in Oregon
 - MOC, CME
 - CCO Incentive Metrics
 - Payment Levers
7. Commitment to share learnings with system level leaders that create the conditions that practices are working within

What are we trying to accomplish?

How will we know that a change is an improvement?

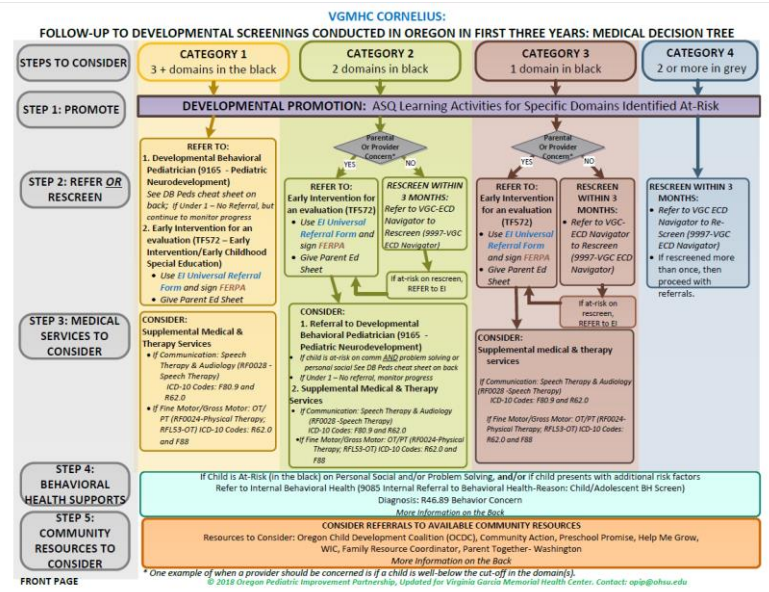
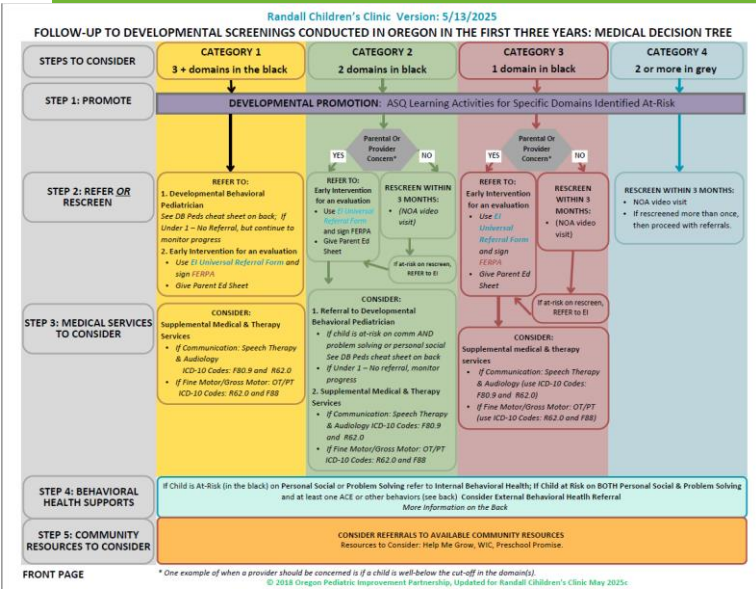
What change can we make that will result in improvement?



Source: Adapted from The Improvement Guide (2008)

- Monthly **site-level meetings** to track progress, identify barriers, and support implementation
 - Requirement that it is **a team from the practice** that represent the various roles in the practice
- **Data to Guide and Inform Improvement Efforts**
 - Every six month data collection across the continuum
 - Office systems in place DO NOT equal that children experience those systems
- **Behavioral Health Learning Curriculum**
 - Targeted focus on birth to five.
- **OPIP Site-Level Training, Improvement Tool Development**
 - OPIP developed specific tools and strategies given our clinical knowledge about HOW to implement and improve.
 - MA, Care Coordination, Primary Care Provider Training
 - Development of Standardized Follow-Up to Screening Decision Trees, Parent Education Supports
 - Electronic Health Record Modification
- **Sustainability & Billing**
 - Grant funding tied to metric, not enough to fully fund positions, eye toward sustainability from strat
 - Using data to advocate
 - Trainings on billing
 - Outlining alignment with incentive metrics

OR TPEC: Supporting QI through Clinical Decision Supports



Developmental Pediatrician Referral Cheat Sheet:

Kid in the **BLACK** on the Communication domain
 +
 Personal-Social domain or Problem Solving Domain

OR

If the child is 'in the BLACK' on 2 or more domains and has any of the following presenting concerns:

- Kids who are not progressing in services as expected or recent increase in symptoms
- Kids who have challenging behaviors with inadequate response to behavioral interventions or medication.
- Kids with secondary medical issues that are not responding to usual treatments (including feeding and nutrition)
- Kids who may be experiencing traumatic events

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

ACEs include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Mother treated violently
- Substance misuse within household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

<https://www.samhsa.gov>

BEHAVIORAL HEALTH SUPPORTS

If child is "in black" on Personal Social an Problem Solving

Concerns such as oppositional, aggressive, overactive or shy/anxious behaviors, significant sleep, feeding, self-soothing, adjusting to new situations, or irritability concerns

And/or Exposure to Adverse Childhood Experiences

CONSIDER USE OF EARLY CHILDHOOD MENTAL HEALTH DX CODES

Preferred first OPTION: Internal Behavioral Health referral. Example of follow-up steps by IBH staff.

