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

DRAFT

Measure Basic Information

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

URL of Specifications: N/A.

Measure Type:

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

Measure Utility:

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

Data Sources:

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

Measurement Period: Calendar Year

2022 Benchmark: Proposal from measure development team is that CCOs are required to attest to all required components. Given this is a new metric, there is no benchmark data available.

Note on telehealth: Not applicable to this Attestation Survey Form

Measure Details

There are four components in this measure:

1) Social-Emotional Health Reach Metric Data Review and Assessment
2) Asset Map of Existing Social-Emotional Health Services and Resources
3) CCO-Led Cross-Sector Community Engagement
4) Action Plan to Improve Social-Emotional Health Service Capacity and Access

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

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

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

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

Relevant Materials:
Appendix A: Example Social-Emotional Health Reach Metric Report Based on Statewide Data (CCOs would receive reports specific to their member population)
Appendix B: Compendium of Codes included in Social-Emotional Health Reach Metric Data

Required Item Details:

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

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

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

- **Answer yes** if you have examined the disaggregated data provided in the aggregate or child level file to understand the populations served by your CCO.
- **Otherwise, answer no.**

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

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

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

	MY 1 Requirements	**MY 2 Requirements**	**MY 3 Requirements**
2.1 The CCO **develops an Asset Map** to capture services and resources in the CCO region that address children's Social-Emotional health, including key characteristics of services and providers to assess capacity and gaps.	CCO completed Asset Map form provided that summarizes capacity for **contracted behavioral health services**. (Must Pass)	CCO updates Asset Map for behavioral health services and completed Asset Map form for **social-emotional health services provided within Patient Centered Primary Care Home integrated behavioral health.** (Must Pass)	CCO updates Asset Map for behavioral health services, integrated PCPCH and completed Asset Map form for **other community-based social-emotional health services, including those provided by early learning.** (Must Pass)
Optional: 2.2 The CCO reviewed key considerations for internal reflection as part of their asset mapping process, to be shared with community partners stakeholders in Component 3.	Text entry (Optional)	Text entry (Optional)	Text entry (Optional)

Relevant Materials:
Appendix C: Sample Asset Map Form

Required Item Details:

2.1 Annually the CCO develops an Asset Map to capture services and resources in the CCO region using the standardized asset map form and templates provided anchored to evidence-based services and with specific indicators informed by stakeholder and improvement pilots that impact access to services.

- **To receive credit**, the CCO will upload developed asset map to attest to the completion of this task using the standardized form provided or ensuring that all components of the standardized form are addressed. The asset map ***must include*** the following components:
  - Location of Clinic or Program Site
  - County(tries) served by Clinic or Program Site
  - Number of Providers who Currently Serve Birth to Five
  - Capacity for New Referrals
  - Race, Ethnicity of Provider(s)
  - Language Spoken by Provider(s)
  - Service Modalities Provided

The CCO must provide information for each component noted above to pass this required item. **Appendix C** provides the standardized asset map form that CCOs can use when collecting the asset mapping information in a way that will allow the CCO to meaningfully attest to this requirement. In MY 1 the CCO will develop an asset map for contracted behavioral health providers, in MY 2 the CCO will develop an asset map for applicable Patient Centered Primary Care Home integrated behavioral health providers who serve children birth to age 5, and in MY 3 the CCO will develop an asset map for other community-based social-emotional health services, including those provided by early learning.

Component 3: CCO-Led Cross-Sector Community Engagement

	MY 1 Requirements	MY 2 Requirements	MY 3 Requirements
3.1 The CCO engaged cross-sector community partners to review and discuss: • **Social-Emotional Health Reach Metric data** • **Asset Map** of Social-Emotional Health Services and Providers • **Barriers and opportunities** to improve Social-Emotional Health service capacity and access.	Must include partners: Yes/No Additional partners: Select at least 4 (Must Pass)	Must include partners: Yes/No Additional partners: Select at least 4 (Must Pass)	Must include partners: Yes/No Additional partners: Select at least 4 (Must Pass)
3.2 The CCO engaged communities experiencing historical and contemporary injustices such as racism and other systemic bias* to review and discuss: • **Social-Emotional Health Reach Metric data** • **Asset Map** of Social-Emotional Health Services and Providers • **Barriers and opportunities** to improve Social-Emotional Health service capacity and access	Select at least 1 (Must Pass)	Select at least 2 (Must Pass)	Select all 3 (Must Pass)

3.3 Select the strategies the CCO implemented to obtain meaningful input from the communities experiencing historical and contemporary injustices engaged in 3.2 above.	Check all that apply (Must Pass)	Check all that apply (Must Pass)	Check all that apply (Must Pass)
Optional: 3.4 Submit a summary of reflections from conversations with cross-sector community partners and families.	Text entry (Optional)	Text entry (Optional)	Text entry (Optional)

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

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

Relevant Materials:

Future tools and resources will be provided to support the community engagement requirements, and specifically the items requiring engagement of communities experiencing historical and contemporary injustices

Required Item Details:

3.1 The CCO engaged cross-sector community partners to review and discuss the Social-Emotional Health Reach Metric data, CCO developed Asset Map of Social-Emotional Health Services and Providers, and Barriers and opportunities to improve Social-Emotional Health service capacity and access

- **Answer yes** if your CCO engaged the required cross-sector community partners from the following three categories:
  1) **All the required cross-sector community partners included in menu**:
     - Primary care practices/providers
     - Behavioral health programs/providers that serve children
     - Early Learning Hub(s)
     - Tribal government(s) and/or the Urban Indian Health Program - *As of May 2021, outreach to Tribal governments is required in this measure component as Tribes are crucial partners in communities on addressing regional and population-specific health needs. These measure specifications may be revised following engagement with the Tribes about this measure requirement, and we are currently working with OHA's Office of Tribal Affairs to determine the venue and timeline for that engagement.*
     - Regional Education Service District(s), including the Early Intervention and Early Childhood Special Education program
     - If applicable, any other CCO serving members in the same region
  2) **At least 2 'Partners Providing Services Aligned with Social Complexity Indicators' which would include partners such as:**
     - Culturally-specific organizations serving children birth to age 5 and their families
     - Local department of human services programs, including offices of child welfare and self-sufficiency
     - Other behavioral health programs/providers serving children birth to age 5 and their families
     - Local criminal justice agencies
     - Other (please define)
  3) **At least 2 Additional Partners, which could include partners such as:**

- Early care and education programs, including preschool and child care programs
- Local public health programs serving children birth to age 5 and their families (e.g., WIC, home visiting)
- Regional health equity coalitions
- Faith-based organizations
- Other community-based organizations serving families with young children (e.g., Family Relief Nursery)

- **Otherwise, answer no**.

