System-Level Social-Emotional Health Metric

Follow-Up Webinar to Answer Questions: SE Reach Metric Data
September 21st 12-1PM

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Katie Unger, Oregon Pediatric Improvement Partnership

Webinar is made possible with funding support from the David and Lucile Packard Foundation

Agenda

I. Level Setting: Review Scope of Measure

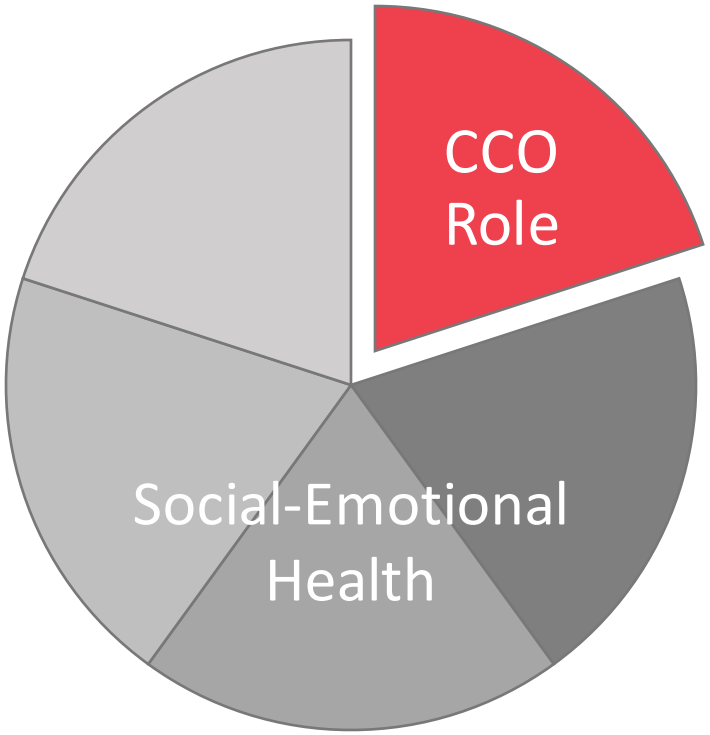
II. Answer Submitted Questions in Survey

III. If Time: Answer Questions Submitted in the CHAT Box that were Not Addressed in 1st Webinar (Recorded)

- (Please enter your questions NOW so that the OPIP staff can identify content)

Scope of CCO System-Level Social-Emotional Metric: Red Piece of the Pie

- Focused on the scope of services that are **within the CCO contract** and **opportunities to impact**.
- Aligned with barriers and gaps in social-emotional health services within the health system and CCO contracts.
- Recognizes the flexibilities and opportunities that the CCO global budget may offer.



OPIP Children's Institute

CCO-Covered Services that Support Social-Emotional Health at the Child-Level

Screening

Assessment

Biggest Pain Points from Parent & Provider Input

Brief Intervention

Treatment Service

OPIP Children's Institute

Analogy of the Bike: Child Level Social Emotional Services within CCO Covered Services Included in the Metric

Within CCO Covered Services:

- **Primary care assessments (including integrated behavioral health) of children identified through existing screens (ASQ, maternal depression)**
- **Primary care screening**

Some "Spokes" are with Specialty Behavioral Health (Year 1 Asset Map): Pain point identified by Early Learning and CBOs of needs within health systems

Some "Spokes" Could be Integrated Behavioral Health in Primary Care

Opportunity for CCOs to Contract with Early Learning CBOs who meet Medicaid contracting requirements

Early Identification: Screening and then Assessments

Referral pathways and Parent Engagement

Intervention/Therapies

Questions Received

1. What are **evidence-based and/or evidence informed** brief intervention and treatment services/programs are available for use with 0-5 year olds that address/satisfy the metric, and what type(s) of CCO provider (physical health, behavioral health, other) is best suited to implement the brief intervention or treatment service?
2. What are the **Evidenced based treatment practices for 0 - 5?** I know of PCIT (which is expensive to provide) and CPP. Talked about a lot in the presentation was providing a brief intervention. Is there an EBP or practice guidelines for Brief Intervention for 0 - 5?
3. Why don't you include screenings done by early learning?
4. Shouldn't we just focus on screening first to increase the rates?