- Assessment
- Potential additional screenings as part of Assessment
- Brief interventions
- If applicable, engagement on external referral

CONSIDER USE OF EARLY CHILDHOOD MENTAL HEALTH DX CODES

Second Option
 Consider External Referral for Specialty Behavioral Health - Infant Early Childhood Mental Health (Leverage Asset Maps Provided)

BACK PAGE

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EHR Decision Supports to Guide the Right Referral at the Right Time



SA40 ABNORMAL ASQ FOLLOW-UP

[Manage User Versions](#)

▼ Diagnoses

▶ Diagnoses [Click for more](#)

▼ Labs

▶ Labs [Click for more](#)

▼ Referrals

▶ ASQ with 2 Domains close to cut off or in the gray [Click for more](#)

▼ SA40 ASQ WITH 1 DOMAIN IN THE BLACK

- REFERRAL TO EARLY INTERVENTION/ECSE
External Referral
- REFERRAL TO EARLY CHILDHOOD NAVIGATOR (Re-screen/Community Resources)
- REFERRAL TO AUDIOLOGY
External Referral
- REFERRAL TO PEDIATRIC SPEECH THERAPY (**IF Communication domain in the black)
External Referral
- REFERRAL TO PEDIATRIC OCCUPATIONAL THERAPY
External Referral
- REFERRAL TO PEDIATRIC PHYSICAL THERAPY (**IF motor domain in the black**)
External Referral
- REFERRAL TO BEHAVIORAL HEALTH (**IF personal social or Prob Solving in the black**)

▶ SA40 ASQ WITH 2 DOMAINS BELOW CUT OFF [Click for more](#)

▶ SA40 ASQ WITH 3 OR MORE DOMAINS BELOW CUT OFF [Click for more](#)

▼ Reminders

- Provide Learning Activities
- Provide Parent Education

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

| ASQ_TOTALS | | | | | | | FOLLOWUP_REFERRAL_C | | | |
|------------|----------|------------------|-----------------|-----------------|-----------------|-----------------|---------------------|---------------------------------------|--|------------------------------------|
| Current | A | BELOW- | | | | | DUNT | TSTZ FOLLOW UP REFERRAL DESCRIP | T143 FOLLOW UP REFERRAL DESCRIPTION | T997 FOLLOW UP REFERRAL DESCRIP |
| gs_Yea | CLOSESTO | COMMUNICATION IP | FINE MOTOR IP | GROSS MOTD | PERSONAL SOCIAL | PROBLEM SOLV | | | | |
| 5 | 1-3 | Close to cutoff | Below cutoff | Above cutoff | Close to cutoff | Close to cutoff | | | | |
| 5 | 1-3 | Above cutoff | Below cutoff | Close to cutoff | Above cutoff | Above cutoff | | 1 REFERRAL TO EARLY INTERVENTION/ECSE | | |
| 5 | 4-0 | Below cutoff | Below cutoff | Above cutoff | Below cutoff | Below cutoff | | 1 REFERRAL TO EARLY INTERVENTION/ECSE | | |
| 5 | 1-1 | Above cutoff | Close to cutoff | Above cutoff | Above cutoff | Below cutoff | | | | |
| 5 | 2-0 | Above cutoff | Below cutoff | Above cutoff | Above cutoff | Below cutoff | | | | |
| 4 | 2-3 | Below cutoff | Close to cutoff | Above cutoff | Above cutoff | Below cutoff | | 2 REFERRAL TO EARLY INTERVENTION/ECSE | | REFERRAL TO EARLY CHILDHOOD SERVIC |
| 4 | 2-2 | Below cutoff | Close to cutoff | Above cutoff | Close to cutoff | Below cutoff | | 1 | REFERRAL TO PEDIATRIC NEURODEVELOPMENT | |
| 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 | | | | |
| 3 | 4-0 | Below cutoff | Below cutoff | Above cutoff | Below cutoff | Below cutoff | | 6 | REFERRAL TO PEDIATRIC NEURODEVELOPMENT | |
| 2 | 1-1 | Below cutoff | Above cutoff | Above cutoff | Above cutoff | Close to cutoff | | 5 REFERRAL TO EARLY INTERVENTION/ECSE | REFERRAL TO PEDIATRIC NEURODEVELOPMENT | REFERRAL TO EARLY CHILDHOOD SERVIC |
| 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 |
| 2 | 1-2 | Above cutoff | Below cutoff | Close to cutoff | Above cutoff | Close to cutoff | | | | |
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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 | 1-2 | Above cutoff | Close to cutoff | Below cutoff | Above cutoff | Close to cutoff | | 1 | | REFERRAL TO EARLY CHILDHOOD SERVIC |

Impact of TPEC Efforts

- **Improved Office Systems and Processes**
 - All four sites improved early childhood development office systems and processes.
- **Improved Staffing with Early Childhood Development Experience to Provide Issue-Focused Interventions**
 - All four sites have **behavioral health** who attended trainings to enhance expertise in issue-focused interventions for young children
 - All four sites enhanced the FTE devoted to serving birth to five in **care coordination and system-navigation**.
 - All four sites have **at least one THW with enhanced birth to five** functions, some exclusively birth to five.
- **Improved Services**
 - All four sites improved in at least one service tracked (screening, issue-focused interventions, referrals)



Children's Lives Impacted: Dr. Jacob's Experience



Primary Care Providers Lives Impacted



Social-Emotional Screening allows provider to start a conversation “which I didn’t always know how to start even when seeing child in room struggling” able to say “we have some systems that can help support you and you’re not alone.” It allowed for more meaningful introduction to BHC.