3.2 The CCO engaged communities experiencing historical and contemporary injustices such as racism and other systemic bias* to review and discuss the Social-Emotional Health Reach Metric data, Asset Map of Social-Emotional Health Services and Providers, and barriers and opportunities to improve Social-Emotional Health service capacity and access.

- **Answer yes** if you engaged at least one population who experience historical and contemporary injustices included in the menu to review and discuss the Social-Emotional Health Reach Metric data, Asset Map of Social-Emotional Health Services and Providers, and barriers and opportunities to improve Social-Emotional Health service capacity and access.
- **Otherwise, answer no.**

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

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

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

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

Future tools and resources will be provided to support this component of work.

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

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

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

- The CCO reviewed existing data that has been collected in the CCO region about families' experience accessing Social-Emotional health services.

- The CCO partnered with and paid parent/family representatives from communities experiencing historical and contemporary injustices to engage on advisory councils or in meetings.
- The CCO included providers and/or advocacy groups that represent communities experiencing historical and contemporary injustices on advisory councils or in partner meetings.
- The CCO attended meetings hosted by families, providers, and/or advocacy groups that represent communities experiencing historical and contemporary injustices (e.g., Early Learning Hub Parent Advisory Council meetings) to hear family perspectives.
- The CCO partnered with families, providers, and/or advocacy groups that represent communities experiencing historical and contemporary injustices to collect new family data (e.g., via focus groups or listening sessions).
- Other (please define)

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

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

Relevant Materials:
Appendix D: Sample Action Plan Template

Required Item Details:
4.1 The CCO has identified at least two target areas to be included in their Action Plan informed by data review, asset mapping, and community conversations in Components 1-3.
- **Answer yes** if your CCO has identified at least two target areas from the options below for improvement informed by Components 1-3 of this measure.
- **Otherwise, answer no.**

Target areas for improving provision of Social-Emotional health services as informed by improvement pilots and stakeholder survey findings (693 surveys submitted) include:

- Workforce development to improve skills of available providers (e.g., training, support for credentialing, tool provision, quality improvement facilitation)
- Workforce development to increase provider diversity and availability (e.g., recruitment strategies, training, support for credentialing or other educational attainment)
- Increase range of Social-Emotional health service modalities provided
- Address access barriers for families (e.g., improve language access supports, provide child care supports, provide transportation supports, expand hours or offer flexible scheduling)
- Improve care coordination for families, including providing support navigating Social-Emotional health services and improving referral pathways
- Address contract or payment barriers for existing providers who provide Social-Emotional health services
- Pursue new contract and payment options for community-based providers to enhance provision of social emotional health services.
- Public health messaging efforts to increase awareness of Social-Emotional health services and/or reduce stigma.
- Other (please define)

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

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

4.3 The CCO has attached/uploaded their Action Plan, including target areas selected and improvement strategies and progress milestones for each target area. (**Appendix D** is a sample Action Plan template to consider when drafting your Action Plan in a way that will allow the CCO to meaningfully attest to this component of the work.)

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

4.4 The CCO has assessed progress on their Action Plan.

- **Answer yes** if your CCO assessed your action plan in the following ways:
  - The CCO assessed whether they achieved progress on their Action Plan, measured by meeting progress milestones the CCO set in the Action Plan.
  - The CCO assessed whether they achieved progress on their Action Plan, measured by making improvements to their Social-Emotional Health Reach Metric data.
  - The CCO involved communities experiencing historical and contemporary injustices to evaluate the success of improvement strategies in the CCO Action Plan and offer suggestions for revising the targets and strategies in the Action Plan.
- **Otherwise, answer no.**

4.5 The CCO has attached/uploaded a revised Action Plan, including target areas selected and improvement strategies and progress milestones for each target area. (**Appendix D** is a sample Action Plan template to consider when drafting your Action Plan in a way that will allow the CCO to meaningfully attest to this component of the work.)

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

Measure Scoring

Summary of System-Level Social-Emotional Health Metric Scoring

Component within CCO Attestation Tool	MY 1	MY 2-3
Component 1: CCO reviews and interprets the provided Social-Emotional Health Reach Metric data Required Items: 1.1-1.3 Optional Items: 1.4	**1.1** 1 point **1.2** 1 point **1.3** 1 point	**1.1** 1 point **1.2** 1 point **1.3** 1 point
Component 2: CCO develops Asset Map of existing Social-Emotional Health Services and Providers Required Items: 2.1 Optional Items: 2.2	**2.1** 1 point	**2.1** 1 point
Component 3: CCO leads Cross-Sector Community Engagement Required Items 3.1-3.3 Optional Items: 3.4	**3.1** 1 point **3.2** 1 point **3.3** 1 point	**3.1** 1 point **3.2** 1 point **3.3** 1 point
Component 4: CCO develops Action Plan to improve provision of Social-Emotional Health Services MY 1 Required Items: 4.1-4.3 MY 2-3 Required Items: 4.4-4.5	**4.1** 1 point **4.2** 1 point **4.3** 1 point	**4.4** 1 point **4.5** 1 point
Total Count of Required Attestation Items	**10 points**	**9 points**
Proposed Scoring Threshold for CCO Meeting the Metric	**10/10 Required Items Completed**	**9/9 Required Items Completed**

Measure Reference Materials

To support this novel measure, Oregon Pediatric Improvement Partnership and Children's Institute have compiled a number of Appendices to support CCOs to meaningfully complete and attest to measure requirements.

Appendix A: Example Social-Emotional Health Reach Metric Report Based on Statewide Data (CCOs would receive reports specific to their member population)
Appendix B: Compendium of Codes for the Child-Level Social-Emotional Health Reach Metric Data
Appendix C: Sample Asset Map Form
Appendix D: Sample Action Plan Template
Appendix E: Summary of Four Components of System-Level Social-Emotional Health Metric

Additional tools and resources to be provided upon adoption of the metric.