Analogy of the Bike: Child Level Social Emotional Services

Early Identification: Screening and then Assessments

Referral pathways and Parent Engagement

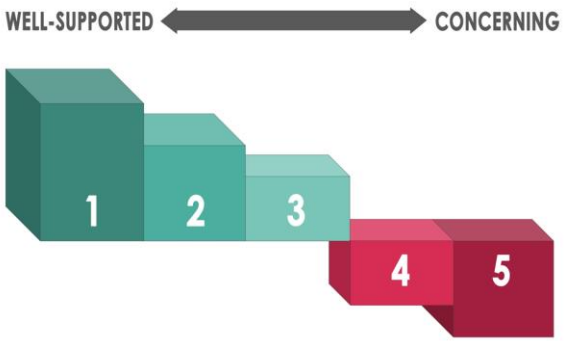
Intervention/Therapies

Q1&2. Evidence-based and/or evidence-informed brief intervention and treatment services/programs available for use with 0-5 year olds

Treatment Services:

- Generally provided by specialty mental health providers
- Listed on Page 15 of SE Metric tech specs: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2022-specifications-%28SE-health%29-8.26.2022%20update.pdf

  - ❖ Table includes therapy modalities based on presenting concern, the delivery method of modality (dyadic, group), the ages they can be used for, and scientific rating (all listed are between 1-3)
  - ❖ **Scientific Rating - Evidence Base for Various Modalities:**



Behavioral Health Services for Children Under Five with Social Emotional Delays

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

Therapy/ Program Name	Delivery Method[1]	Age of Child	Scientific Rating	Organization(s)	Number of Provider(s)
SERVICES TARGETED TO CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS					
Parent Child Interaction Therapy (PCIT)*	Dyadic	1-7	1		
** PCIT is also effective program for children with known trauma history (see categories below).*					
Generation-PMTO	Dyadic, Family, or Group	2-18	1		
Triple P Positive Parenting Program	Level 3 - Dyadic Level 4 - Group	0-12	2		
Theraplay	Dyadic	0-18	3		
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)					
Collaborative Problem Solving	Family, Individual	3-21	1		
Play Therapy	Family, Individual	3-12	3		
Helping the Non-compliant Child	Dyadic	3-8	3		
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY					
Child Parent Psychotherapy (CPP)	Dyadic	0-5	2		
Eye Movement Desensitization and Reprocessing (EMDR)	Individual	2-17	1**		
Attachment Regulation and Competency (ARC)	Dyadic, Family, or Individual	0-21	NR		
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)					
Trauma Focused CBT	Dyadic	3-18	1		
SERVICES TARGETED TO CHILDREN WITH AT-RISK PARENTS/ FAMILIES					
Family Check-Up	Dyadic	2-17	1		
Attachment and Biobehavioral Catch-up (ABC)	Dyadic	0-2	1		
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)					
Incredible Years*	Dyadic or Group	4-8	1		
** Incredible Years is also good for children with disruptive behavior problems (see categories above).*					

Q1&2. Evidence-based and/or evidence-informed brief intervention and treatment services/programs available for use with 0-5 year olds

Brief Intervention:

- Generally provided by integrated behavioral health providers in primary care (social worker, psychologist)
- Need to consider evidence, patient characteristics/needs/preferences, practitioner expertise, and environmental context
- May include:
  - Integrated primary care therapies (IPC) – often adaptations of parent management training (such as PCIT, Triple P)
  - Uses common elements approach
    - Takes elements from evidence-based therapies to address specific behavior concern (i.e. limit setting, rewards)
- Could bill Health & Behavior Intervention codes or Preventive Medicine Counseling codes

Riley, A; (2020) . Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk Receive Best Match Follow-Up; Internal Behavioral Health Training. [PowerPoint presentation] Bend, OR.

Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk Receive Best Match Follow-Up

Internal Behavioral Health Training
January 22nd 10AM-2PM

Early Learning & Wellness
LAST A LIFETIME
EARLY LEARNING HUB OF CENTRAL OREGON

OPIP
Oregon Pediatric Improvement Partnership

Ecology of Social-Emotional Delays

Important to recognize **multiple determinants** and **social-ecological** contributors leading to behavior concerns:

Social Ecology:
- Marital Conflict/Divorce
- Maternal Social Isolation
- Aversive Extended Family
- Low Control Neighborhood
- Poverty/Crime

Child Characteristics
- Negative Temperament
- Emotional Dysregulation or Mood Disorder
- Hyperactive-Impulsive

Parent Characteristics
- Adult ADHD
- Depression/ Mood Disorder
- Early Child-Bearing/ Single Unemployed
- Substance Dependence/Abuse
- Illness (medical/psychiatric)

Disrupted Parenting
- Maternal Social Isolation
- Aversive Extended Family
- Low Control Neighborhood
- Poverty/Crime

The four factor model of child oppositional defiant behavior. From R. A. Barkley (2013). Defiant Children: A Clinician's Manual for Assessment and Parent Training (3rd ed.). New York: Guilford Press. Copyright 2013 by the Guilford Press.

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Ecology of Social-Emotional Delays

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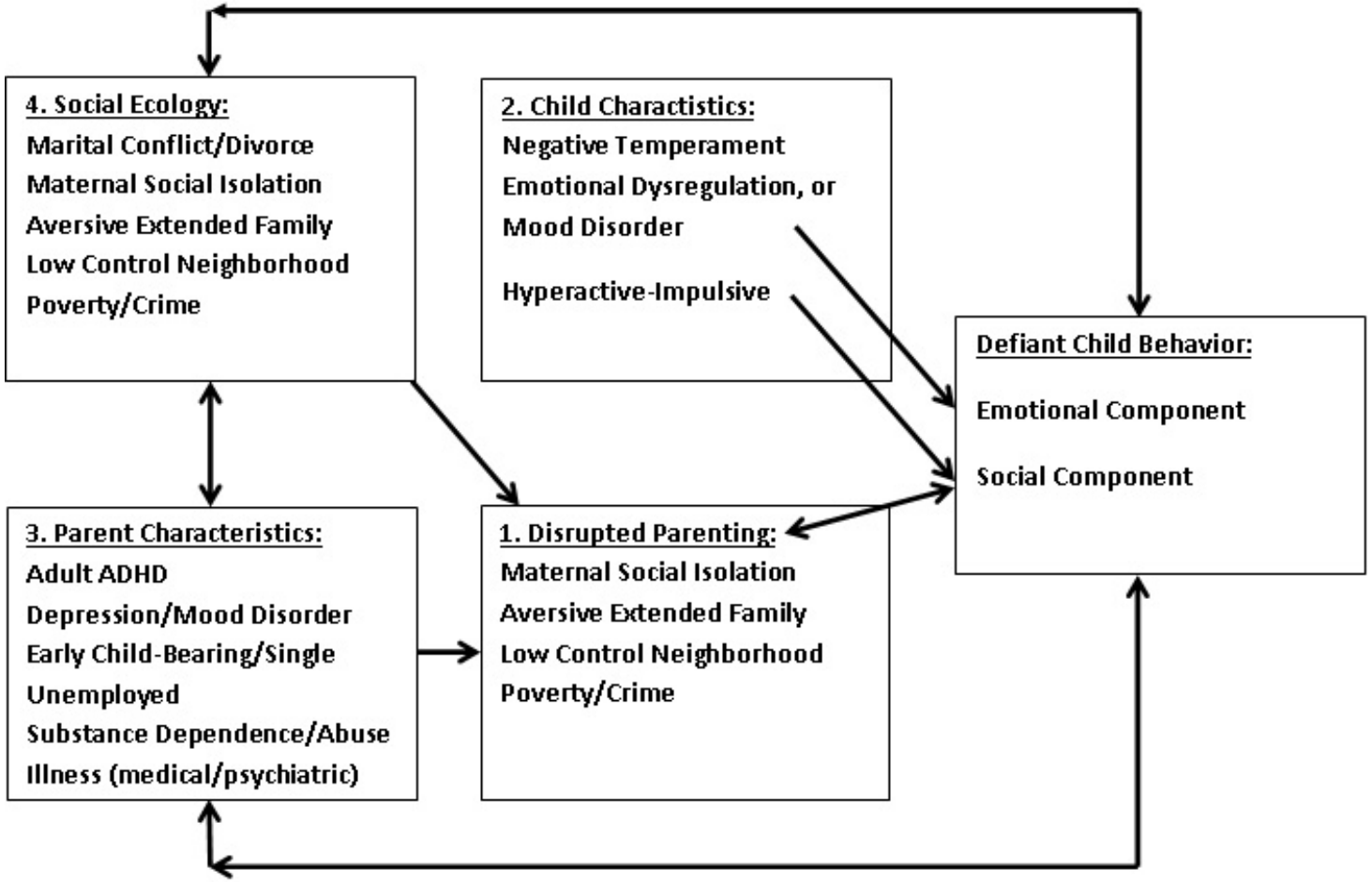