-Primary Care Provider at FQHC

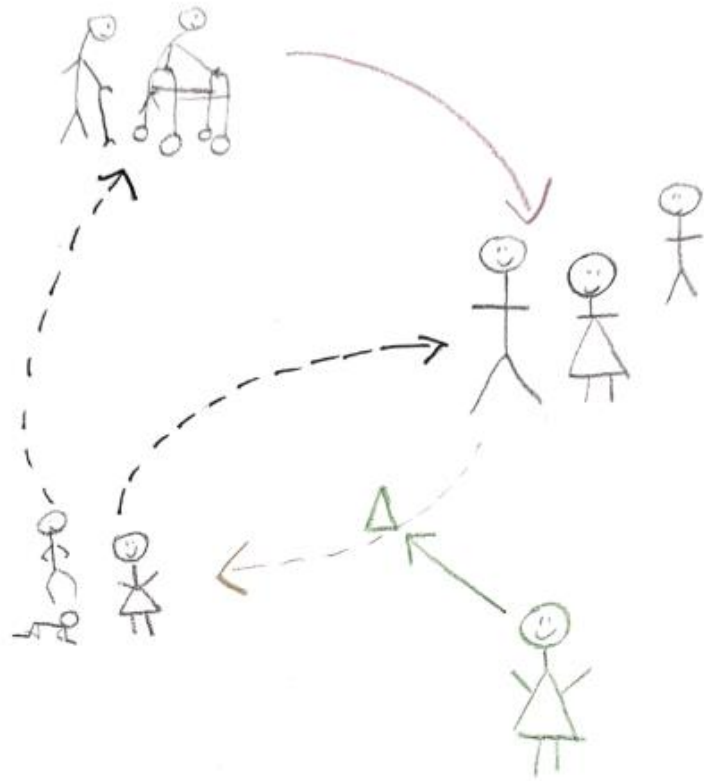
Standardization was most the impactful change . 1) Standardization of knowing who to send to EI, Autism eval, and behavioral health with a decision tree reduced PCP variability and allowed for awareness of who should be referred. 2) Standardization of workflows for follow up steps to screening. **Used to see patients come back without getting supports, now “almost never see patients falling through” – they are getting to services they need.**

-Primary Care Provider at Private Practice

Having TPEC funding made [the site] more comfortable to **invest in care coordinators/pt navigators** who were solely dedicated to this age group. “The patient navigators are the safety net and I sleep better at night having them”

- Primary Care Provider at Private Practice

[OPIP’s] Training of PCPs gave clinicians more confidence in themselves, “awareness of who could benefit from BH support, and also know they don’t need to know all that stuff because there is someone with expertise who could support”. **-Primary Care Provider at FQHC**



Behaviorist breaking cycle of generational trauma. Toddler referred for (+) PASC, learned about naming feelings & deep breathing, and now she's helping older generations process their big feelings, too!

Behavioral Health Providers Lives Impacted

Building expertise and focus around parenting support with TPEC has **increased job satisfaction**, [she] loves talking to parents-receiving support and knowledge around that helps her be more competent as a clinician.

-Behavioral Health Clinician at Hospital Based Primary Care Clinic

Learning about this project in the interview process and how [the clinic] prioritized this age group was a factor in her accepting this job.

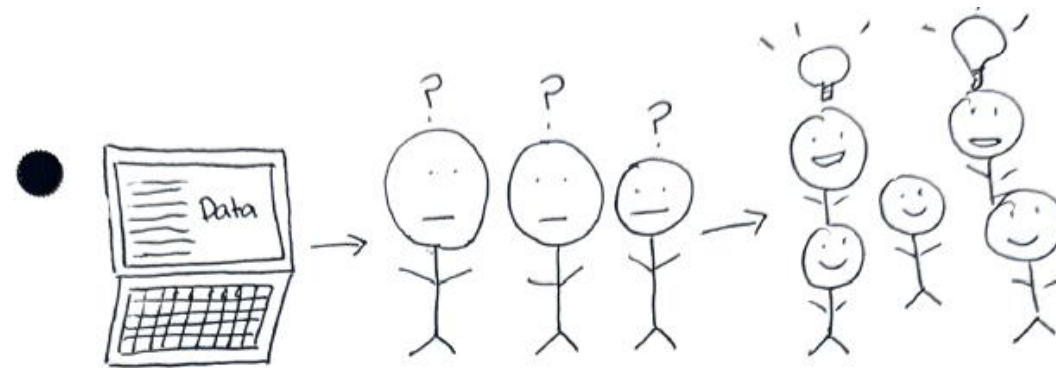
-Newly Hired Behavioral Health Clinician Hospital Based Primary Care Clinic



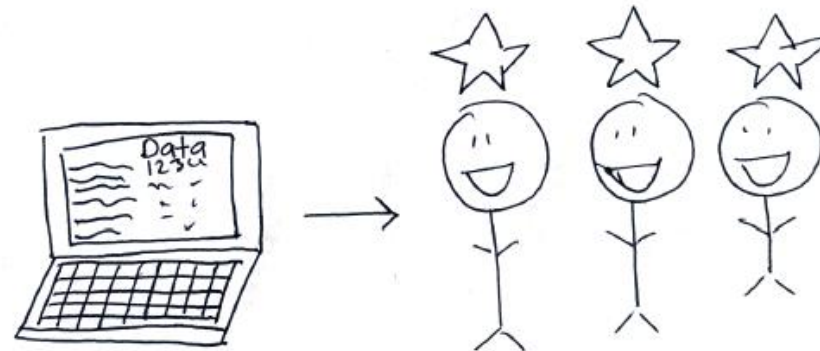
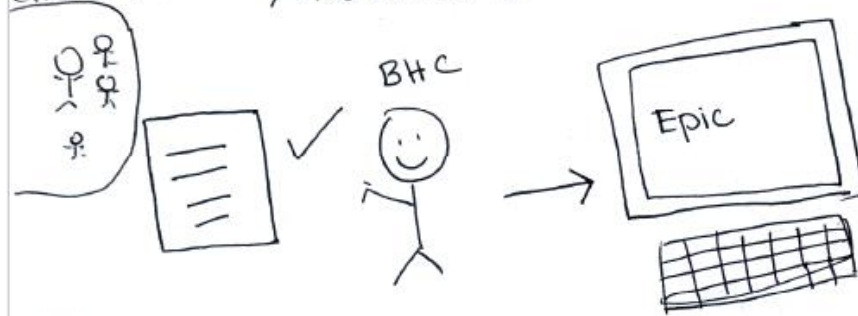
A big success has been more support and focus on behavioral health support for kids ages 1-5. She has wanted to work with young children and “Now there is time set aside” for this age group. Before this work, she had to think “way, way back to even remember a young kid I worked with.” But now she has time set aside for warm handoffs, and sees 5-6 young kids a month.