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

OHA will provide two data findings:

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

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

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

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

CCO Total

Social Emotional Health Reach Metric Findings: 2016-2019*

Factor	2016	2017	2018	2019
2016-2019 Findings	4.64%	4.90%	5.72%	6.46%

Social Emotional Health Reach Metric Findings: Latest Rolling Period**

Factor	Assessments	Services	Any	Denominator	Assessments Rate	Services Rate	Any Rate
Overall	2634	1949	3296	69885	3.77%	2.79%	4.72%

Social Emotional Health Reach Metric Findings by Child Health Complexity Data***

Factor	Assessments	Services	Any	Denominator	Assessments Rate	Services Rate	Any Rate
Overall	5434	4036	6871	123175	4.41%	3.28%	5.58%

Social Emotional Health Reach Metric Findings by Child Health Complexity Data: Social Complexity***

Factor	Assessments	Services	Any	Denominator	Assessments Rate	Services Rate	Any Rate
3+ Social Complexity Factors	3371	2631	4090	35716	9.44%	7.37%	11.45%
1-2 Social Complexity Factors	1579	1229	2138	51082	3.09%	2.41%	4.19%
0 Social Complexity Factors	484	176	643	36377	1.33%	0.48%	1.77%

Social Emotional Health Reach Metric Findings by Child Health Complexity Data: Social Complexity Factors***

Factor	Assessments	Services	Any	Denominator	Assessments Rate	Services Rate	Any Rate
Poverty –TANF (Child or Either/Both Parent), Below 37% of Poverty Level	3196	2414	3883	48027	6.65%	5.03%	8.09%
Foster care – Child received foster care services since 2012	1702	1231	1959	8419	20.22%	14.62%	23.27%
Parent death – Death of parent/primary caregiver in OR	54	50	67	495	10.91%	10.10%	13.54%
Parental incarceration – Parent incarcerated or supervised by the Dept. of Corrections in Oregon	1586	1240	1948	21135	7.50%	5.87%	9.22%
Mental Health: Child – Received mental health services through DHS/OHA	3553	3304	4504	19923	17.83%	16.58%	22.61%
Mental Health: Parent – Received mental health services through DHS/OHA	3263	2543	4019	48665	6.71%	5.23%	8.26%
Substance Abuse: Child – Substance abuse treatment through DHS/OHA	Too small to report						
Substance Abuse: Parent – Substance abuse treatment through DHS/OHA	1815	1378	2192	21893	8.29%	6.29%	10.01%
Child abuse/neglect: ICD-9, ICD-10 dx codes related used by provider	1887	1463	2202	7315	25.80%	20.00%	30.10%
Potential Language Barrier: Language other than English listed in the primary language	888	614	1063	15048	5.90%	4.08%	7.06%
Parent Disability: Parent is eligible for Medicaid due to recognized disability	417	315	496	4090	10.20%	7.70%	12.13%

Children with Social Factor that had Social Emotional Assessments and/or Services

*2016-2019 Findings: Reference period calendar years 2016, 2017, 2018, 2019. CCO attribution as of last day of each year. Include continuous enrollment criterion.

**Latest Rolling Period Findings: Reference period October 2019 – September 2020. CCO attribution as of as of 12/31/2020. Include continuous enrollment criterion.

***Child Health Complexity Findings: Reach metric claims reference period January – December 2019. Child health complexity reference period January 2017 – December 2019. CCO attribution as of 5/31/2020. Do not include continuous enrollment criterion.

1. MH assessment and service utilization among CCO members under age 6; 2016 - 2020

a. 2016 Rate - % of children under age six receiving any of the assessments/services outlined List 1-5 in 2016

i. Measurement period: Jan 1, 2016 - Dec 31, 2016
ii. Denominator: Unique number of members ages 0-5 as of December 31, 2016 who meet the continuous enrollment criteria below
iii. Numerator: Unique number of children who receive any of the assessments or procedure codes in List 1-5 in 2016
iv. Continuous enrollment criteria: continuously enrolled for the full year in the measurement year, with one allowable gap up to 45 days.
v. Stratification: Statewide, by CCO, and by County

b. 2017 Rate - % of children under age six receiving any of the assessments/services outlined List 1-5 in 2017

i. Measurement period: Jan 1, 2017 - Dec 31, 2017
ii. Denominator: Unique number of members ages 0-5 as of December 31, 2017 who meet the continuous enrollment criteria below
iii. Numerator: Unique number of children who receive any of the assessments or procedure codes in List 1-5 in 2017
iv. Continuous enrollment criteria: continuously enrolled for the full year in the measurement year, with one allowable gap up to 45 days.
v. Stratification: Statewide, by CCO, and by County

c. 2018 Rate - % of children under age six receiving any of the assessments/services outlined List 1-5 in 2018

i. Measurement period: Jan 1, 2018 - Dec 31, 2018
ii. Denominator: Unique number of members ages 0-5 as of December 31, 2018 who meet the continuous enrollment criteria below
iii. Numerator: Unique number of children who receive any of the assessments or procedure codes in List 1-5 in 2018
iv. Continuous enrollment criteria: continuously enrolled for the full year in the measurement year, with one allowable gap up to 45 days.
v. Stratification: Statewide, by CCO, and by County

a. 2019 Rate - % of children under age six receiving any of the assessments/services outlined List 1-5 in 2019

i. Measurement period: Jan 1, 2019 - Dec 31, 2019
ii. Denominator: Unique number of members ages 0-5 as of December 31, 2019 who meet the continuous enrollment criteria below
iii. Numerator: Unique number of children who receive any of the assessments or procedure codes in List 1-5 in 2019
iv. Continuous enrollment criteria: continuously enrolled for the full year in the measurement year, with one allowable gap up to 45 days.
v. Stratification: Statewide, by CCO, and by County

Field	Description
MEASURE_YEAR	Year of Measure Definition
DTE_MAX	Last Day of Measurement Year
DTE_EXTRACT	Date of Extract from DSSURS
DTE_POST	File Creation Date
MEASURE	Measure Name
ID_MEDICAID	External Member ID/Prime ID
DTE_BIRTH	Member Date of Birth
NUM_AGE_ANCHOR	Member Age on Anchor Date/End of Measurement Year
CCO_Name	CCO Name
CDE_COUNTY	Last County of Member Residence in Measuremen Year
FLAG_CE	Continuous Enrollment Flag (1=CE, 0=not CE)
TOT_COV_DAYS	Number of Covered Days in CCO
FLAG_ANY_DX	Numerator Any Diagnosis
FLAG_1	Numerator List 1 Any Diagnosis
FLAG_2	Numerator List 2 Any Diagnosis
FLAG_3	Numerator List 3 Any Diagnosis
FLAG_4	Numerator List 4 Any Diagnosis
FLAG_5	Numerator List 5 Any Diagnosis
N_CLMS	Total Number of Numerator Claims