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Input from an Expert: Research-based integrated primary care (IPC) therapies

- Most early childhood IPC research has focused on mild to moderate risk
- Some studies use technology or target PCPs/well-visits to enhance care
- Most studies use co-located adaption of parent management training (PMT), e.g., PCIT, Triple P, Incredible Years, Brief Parent Training (Brown et al., 2018)

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Input from an Expert: How are IPC therapies different?

- Traditional programs developed for mental health settings are:
  - Lengthy (12-16 sessions of 60 min or more)
  - Intensive (e.g., coaching to mastery criteria)
  - Exhaustive (all components delivered)
  - Individualized (1 or more sessions devoted to assessment, dependent on progress, etc.)
- IPC programs are *relatively*
  - Brief (2-12 sessions, 30-120 min)
  - Selective ("most important" components)
  - Didactic/educational
  - Group-based
  - Generalized

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Input from an Expert: Theoretical Framework for Selecting Parent Management training (PMT) Intervention Elements

- Evidence-based PMT interventions are grounded in a merging of Attachment Theory and Social Learning Theory with a heavy emphasis on operant conditioning (learning via consequences)
- Goals
  - Secure attachment
  - Clear and appropriate expectations
  - Strategic consequences for both desired and undesired behavior
  - Generally, Authoritative parenting
- Customizing intervention elements requires *sophisticated* use of the *fundamentals* of behavior

Riley, A; (2020) . Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk Receive Best Match Follow-Up; Internal Behavioral Health Training. [PowerPoint presentation] Bend, OR.

Input from an Expert: PMT elements correspond to the fundamentals of behavior

- Signals
  - Limit-setting
  - Instruction delivery
- Consequences to increase behavior
  - Differential attention
  - Contingent praise
  - Rewards
- Consequences to decrease behavior
  - Strategic ignoring
  - Time-out
- Setting events
  - Scheduled parent-child play
  - Parent stress management
  - Problem-solving (parent)

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The Kitchen Sink Dilemma

- PMT research has focused on symptom clusters that are treated with multi-component therapy packages
- This doesn't work for most parents or most primary care settings
- Given only a few sessions (often 1), how do you know what to focus on?

- Non-compliance
- Emotional lability
- Aggression
- Hyperactivity
- Impulsiveness
- Argumentativeness
- Defiance
- Whining
- Destruction of objects
- Tantrums
- Inappropriate talk