-Behavioral Health Clinician at FQHC

Impact on Office Systems and Processes

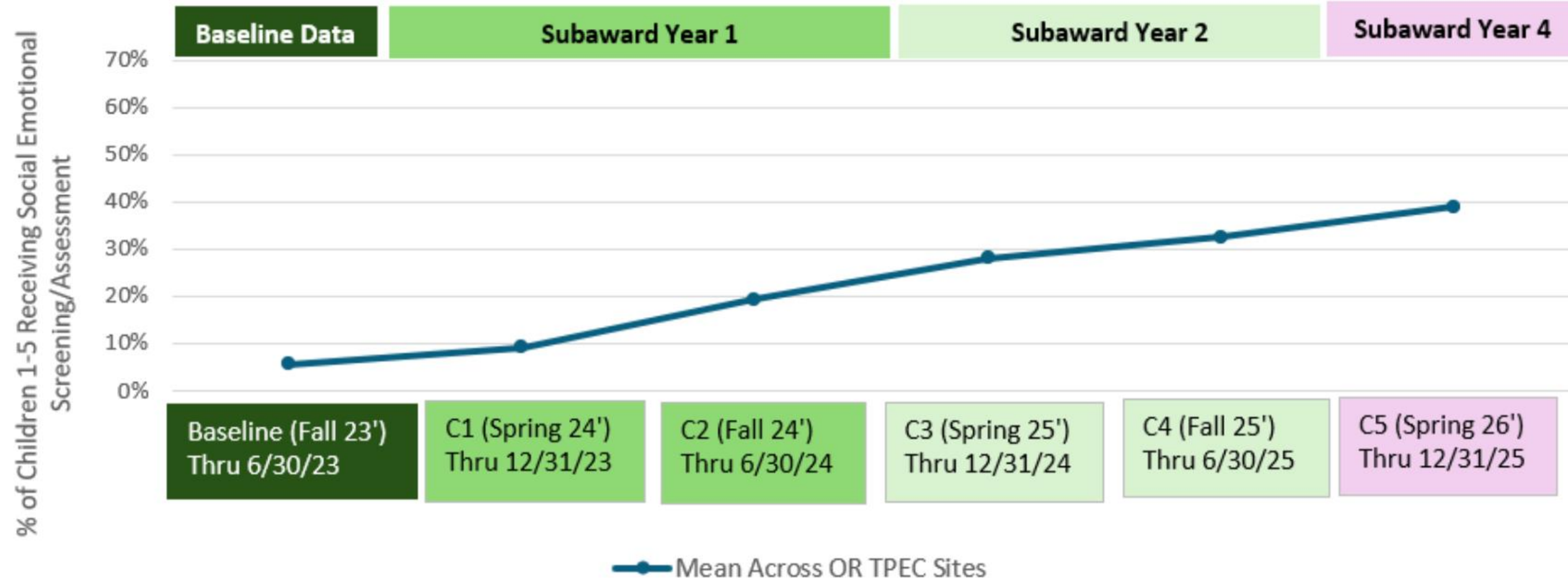


Clinic workflow/documentation

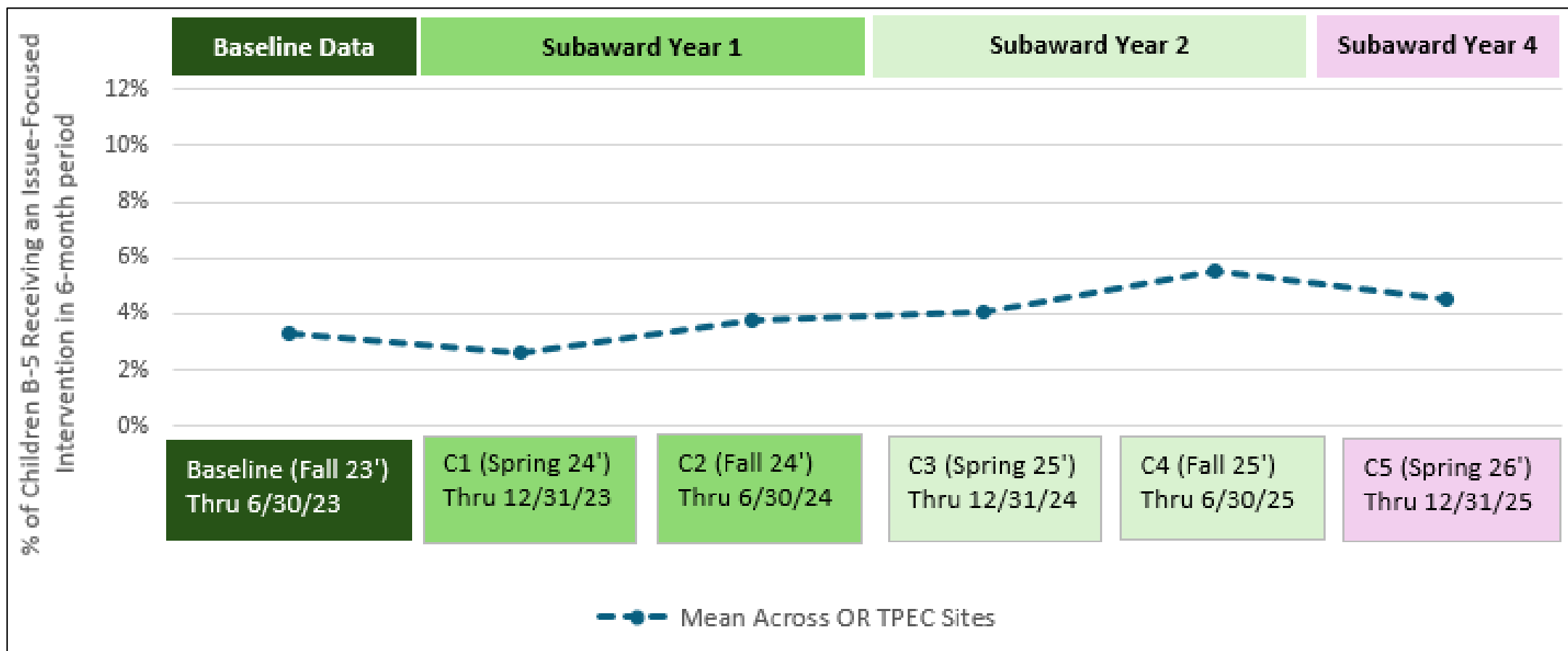