MEASURE_YEAR	DTE_MAX	DTE_EXTRACT	DTE_POST	MEASURE	ID_MEDICAID	DTE_BIRTH	NUM_AGE_ANCHOR	CCO_NAME	CDE_COUNTY	FLAG_CE	TOT_COV_DAYS	FLAG_ANY_DX	FLAG_1	FLAG_2	FLAG_3	FLAG_4	FLAG_5	N_CLMS

Appendix A: Example SE Health Reach Metric Report

List 1) CPT codes that are assessments, but since these are generally done by a BH provider, they should count as BH touches/interventions.
Billing Code
90791
90792
90801
90802
96101 - 96103
96116
96118 - 96120
96125
96127
96130 - 96131
96132 - 96133
96136 - 96137
96138 - 96139
96150 - 96151
0359T
H0002
H0031

List 2) Any Billing Code + Any of the ICD-10 Codes listed + Any of the Provider Taxonomy Codes -- These are assessments that we aren't sure would be done by a MH provider

Billing Codes	ICD-10 Codes	Medicare Specialty Codes	Description of Provider
96105	Z69.010, Z69.020	37	DB Peds
96111	F90.0-F90.2, F90.9	62	Psychologist
99381 - 99383	F98.3, F50.9, F98.21	80	LCSW
99391 - 99393	F43.10	261QM0801X (taxonomy code)	Community Mental Health Center
	F84.0, F84.3-F84.9	68	Clinical psychologist
	F32.0, F32.1, F34.89, F39	86	Neuropsychiatrist
	F43.0		
	F50.9		
	F93.0		
	F41.1, F41.8		
	F91.3, F91.9		
	F34.1		
	F43.20 - F43.25, F43.8,		
	Z62.810- Z62.812, Z62.820, Z62.8 also Z63.8		
	F95.0-F95.2, F95.9		
	F94.1, F94.2		
	F40.10		
	F42.2, F63.3, F42.9		
	F98.1		
	F94.0		
	F50.9		
	Z76.2		

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.
Billing Code
90804 -90809
90810 - 90815
90816 -90822
90823 - 90829
90832 -90838
90839
90840
90845
90846
90847
90849
90853
90857
90875 -90876
96152
96153
96154
96155
98960
98961
98962
99078
99483
0364T - 0365T
0368T - 0369T
0370T
G0176
G0177
G0409
G0410
G0411
G0155
H0004
H0023
H0024
H0025
H0032
H0035
H0036 - H0037
H0038
H0039 - H0040
H1011
H2011
H2012

H2013
H2014
H2017 - H2018
H2019 - H2020
H2021 - H2022
H2030 - H2031
S9482
S9484 - S9485
T2048

List 4) For any Billing code listed, paired with any ICD-10 code listed	
Billing Code	**ICD-10 Codes**
99341 - 99345	Z69.010, Z69.020
99346	F90.0-F90.2, F90.9
99347 - 99350	F98.3, F50.9, F98.21
99401 - 99404	F43.10
99411 - 99412	F84.0, F84.3-F84.9
99501, 99502, 99510	F32.0, F32.1, F34.89, F39
H2015 - H2016	F43.0
S5111	F50.9
S9446	F93.0
	F41.1, F41.8
	F91.3, F91.9
	F34.1
	F43.20 - F43.25, F43.8,
	Z62.810- Z62.812, Z62.820, Z62.8 also Z63.8
	F95.0-F95.2, F95.9
	F94.1, F94.2
	F40.10
	F42.2, F63.3, F42.9
	F98.1
	F94.0
	F50.9
	Z76.2

List 5) Any Billing Code + Any of the ICD-10 Codes listed + Any of the Provider Taxonomy Codes			
Billing Code	**ICD-10 Codes**	**Medicare Specialty Codes**	**Description of Provider**
99201 - 99205	Z69.010, Z69.020	37	DB Peds
99211 - 99215	F90.0-F90.2, F90.9	62	Psychologist
99217	F98.3, F50.9, F98.21	80	LCSW
99218 - 99220	F43.10	261QM0801X (taxonomy code)	Community Mental Health Center
99221-99223	F84.0, F84.3-F84.9	68	Clinical psychologist
99231 - 99233	F32.0, F32.1, F34.89, F39	86	Neuropsychiatrist
99238 - 99239	F43.0		
99241 - 99245	F50.9		
99251 - 99255	F93.0		
99281- 99285	F41.1, F41.8		
G0451	F91.3, F91.9		
G0463	F34.1		
G0467	F43.20 - F43.25, F43.8,		
G0469	Z62.810- Z62.812, Z62.820, Z62.8 also Z63.8		
G0470	F95.0-F95.2, F95.9		
H2000	F94.1, F94.2		
T1015	F40.10		
T1025	F42.2, F63.3, F42.9		
T1026	F98.1		
T2038	F94.0		
	F50.9		
	Z76.2		

Development of Pediatric Behavioral Health Reach Metric for Children 0-5:
Overview of Metrics to Consider

This document provides an overview of the pediatric behavioral health assessment and service billing codes currently being considered for the behavioral health reach metric for children 0-5. This guide is meant to be a process to determine all possible billing codes that would be considered for the numerator to indicate that a child ***age 0-5*** *received BH assessment or services.This document also summarizes coverage within OHP as of 5/2020*

The sheet following sheets include those biling codes that would reasonably apply to a family with young children age 0-5 and are recommended by OPIP to be included in the SE metric

List 1) CPT codes that are assessments, but since these are generally done by a BH provider, they should count as BH touches/interventions in the numerator of our BH reach metric

List 2) CPT codes that are assessments but we are uncertain if a BH provider would ever use those codes for services they provide, because they are used by primary care providers and would not be specific enough. BUT if BH providers would use them, they should be paired with appropriate MH diagnosis code and provider type.**Note, in Oregon, provider type is not documented easily, and therefore may not be a feasible requirement in a reach metric

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.