- Differential attention
- Strategic ignoring
- Scheduled parent-child play
- Limit-setting
- Rewards
- Problem-solving
- Time-out
- Instruction delivery
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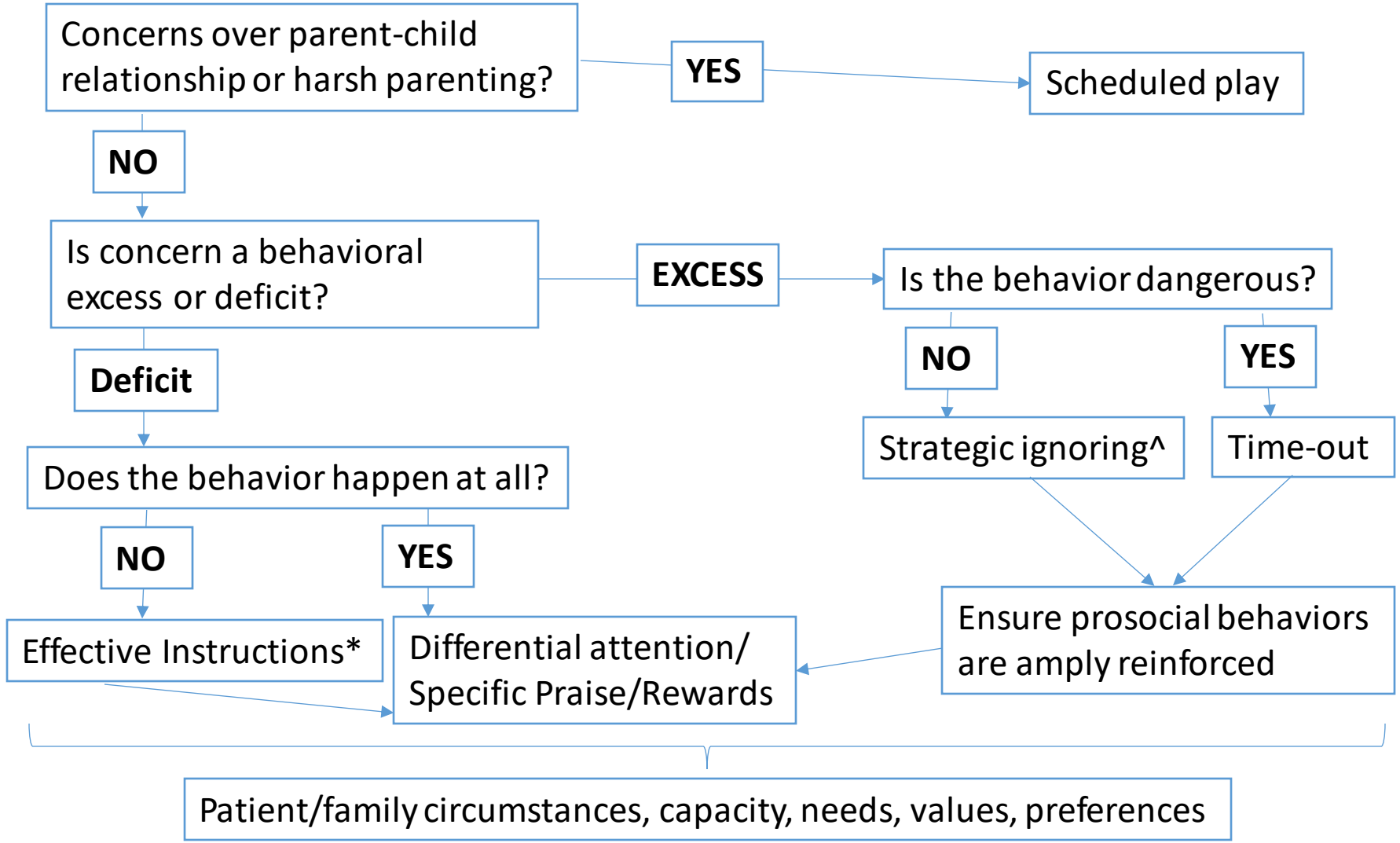
Example of Input from an Expert: Decision Framework



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*May be approximation of terminal goal behavior; ^Consider tolerability of extinction burst

Example of Input from an Expert: Considerations

- Ideally, you can cover some of each element, but it's not probable in most cases
- Providing guidance that addresses parents' concern first may be best (even if it's not your primary concern)
- Focus on feasibility of implementation
- When in doubt, err on the side of relationship building and positive reinforcement strategies
- Remember that your expertise is part of evidence-based decision making

Riley, A; (2020) . Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-Risk Receive Best Match Follow-Up; Internal Behavioral Health Training. [PowerPoint presentation] Bend, OR.

Resources on Evidence-Based Therapies

- https://effectivechildtherapy.org/

- Policy Statement on Addressing Early Childhood Emotional and Behavioral Problems (December 2016) https://publications.aap.org/pediatrics/article/138/6/e20163023/52605/

- AAP guide (December 2021) : Mental Health Strategies for Pediatric Care https://shop.aap.org/mental-health-strategies-for-pediatric-care-paperback/

Q3: What SHOULD be the SE Reach metric rate be? What are we aiming for with benchmarks?