Metric 1.3: Social-Emotional Screening/Assessment Claims

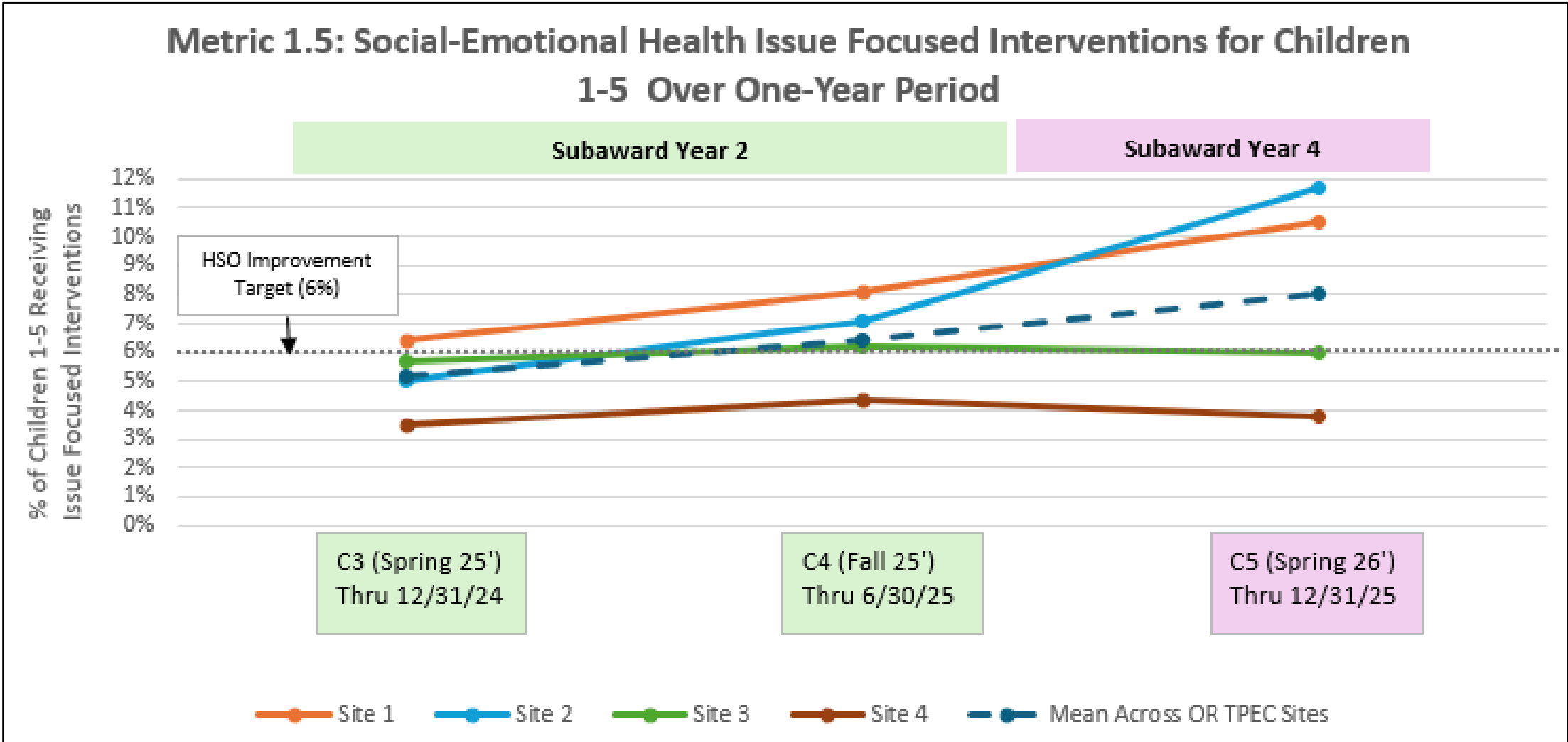
Metric 1.3: Social Emotional Screening/Assessment (1-5 yrs) Over One-Year Period