List 4) CPT codes, if paired with an appropriate mental health diagnosis, could count as a BH touch

List 5) CPT codes that should be paired to an appropriate MH code and also require a provider type to qualify as a BH touch, since they are generally too broad to count if there is no documentation of who provided the service. **Note, in Oregon, provider type is not documented easily, and therefore may not be a feasible requirement in a reach metric

"Diagnostic Workup File" includes a crosswalk of the HERC prioritized line for psychiatric codes, and those diagnostic codes that we deemed are applicable to age 0-5. These are also crossreferenced with the OHA diagnostic crosswalk created by Laurie Theodorou found here: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/DevScreeningFollowUp-Oregon-Early-Childhood-Diagnostic-Crosswalk.pdf

List 1) CPT codes that are assessments, but since these are generally done by a BH provider, they should count as BH touches/interventions.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
90791	Psychiatric Diagnostic Evaluation		Yes
90792	Psychiatric Diagnostic Evaluation, by a medically licensed professional		Yes
90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION		Yes
90802	INTERACTIVE PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF COMMUNICATION		Yes
96101 - 96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report (retired 2019)		Yes
96116/96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report (new in 2019: 96121 for each additional hour)		
96118 - 96120	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test)		
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour		
96127	brief behavioral or emotional assessments for reimbursement. These assessments may include any standardized screening instruments that will provide both scoring and further documentation to the healthcare provider.		Yes
96130 - 96131	PSYCHOLOGICAL TESTING EVALUATION BY QUALIFIED HEALTH CARE PROFESSIONAL		Yes

List 1) CPT codes that are assessments, but since these are generally done by a BH provider, they should count as BH touches/interventions.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
96132 - 96133	NEUROPSYCHOLOGICAL TESTING EVALUATION BY QUALIFIED HEALTH CARE PROFESSIONAL		
96136 - 96137	PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY QUALIFIED HEALTH CARE PROFESSIONAL		Yes
96138 - 96139	PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY TECHNICIAN		Yes
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only (new in 2019)		
96150 - 96151	HEALTH AND BEHAVIOR ASSESSMENT (EG, HEALTH-FOCUSED CLINICAL INTERVIEW, BEHAVIORAL OBSERVATIONS, PSYCHOPHYSIOLOGICAL MONITORING, HEALTH-ORIENTED QUESTIONNAIRES), EACH 15 MINUTES FACE-TO-FACE WITH THE PATIENT (retired in 2020)		
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making) (new in 2020, to replace 96150-51)		
97151	Behavior identification assessment, administered by a physician or other qualified health care professional (new in 2019)		
97152	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional (new in 2019)		
0359T	BEHAVIOR IDENTIFICATION ASSESSMENT (retired in 2019)		
0360T-0361T	Observational behavioral follow-up assessment (retired in 2019)		
0362T-0363T	Exposure behavioral follow-up assessment (0363T retired in 2019)		
H0002	Behavioral Health screening to determine eligibility for admission to treatment program		Yes

List 1) CPT codes that are assessments, but since these are generally done by a BH provider, they should count as BH touches/interventions.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
H0031	Mental health assessment, by non-physician		Yes

List 2) CPT assessment codes that we are uncertain if a BH provider would ever use those codes for services they provide, because they are used by primary care providers and would not be specific enough. BUT if BH providers would use them, they should be paired with appropriate MH diagnosis code and provider type.

Billing Code	Description	HERC Prioritized List (Line listed, if blank, not included)	Diagnostic Workup File (if blank, not included)
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	96	
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report		Yes
96112-96113	Developmental test administration by physician or other qualified healthcare professional, with interpretation and report (new in 2020, to replace 96111)		
99381 - 99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient	120, 446, 546	Yes
99391 - 99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient	120, 446, 554	Yes

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
90785	Interactive complexity code		
90804 -90809	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY FACE-TO-FACE WITH THE PATIENT;		
90810 - 90815	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN OFFICE OR OUTPATIENT FACILITY, FACE-TO-FACE WITH THE PATIENT;		
90816 -90822	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, FACE-TO-FACE WITH THE PATIENT;		
90823 - 90829	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES, LANGUAGE INTERPRETER, OR OTHER MECHANISMS OF NON-VERBAL COMMUNICATION, IN AN INPATIENT HOSPITAL, PARTIAL HOSPITAL OR RESIDENTIAL CARE SETTING, FACE-TO-FACE WITH THE PATIENT;		
90832 -90838	Individual psychotherapy	4, 7, 120, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 449, 458, 462, 473	
90839	Patient in crisis add-on 60 minutes	4, 7, 120, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 449, 458, 462, 474	
90840	patient in crisis add-on each additional 30 minutes	4, 7, 120, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 449, 458, 462, 475	

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
90845	Psychoanalysis		
90846	Family psychotherapy without patient present	4, 7, 120, 121, 149, 173, 193, 203, 290, 381, 388, 414, 421, 444,449, 458, 462, 470	
90847	Family psychotherapy with patient present	4, 7, 120, 121, 173, 193, 203, 290, 381, 388, 414, 421, 444, 449, 458, 462, 470	
90849	Family psychotherapy, multiple-family group	4, 7, 120, 121, 149, 173, 193, 203, 290, 381, 388, 414, 421, 444, 449, 458, 462, 470	
90853	Group psychotherapy	4, 7, 120, 149, 173, 203, 290, 381, 388, 414, 421, 444, 449, 458, 462, 470	
90857	INTERACTIVE GROUP PSYCHOTHERAPY		
90875 -90876	Individual psychophysiological therapy incorporating biofeedback training by any modality		
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions		
90887	Consultation with family - Explanation of psychiatric, medical examinations, procedures, and data to other than patient.		
96152	HEALTH AND BEHAVIOR INTERVENTION, INDIVIDUAL EACH 15 MINUTES (retired in 2020)		
96153	HEALTH AND BEHAVIOR INTERVENTION, GROUP EACH 15 MINUTES (retired in 2020)		
96154	HEALTH AND BEHAVIOR INTERVENTION, FAMILY AND PATIENT EACH 15 MINUTES (retired in 2020)		