Interventions/Therapies

- **Brief interventions** that could be provided by eligible billing providers such as Integrated Behavioral Health, Home Visiting Nurse or eligible providers (which is something that ban be addressed in 1.3* of the metric – how to consider contracting models)

OR

- **Treatment services** (individual, family or group psychotherapy) provided by Specialty Behavioral Health that can include, but are not limited, to dyadic therapies, group therapies, and other services provided by Specialty Behavioral Health (Note: This is NOT specific to one type of modality or one set of services)

Children That Will Have Dx: 12-17%

High ACEs in Oregon: 28.9% (41,883) had 3 or more

Screening/Assessments

- Bright Futures recommended **screening tools** to assess for social-emotional health that primary care providers may use: Example: Pediatric Symptom Checklist

OR

- **Assessment** integrated behavioral health may do for children referred to them based on clinical judgment or ASQ or MCHAT results such as ASQ-SE or brief evaluation tools

Recommendations Call for All Children to be Screened in First Five Years

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Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																	
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																					
Weight for Length		●	●	●	●	●	●	●	●	●	●																						
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																	
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★	★
Hearing		●[8]	●[9] →	→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	←	●[10] →	←	← ● →	←	←	● →	←	● →	●	→
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																	
Maternal Depression Screening[11]				●	●	●	●																										
Developmental Screening[12]								●			●		●																				
Autism Spectrum Disorder Screening[13]											●	●																					
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																	
Newborn Blood		●[19]	●[20] →	→																													
Newborn Bilirubin[21]		●																															
Critical Congenital Heart Defect[22]		●																															
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★																
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	★	←			●	→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←	● →		★	★	★		
Hepatitis B Virus Infection[31]		★ →	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
Hepatitis C Virus Infection[32]																													●	→	→	→	→
Sudden Cardiac Arrest/Death[33]																						★	→	→	→	→	→	→	→	→	→	→	→
Cervical Dysplasia[34]																																	●
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★	★	★																
Fluoride Varnish[37]							←	→	→	→	●	→	→	→	→	→																	
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

Zoom In on Developmental/Social/Behavioral Domain

	INFANCY									
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Developmental Screening[12]								●		
Autism Spectrum Disorder Screening[13]										
Developmental Surveillance		●	●	●	●	●	●		●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

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Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health

Andrew Garner, MD, PhD, FAAP,[a,b] Michael Yogman, MD, FAAP[c,d]
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, COUNCIL ON EARLY CHILDHOOD

By focusing on the safe, stable, and nurturing relationships (SSNRs) that buffer adversity and build resilience, pediatric care is on the cusp of a paradigm shift that could reprioritize clinical activities, rewrite research agendas, and realign our collective advocacy. Driving this transformation are advances in developmental sciences as they inform a deeper understanding of how early life experiences, both nurturing and adverse, are biologically embedded and influence outcomes in health, education, and economic stability across the life span. This revised policy statement on childhood toxic stress acknowledges a spectrum of potential adversities and reaffirms the benefits of an ecobiodevelopmental model for understanding the childhood origins of adult-manifested disease and wellness. It also endorses a paradigm shift toward relational health because SSNRs not only buffer childhood adversity when it occurs but also promote the capacities needed to be resilient in the future. To translate this relational health framework into clinical practice, generative research, and public policy, the entire pediatric community needs to adopt a public health approach that builds relational health by partnering with families and communities. This public health approach to relational health needs to be integrated both vertically (by including primary, secondary, and tertiary preventions) and horizontally (by including public service sectors beyond health care). The American Academy of Pediatrics asserts that SSNRs are biological necessities for all children because they mitigate childhood toxic stress responses and proactively build resilience by fostering the adaptive skills needed to cope with future adversity in a healthy manner.

abstract

[a]Partners in Pediatrics, Westlake, Ohio; [b]School of Medicine, Case Western Reserve University, Cleveland, Ohio; [c]Cambridge Hospital, Cambridge, Massachusetts; and [d]Harvard Medical School, Harvard University, Boston, Massachusetts

Dr Garner collaborated in conceptualizing and drafting this document, took the lead in reconciling the numerous edits, comments, and suggestions made by many expert reviewers, and made significant contributions to the manuscript; Dr Yogman collaborated in conceptualizing and drafting this document and made significant contributions to the manuscript; and all authors approved the final manuscript as submitted.