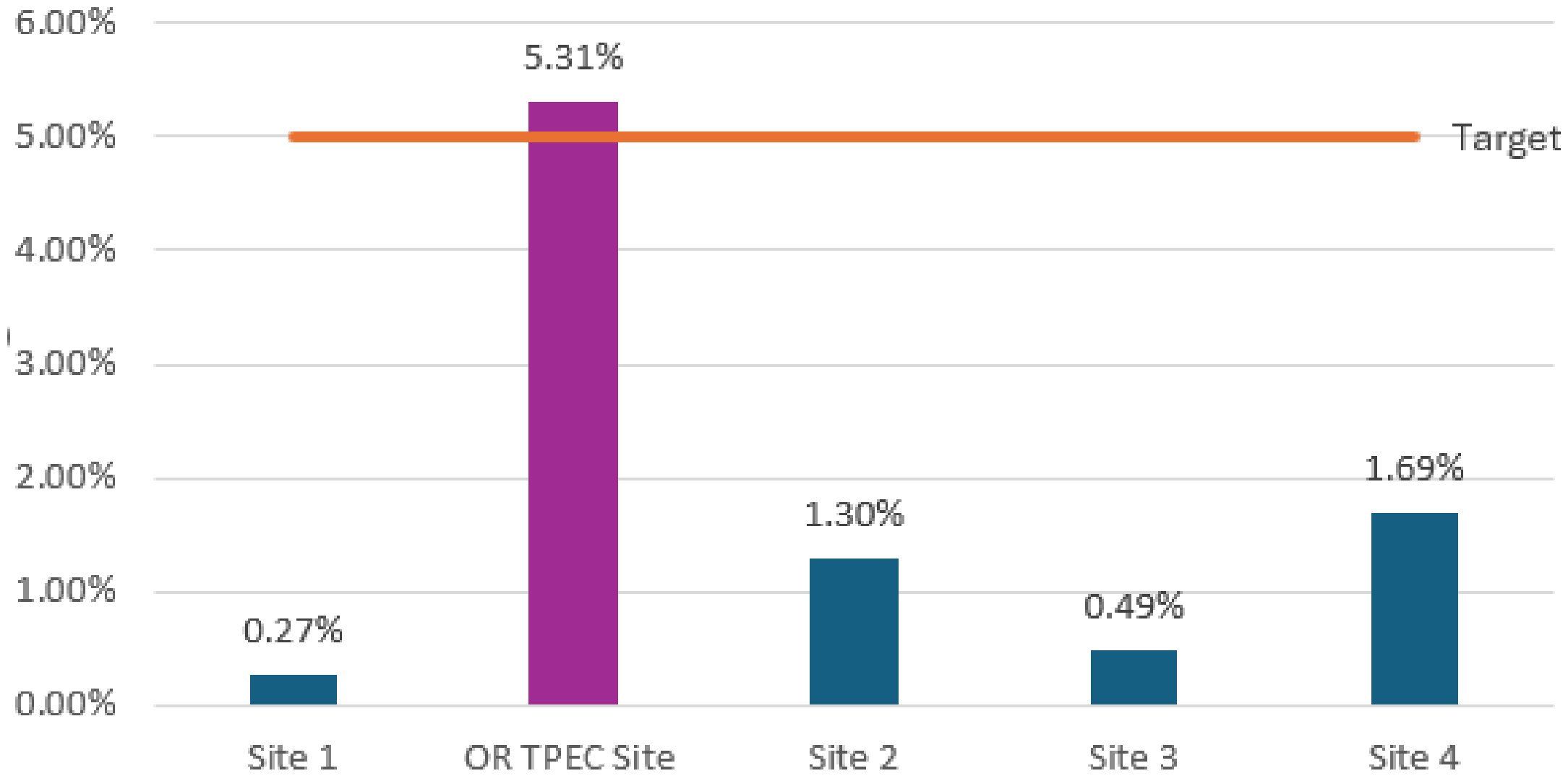
Children who Received Issue-Focused Interventions from Staff with ECD Expertise (Aligned with CCO Incentive Metric)



Metric 1.5: Aligned with Young Children Receiving Issue-Focused Interventions CCO Incentive Metric: Their Own Data