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
96155	HEALTH AND BEHAVIOR INTERVENTION, FAMILY EACH 15 MINUTES (retired in 2020)		
96158-96159	Health behavior intervention, individual, face-to-face (new in 2020)		
96164-96165	Health behavior intervention, group (2 or more patients), face-to-face (new in 2020)		
96167-96168	Health behavior intervention, family (with the patient present), face-to-face (new in 2020)		
96170-96171	Health behavior intervention, family (without the patient present), face-to-face (new in 2020)		
97153	Adaptive behavior treatment by protocol, administered by technician (new in 2019)		
97154	Group adaptive behavior treatment by protocol, administered by technician (new in 2019)		
97155	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional (new in 2019)		
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (new in 2019)		
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (new in 2019)		

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional (new in 2019)		
98960	education & training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient		
98961	2-4 patients - Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patient		
98962	- 5-8 patients - Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients		
99078	Physician educational services in a group	120, 446, 554	
99483	Cognition-focused evaluation, including a pertinent history and examination of the patient		Yes
0364T - 0365T	Adaptive Behavior Treatment by Protocol, Administered by Technician (retired in 2019)		
0366T-0367T	Group adaptive behavior treatment by protocol (retired in 2019)		

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
0368T - 0369T	Adaptive Behavior Treatment with protocol modification administered by physician or other qualified health care professional (retired in 2019)		
0370T	Family Adaptive Behavior treatment guidance, administered by physician (retired in 2019)		
0371T	Multiple-family group adaptive behavior treatment guidance (retired in 2019)		
0372T	Group adaptive behavior treatment with protocol modification (retired in 2019)		
0373T-0374T	Adaptive behavior treatment with protocol modification (0374T retired in 2019)		
G0176	Activity therapy (music, dance, are or play therapies) related to the care and treatment of patient's disabling menthal health problems per session (45 min or more)	7, 121, 149, 173, 193, 203, 381, 388, 414, 421, 432, 444, 449, 458, 462, 470, 473	
G0177	Training and educational services related to care and treatment of patient's disabling mental health problems per session (45 minutes or more)	7, 121, 149, 173, 193, 203, 381, 388, 414, 421, 432, 444, 449, 458, 462, 470, 473	
G0409	Social work and psychological services directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a core-qualified social workers or a psychologist in a core)		
G0410	Group psychotherapy other than of a multiple-family group, in a particular hospitalization setting, approximately 45 to 50 minutes	4, 7, 149, 173, 203, 290, 381, 449, 470	

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
G0411	Interactive group psychotherapy, in a partial hospitalization setting	4, 7, 149, 173, 203, 290, 381, 449, 470	
G0155	Services of CSW in home health or hospice settings		
H0004	Behavioral health counseling and therapy per 15 minutes	4, 7, 121, 149, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 449 458, 462, 470	
H0023	BEHAVIORAL HEALTH OUTREACH SERVICE (PLANNED APPROACH TO REACH A TARGETED POPULATION)	4, 7, 121, 149, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 449, 458, 462, 470, 473	
H0024	BEHAVIORAL HEALTH PREVENTION INFORMATION DISSEMINATION SERVICE (ONE-WAY DIRECT OR NON-DIRECT CONTACT WITH SERVICE AUDIENCES TO AFFECT KNOWLEDGE		
H0025	BEHAVIORAL HEALTH PREVENTION EDUCATION SERVICE (DELIVERY OF SERVICES WITH TARGET POPULATION TO AFFECT KNOWLEDGE, ATTITUDE AND/OR BEHAVIOR)		
H0032	MENTAL HEALTH SERVICE PLAN DEVELOPMENT BY NON-PHYSICIAN	4, 7, 121, 149, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 449, 458, 462, 470, 473	
H0035	Mental health partial hospitalization, treatment, less than 24 hours	4, 7, 121, 149, 173, 203, 290, 388, 381, 444, 449, 458, 470, 473	
H0036 - H0037	Community psychiatric supportive treatment	7, 121, 149, 173, 203, 290, 381, 388, 414, 421, 432, 444, 449,	
H0038	SELF-HELP/PEER SERVICES, PER 15 MINUTES	4, 7, 120, 121, 149, 173, 193, 203, 290, 381, 388, 414, 421	
H0039 - H0040	Assertive community treatment	7, 149, 173, 203, 381, 414, 432, 462	
H1011	FAMILY ASSESSMENT BY LICENSED BEHAVIORAL HEALTH PROFESSIONAL FOR STATE DEFINED PURPOSES		

List 3) CPT codes that could stand alone and be counted in the numerator of our BH reach metric.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
H2011	Crisis intervention service, per 15 minutes		Yes
H2012	Behavioral health day treatment, per hour	7, 121, 149, 173, 203, 290, 381, 388, 414, 421, 432, 444, 449, 458, 462, 470, 473	
H2013	Psychiatric health facility service, per diem	4, 7, 121, 149, 173, 203, 290, 381, 388, 414, 449, 462, 470	
H2014	Skills training and development, per 15 minutes	7, 121, 149, 173, 193, 203, 381, 388, 414, 421, 432, 444, 449, 458, 462, 470, 473	
H2017 - H2018	Psychosocial rehabilitation services	203	
H2019 - H2020	Therapeutic behavioral services	203	
H2021 - H2022	COMMUNITY-BASED WRAP-AROUND SERVICES	7, 121, 149, 173, 193, 290, 381, 388, 414, 421, 432, 444, 449, 458, 462, 470, 473	
H2030 - H2031	MENTAL HEALTH CLUBHOUSE SERVICES		
S9482	FAMILY STABILIZATION SERVICES, PER 15 MINUTES		
S9484 - S9485	Crisis intervention mental health service	7, 121, 149, 173, 193, 203, 290, 381, 388, 421, 432, 444, 449, 458, 462, 470, 473	Yes

List 4) CPT codes, if paired with an appropriate mental health diagnosis, could count as a BH touch			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
99341 - 99345	Home visits, new patient	4, 7, 120, 121, 149, 173, 203, 290, 381, 388, 414, 421, 432, 444, 446, 449, 458, 462, 470, 473, 554	Yes
99346	nurse home visit, without the provider	4, 7, 120, 121, 149,173, 203, 290, 381, 388, 414, 421, 432, 444, 446, 449, 458, 462, 470, 473, 554	
99347 - 99350	Home visit, established patient, minor problem, 15 minutes	4, 7, 120, 121, 149, 173, 203, 290, 381, 388, 414, 421, 432, 444, 446, 449, 458, 462, 470, 473, 546	Yes
99401 - 99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure);	120, 446, 546	Yes
99411 - 99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure)	120, 446, 546	Yes
99501	Home visit for postnatal assessment and follow-up care		
99502	Home visit for newborn care and assessment		
99510	Home visit for individual, family, or marriage counseling		
H2015 - H2016	Comprehensive community support services		
S5111	HOME CARE TRAINING, FAMILY; PER SESSION		