To cite: Garner A, Yogman M, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, COUNCIL ON EARLY CHILDHOOD. Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote

Citation: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Questions Received

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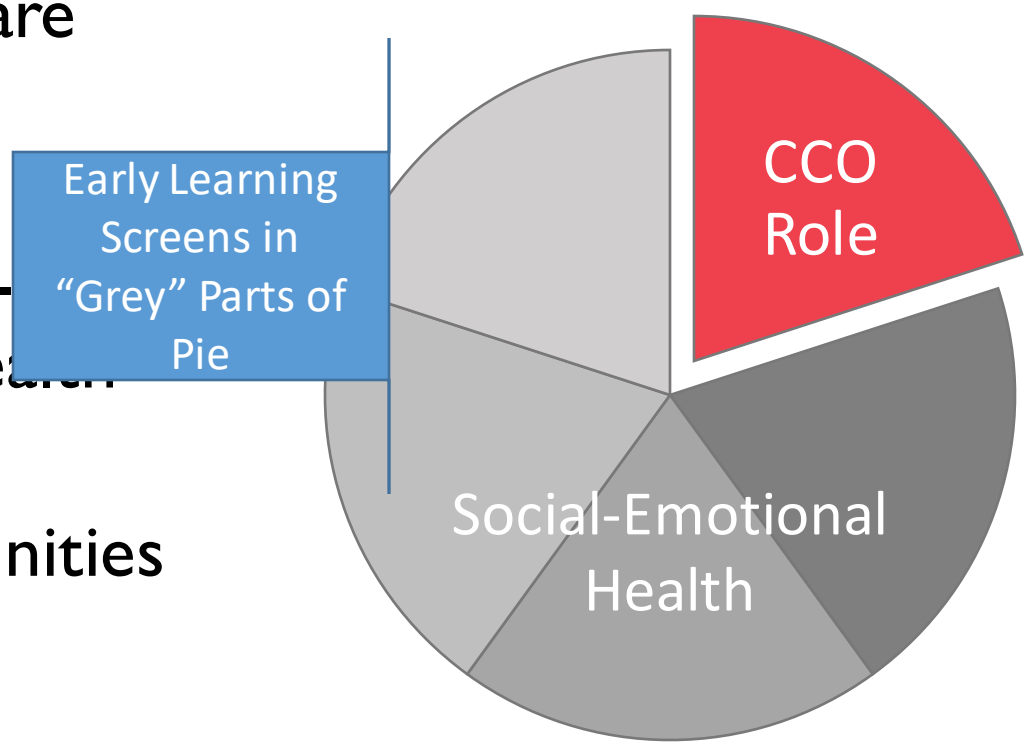


OPIP Children's Institute

Early Learning Refers (Pushes on a Pedal) and Needs Therapy Services for Children, Primary Care Provider Awareness and Support