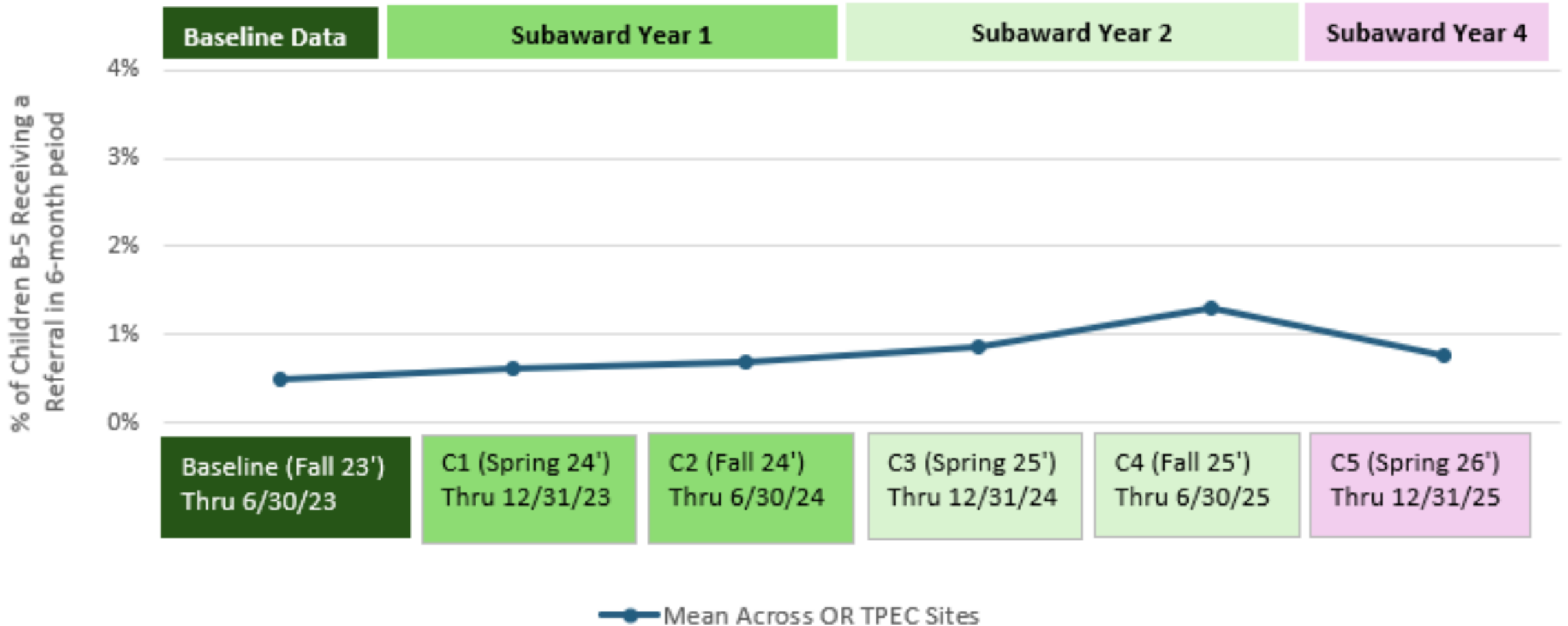


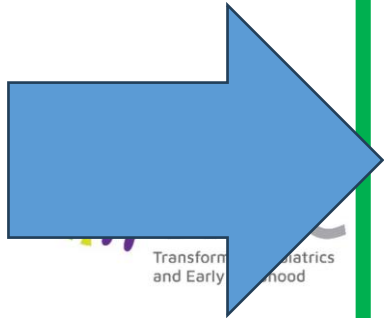
Example: OR TPEC Site Part of Larger Systems are Significantly Higher on CCO Incentive Metric Despite Same PCPCH Tier Levels (Current Dashboard)



Referrals to External Specialty Behavioral Health

Metric 2.3: Referrals to Specialty Behavioral Health Over Six-Month Period



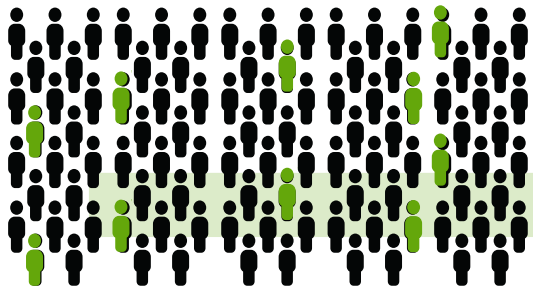


- Relative to Areas of Focus within CHAC – Key Learning
 - What it takes to improve **social-emotional services** at the clinic level and implications for future work
 - Then, within these factors, payment Barriers to sustaining the services increased
 - Recent Overarching Barrier - Environmental factor

Early Childhood Continuum of Services to Ensure Children Receive Issue-Focused Interventions

Continuum of Social-Emotional Services

All Children as Part of Population-Wide Surveillance & Screening



Bright Futures Recommends **Social-Emotional** Screening as part of robust well-child care



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

PCP-Provided Parent Guidance & Education



Issue-Focused Intervention & Treatment Services

Brief Intervention



Treatment Service



Patient-Centered Primary Care Home



Blue Boxes:
For Subset of Children Who Need It
Issue Focused Interventions

Surveillance & Screening
Identifying
Potential
Delays For
Full
Population

Primary Care Provider
Response to
Issues Identified
in Visit or
Screening Tool

- Guidance & Education
- If Needed: Referral Internally or Externally

*For children
who need
additional
supports*

Integrated Behavioral Health
Assessments & Brief Interventions

Referrals to External Services

System Navigation Support

*Small Subset:
Children requiring
ongoing
therapeutic needs*

External Behavioral Health Services
Therapeutic Interventions

1. People: **Behavioral** Health needed in Primary Care.
Attestations don't always equal right ratios.
2. Targeted **Focus on Birth to Five and Protected Time for This Population** (Current state is focus on adults or school aged kids)
3. Training needed **Birth to Five, Generalizable non-proprietary models that work in primary are (OPIP's model works, Quantitative shows rates increase)**



Key Learning About Behavioral Health:

- All four sites experienced transition of their trained behavioral health staff.
- This required training of the new staff (which needs to be ongoing)



Need to address the reasons why there is turnover:

- Payment to primary care which impacts salary
- Intense role IBH play vs. private practice behavioral health provider

Learnings Related to Transforming Behavioral Health: We have a Curriculum that Works

OR TPEC Participants on OPIP Trainings and Impact on Expanding Services in Primary Care

Gained so much expertise in this project, the trainings from OPIP and Andrew Riley were super helpful, as was meeting with Dr. Riley more often. They “don’t have a lot of clinical supervision at Metro and so being able to learn from him made a huge impact.”

-Behavioral Health Clinician at Private Practice

OPIP’s “Andrew Riley’s trainings were most helpful-“more than any training that they paid for.”

-Behavioral Health Clinician at Hospital-Based Primary Care Sites

She wanted to do this work with young kids and [this project] helped her be more flexible, and realize she could “adjust my previous one-hour interventions and make them work in 30 minutes”

“That was a big challenge for me: taking what I know, turning it into appropriate support in primary care”

-Behavioral Health Clinician at FQHC

Super helpful to have funding for additional trainings. Even Triple P gave [her] confidence and clarity in helping with specific challenges these families faced, that getting super concrete and making a plan is a mental health service [for this age group].

-Behavioral Health Clinician at Private Practice

Opportunities to Address Payment Barriers

- ✓ Global budget for behavioral health for young children should appropriately go to **behavioral health in primary care** given the data shows that is 70% of services.
- ✓ FFS Coverage: Ensure **services are covered and require CCOs/Health Plans within CCO to pay DMAP rates**, for all provider types, for behavioral health service rendered, regardless of setting. (*Aligned with Primary Care Payment Reform Collaborative recommendations*)
- ✓ Ensure that primary care receives **BEHAVIORAL health PMPM** to support unbillable, but critical services, aligned with evidence-based services (*Aligned with Primary Care Payment Reform Collaborative recommendations*)
 - Warm handoffs, engagement in well-child visit
 - Engagement in external service, navigation
 - Huddles and training with PCPs to provide updates on who to refer

Trainings and Supports Needed at the Primary Care Site Level:

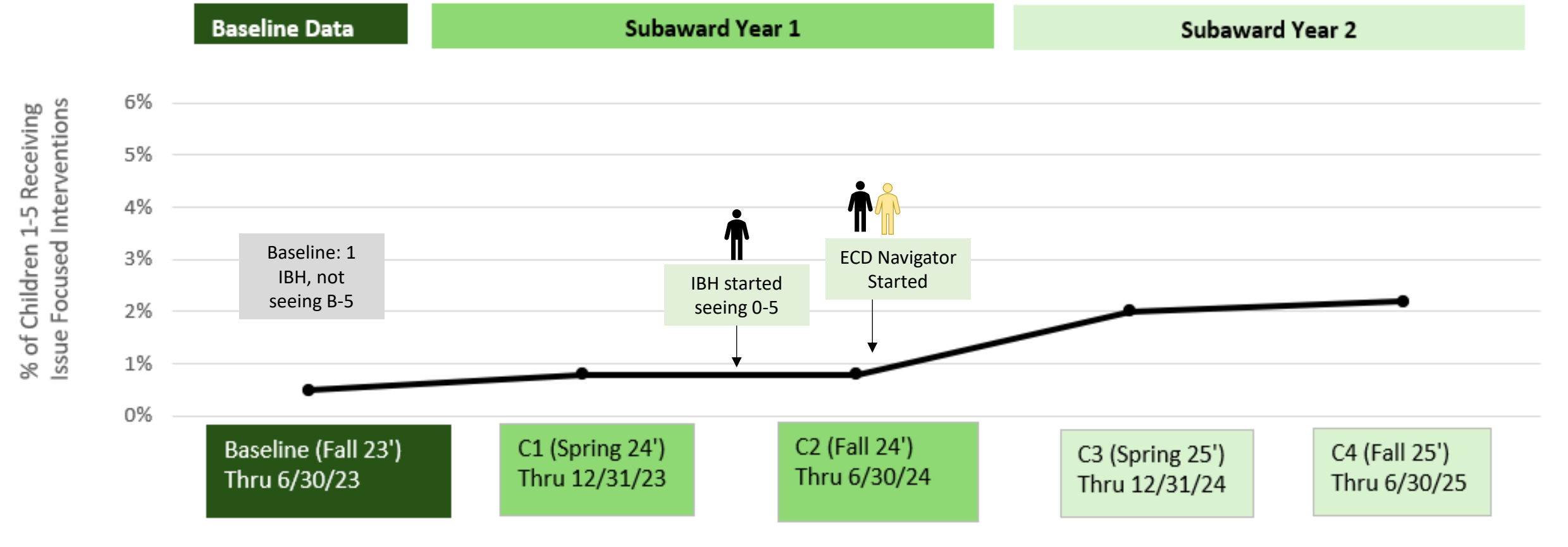
- **Learning Collaborative and onsite facilitation models work**
- **It is not if you have behavioral health, then they will serve birth to five**
 - Site level work then needed within primary care site on the continuum from screening to services
 - Screening **does not** equal referrals – need to focus on standardized follow-up.
- **Most YOUNG children** receive services internally
 - Evidence-base and parent report → Behavioral health preferred in primary care
 - For the small set needing external services, significant and unfunded engagement and system navigation from primary care has been needed.

Learnings Related to Care Coordinators and THWs

- Care Coordinators Played a Critical Role and Were Needed within Given Limitations of Centralized Referral Resources
 - Access to Care (e.g. calling families with previous SDOH needs before well-child visits)
 - Engagement within the clinic
 - System navigation – Many services OUTSIDE of Health Care
 - Addressing SDOH
- Primary care providers and behavioral health noted this THW enhancement was a key success of TPEC
- In two of the sites, on site THW's received specific training on birth to five services and interventions
 - No specific training models available right now for this population
 - Currently combining forces with Dr. Peterson's Kindergarten Readiness Work

Subset of Issue-Focused Therapy Services Claims (IBH Only) – Example from One Site

Metric 1.4: Social-Emotional Health in 1–5-Year-Olds - Issue-Focused Therapy Services in Primary Care (IBH Only) Over One-Year Period



= Doesn't bill but contributes to pathway to IBH

Barriers to Sustainability of THWs & Care Coordination

- As of right now, **none** of the OR TPEC sites can sustain their THW through FFS and PMPM payments (if received) and many are considering cuts.
- **PMPMs don't cover time and are decreasing.**
 - Recently HSO Health plans cutting THW PMPM
 - PMPM rates by PCPCH Tier not sufficient given what is provided
- **Barriers to THW Payment Sustainability**
 - Payment received is not always aligned with OHA THW Payment outlined
 - FFS payment quite small for services they can bill, doesn't cover their salary
 - Private payors don't pay
 - Barriers to billing in FQHCs

1. FFS Coverage: Ensure **services are covered and Require CCOs/Health Plans within CCO to pay DMAP rates**
2. PMPMs for THWs that are also tied to reach rates for specific populations
3. Provide training for these staff for specific services for children

- Practices required to serve uninsured are extremely vulnerable right now.
- Practices with large proportions of Medicaid-insured are vulnerable right now.
- Practices that have large populations that may fear accessing health care right now are observing historic declines in access to care.
 - Impact attributions
 - Impact quality metrics

- High-Level Overview of Oregon Transforming Pediatrics for Early Childhood

- Relative to Areas of Focus within CHAC – Key Learning

- What it takes to improve **social-emotional services** at the clinic level and implications for future work

- Then, within these factors, payment Barriers to This Work Being Sustained

- Recent Overarching Barrier - Environmental factor

- 
- Looking forward with hope and opportunity



- Data shows that we can improve services for children using the models used in OR TPEC.
Elements of this work can be spread to other sites and will be needed.
- Work is aligned with EPSDT Requirement and Incentive Metric.
- Upstream work with young children may support behavioral health provider retention and balance in complex times
- Primary care-based solutions are cost effective relative to downstream consequences and intensive services.
- Young children are more likely to stay insured in changes, and there is an opportunity for dyadic support to parents who may have lost their insurance.

We Can Make a Difference!

Addressing Issues BEFORE Crisis, While Synapses are Forming & **Families are Engaged**

Human Brain Development

Synapse Formation Dependent on Early Experiences