List 4) CPT codes, if paired with an appropriate mental health diagnosis, could count as a BH touch			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
S9446	PATIENT EDUCATION, NOT OTHERWISE CLASSIFIED, NON-PHYSICIAN PROVIDER, GROUP, PER SESSION		

List 5) CPT codes that should be paired to an appropriate MH code and also require a provider type to qualify as a BH touch, since they are generally too broad to count if there is no documentation of who provided the service.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
99201 - 99205	Office or other outpatient visit for the evaluation and management of a new patient	4, 7, 120, 121, 149, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 446, 449, 458, 462, 470, 473, 554	Yes
99211 - 99215	Office or other outpatient visit for the evaluation and management of an established patient	4, 7, 120, 121, 149, 173, 193, 203, 290, 381 388, 414, 421, 432, 444, 446, 449, 458, 462, 470, 473, 554	Yes
99217	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services	4, 7, 120, 149, 173, 203, 290, 381, 449, 470	Yes
99218 - 99220	Initial observation care, per day, for the evaluation and management of a patient	4, 7, 120, 149, 173, 290, 381	Yes
99221-99223	initial hospital care, per day, for the evaluation and management of a patient	4, 7, 120, 149, 173, 290, 381	Yes
99231 - 99233	subsequent hospital care	4, 7, 120, 149, 173, 290, 381,	Yes
99238 - 99239	Hospital discharge day management	4, 7, 120, 149, 173, 290, 381,	Yes
99241 - 99245	office consultations with new or established patients		
99251 - 99255	Inpatient consultation for a new or established patient		
99281- 99285	Emergency department visit for the evaluation and management of a patient	7, 120, 173, 203, 290, 446, 554	Yes

List 5) CPT codes that should be paired to an appropriate MH code and also require a provider type to qualify as a BH touch, since they are generally too broad to count if there is no documentation of who provided the service.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
G0451	Development testing, with interpretation and report, per standardized instrument form (G0451)		
G0463	Hospital outpatient clinic visit for assessment and management of a patient	4, 7, 120, 121, 149, 173, 193, 203, 290, 388, 414, 421, 432, 444, 446, 449, 458, 462, 470, 473, 554	Yes
G0467	FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISIT, ESTABLISHED PATIENT; A MEDICALLY-NECESSARY, FACE-TO-FACE ENCOUNTER (ONE-ON-ONE) BETWEEN AN ESTABLISHED PATIENT AND A FQHC PRACTITIONER DURING WHICH TIME ONE OR	4, 7, 120, 121, 149, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 446, 449,458, 462, 470, 473, 554	
G0469	FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISIT, MENTAL HEALTH, NEW PATIENT; A MEDICALLY-NECESSARY, FACE-TO-FACE MENTAL HEALTH ENCOUNTER (ONE-ON-ONE) BETWEEN A NEW PATIENT AND A FQHC PRACTITIONER DURING WHICH TIME ONE OR MORE FQHC SERVICES ARE RENDERED AND INCLUDES A TYPICAL BUNDLE OF MEDICARE-COVERED SERVICES THAT WOULD BE FURNISHED PER DIEM TO A PATIENT RECEIVING A MENTAL HEALTH VISIT	4, 7 ,121, 149, 173, 193, 203, 290, 381, 388, 414, 421, 444, 449, 458, 462, 470, 473	

List 5) CPT codes that should be paired to an appropriate MH code and also require a provider type to qualify as a BH touch, since they are generally too broad to count if there is no documentation of who provided the service.			
Billing Code	**Description**	**HERC Prioritized List (Line listed, if blank, not included)**	**Diagnostic Workup File (if blank, not included)**
G0470	FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISIT, MENTAL HEALTH, ESTABLISHED PATIENT; A MEDICALLY-NECESSARY, FACE-TO-FACE MENTAL HEALTH ENCOUNTER (ONE-ON-ONE) BETWEEN AN ESTABLISHED PATIENT AND A FQHC PRACTITIONER DURING WHICH TIME ONE OR MORE FQHC SERVICES ARE RENDERED AND INCLUDES A TYPICAL BUNDLE OF MEDICARE-COVERED SERVICES THAT WOULD BE FURNISHED PER DIEM TO A PATIENT RECEIVING A MENTAL HEALTH VISIT	4, 7, 121,149, 173, 193, 203, 290, 381, 388, 414, 421, 432, 444, 449, 458, 462, 470, 473	
H2000	Comprehensive multidisciplinary evaluation		Yes
T1015	Clinic visit/encounter, all-inclusive		
T1025	INTENSIVE, EXTENDED MULTIDISCIPLINARY SERVICES PROVIDED IN A CLINIC SETTING TO CHILDREN WITH COMPLEX MEDICAL, PHYSICAL, MENTAL AND PSYCHOSOCIAL IMPAIRMENTS, PER DIEM		
T1026	INTENSIVE, EXTENDED MULTIDISCIPLINARY SERVICES PROVIDED IN A CLINIC SETTING TO CHILDREN WITH COMPLEX MEDICAL, PHYSICAL, MEDICAL AND PSYCHOSOCIAL IMPAIRMENTS, PER HOUR		
T2038	COMMUNITY TRANSITION, WAIVER; PER SERVICE		

Appendix C: Sample Asset Map Form

THIS SAMPLE FORM WILL SUPPORT CCOS IN COMPLETING AND ATTESTING TO THIS COMPONENT OF THE WORK

Year 1: Required to complete table for all contracted **behavioral health providers** within contract.

- Focused on assets and services specific to children birth to five that are who the CCO contracts with to specifically provide mental and behavioral health services. These are providers that specifically serve this population and serve publicly insured (Medicaid/CHIP) children.
- This should include contracted providers that PCPCH clinics note being "co-located" within in PCPCH 3.C.1.

Year 2: Required to complete for contracted **Patient Centered Primary Care Homes** who have attested to the PCPCH standards with Standard 3C3 to indicate that they provide **integrated behavioral health services** including population-based, same-day consultations by behavioral health providers. https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2020-PCPCH-TA-Guide.pdf

Year 3: Required to complete for **Early learning providers** and **other community-based Social-Emotional services** identified in Attestation Component 3 in Years 1 and 2.