Early Identification: Screening and then Assessments

Referral pathways and Parent Engagement

Intervention/Therapies

CCO-Covered Services that Support Social-Emotional Health at the Child-Level

Screening

Assessment

Biggest Pain Points from Parent & Provider Input

Early Learning Responses Emphasized Need

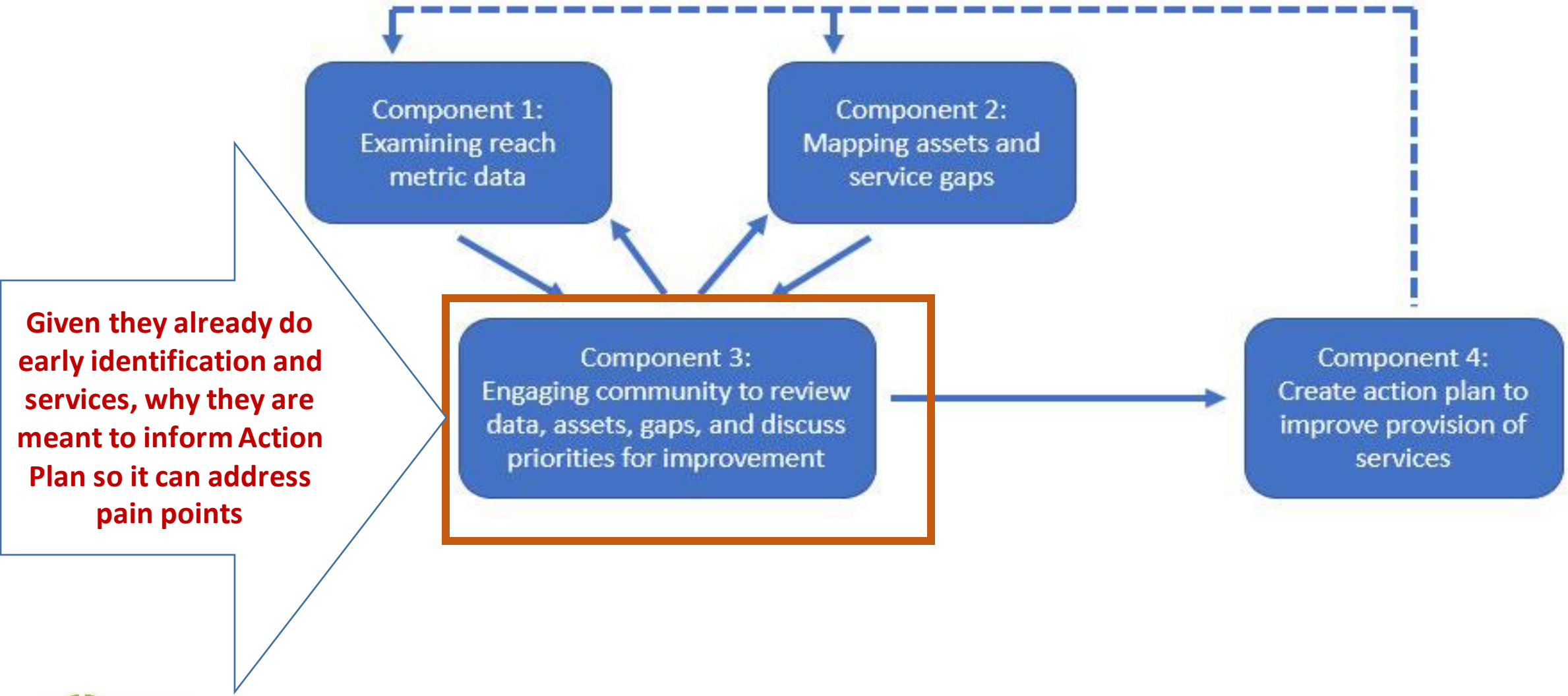
Brief Intervention

Treatment Service

- Metric is not all Social-Emotional Services.
- Metric is **CCO Covered Social Emotional Services** at child-level for these specific domains.

OPIP Children's Institute

System Level **Social-Emotional Metric: Importance of Early Learning Perspective**



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Q4: Shouldn’t we just focus on screening first to increase the rates?

Analogy of the Bike

Early Identification: Screening and then Assessments

Referral pathways and Parent Engagement

Intervention/Therapies

Shouldn't we just focus on screening first to increase the rates?

Overall Supply of Behavioral Health

What we Already Know in Exploring Services for Children and Heard from HAKR Survey:

- There are many cases of unmet need and the biggest pain point identified was in service delivery (supply of services are low)
- Component 2 will likely expose gaps in service or service capacity available for the children providers across sectors are already identifying and noting frustrations in CCO covered services.
- Why examining data in the context of the asset map is critical.
- Why hearing from community partners OUTSIDE CCO services that need CCO services for children they are identifying is critical in action plan development.

Shouldn’t we just focus on screening first to increase the rates?

If we focus our efforts ONLY on **screening we are increasing the demand** for services, but the **supply of intervention & therapy services will remain low**

Providers (e.g. Early Head Start/Head Start, Home Visiting, EI/ECSE, Relief Nurseries) in other sectors who are already screening and doing brief interventions noting a need for children they see and serve now.

Need to consider family-centered approaches.

Shouldn't we just focus on screening first to increase the rates?

- Component 2 of the metric is anchored to asset mapping of the systems that can provide services for children identified.
  - Assessing availability and capacity of the system to provide the "**Intervention and Therapy Services**" claims in the Social-Emotional reach metric.
  - If Asset Mapping done in Component 2 shows capacity and availability, then a focus on screening may be a good follow-up.
- OPIP's experience in hearing from front-line primary care, community based and early learning providers is that there are not services for children they are identifying through their current efforts, current screens (ASQ, maternal depression, MCHAT).
  - Therefore, the priority was on enhancing the interventions and therapies available across the spectrum of places it could be provided (integrated behavioral health, specialty behavioral health).
  - Includes a focus on interventions that are right match and will increase engagement
  - Includes consideration of referral pathways