- A specific asset map template will be developed to capture these assets based on CCOs responses in Year 1 to Attestation Components of partners engaged.
- A draft of the Year 3 potential providers is provided for example purposes of Social-Emotional services identified in previous proof pilots of improvement efforts. That said, these services will be highly individualized to each community and the community settings and to areas in which the intended community-level engagement identifies a need and opportunity to build or leverage supports and services in the community.

Appendix C: Sample Asset Map Form

Year 1 Asset Map: Contracted Behavioral Health Providers – Social Emotional Services for Birth to Five	**Behavioral Health Organizations Contracted with CCO That Have Providers Who Serve Children Birth to Five**					
	Organization #1	**Organization # 2**	**Organization #3**	**Organization # 4**	**Organization # 5**	**Organization # 6**
Location of Clinic Sites (City)						
County(ies) Served by the Clinic Site						
Number of Providers Who Currently Serve Birth to Five and Have Applicable Skill Sets ***(Drop down that will customize form)***						
Average Capacity for New Referrals Specific to Birth to Five (per week) ***(Drop down of standard options)***						
Provider(s) Identified Race, Ethnicity ***(Drop down of REAL-D Categories)***						
Languages the Provider(s) are able to Provide Services for Birth to Birth to Five ***(Drop down of languages aligned with CLAS metric)***						
Modalities the Provider(s) Offer ***(Drop down of evidence-based modalities*, addition of an "other". See Next Page.)***						

Appendix C: Sample Asset Map Form

Evidence-based modalities for Children Birth to 5:

Behavioral Health Therapy For Children <5	Delivery Method	Organization (s)	# of Providers
SERVICES TARGETED TO CHILDREN WITH DISRUPTIVE BEHAVIOR PROBLEMS			
Parent Child Interaction Therapy (PCIT) * PCIT is also an effective program for children with known trauma history	Dyadic		
Generation-PMTO	Dyadic, Family, Group		
Triple P (Positive Parenting Program)	Group		
Theraplay	Dyadic		
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)			
Collaborative Problem Solving	Family, Individual		
Play Therapy	Family, Individual		
Helping the Non-compliant Child	Dyadic		
SERVICES TARGETED TO CHILDREN WITH KNOWN TRAUMA HISTORY			
Child Parent Psychotherapy (CPP)	Dyadic		
Eye Movement Desensitization and Reprocessing (EMDR)	Individual		
Attachment Regulation and Competency (ARC)	Dyadic, Family, Individual		
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)			
Trauma Focused CBT	Dyadic		
SERVICES TARGETED TO CHILDREN WITH AT-RISK PARENTS/ FAMILIES			
Family Check-Up	Dyadic		
Attachment and Biobehavioral Catch-up (ABC)	Dyadic		
SERVICES VALID FOR CHILDREN OLDER THAN 3 (PATHWAYS PROJECT IS PRIMARILY FOCUSED ON CHILDREN UNDER 3)			
Incredible Years * Incredible Years is also good for children with disruptive behavior problems	Group		
OTHER SERVICES PROVIDED WITHIN THE COMMUNITY:			
Marriage and Family Therapist or Child Counselling	Varies		
Other Modalities without evidence base (Dance Therapy, Art Therapy, Equine Therapy, etc.)	Varies		

Dyadic therapies are those done with the parent and the child together
Group therapies can be group-level classes delivered to a group of parents with out children present, or delivered to a group of families with both children and caregivers present

For more information about these modalities, www.cebc4cw.org provides a comprehensive overview.

Appendix C: Sample Asset Map Form

Year 1: Reflection to the Capacity Mapping Including in Other Components of the Attestation for Specialty Behavioral Health

- Use the Social-Emotional Reach Metric findings and the specific findings around children birth to five to consider how many children would potentially benefit from these services, and are not getting them, compared with the number of available new referrals.
- Each "row" of the map reflects an area for where there may be a gap in access as compared to the need.
    - For each characteristic (geography, provider availability for new referrals, provider race or ethnicity, languages spoken by the provider, modalities offered) consider where there are opportunities for discussion and reflection in Attestation Component #3 when engaging community based providers.
    - Consider community based organizations and advocacy groups that represent children and families in your community and consider community-based educational opportunities for enhanced understanding of what services do exist and how they can address the factors in the data. Engage these communities potentially impacted by gaps and consider how they can be engaged on solutions.

Appendix C: Sample Asset Map Form

Year 2 Asset Map: ***Social Emotional Services within Patient Centered Primary Care Homes who Attested to 3.C.3 as Having Integrated Behavioral Health***	**Patient Centered Primary Care Homes** To Which CCO Members Birth to Five Are Attributed and Who Attested to Standard 3.C.3 to indicate that they provide **integrated behavioral health (IBH) services**.		
	# 1	**# 2**	**# 3**
Location of Clinic Site (City)			
Number of IBH Providers Who Currently Serve Birth to Five and Have Applicable Skill Sets ***(Drop down that will then customize form)***			
Average Capacity for New Referrals Specific to Birth to Five (per week) ***(Drop down of standardized and feasible # options per provider noted)***			
Provider(s) Identified Race, Ethnicity ***(Drop down of REAL-D Categories)***			
Languages the Provider(s) are able to Provide Services for Birth to Birth to Five ***(Drop down of languages aligned with CLAS metric)***			
Screening and Assessments: Does this provider currently conduct applicable social emotional assessments and screenings for birth to five (*Drop down of tools in compendium)***			
Services Provider(s) Offer: What brief interventions does this provider offer that are, or could be, submitted through claims that address Social-Emotional health?*(Drop anchored to special claims and codes in this section aligned with reach metric)*			
Dyadic Therapy Modalities the Provider(s) Offer: What behavioral health services does this provider offer *(Drop anchored to specific modalities)*			
Other Social Emotional Services Provided Not Captured Above: (Open Field Text)			

Appendix C: Sample Asset Map Form

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

Screening and Assessment Tools that are allowable under code 96217:

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

Additional Assessment and Screening Tools Documented to Support Other Claims:

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

Year 2: Reflection to the Capacity Mapping Including in Other Components of the Attestation for Specialty Behavioral Health

- How many of the PCPCHs you contract with that serve children do not have Internal Behavioral Health (IBH)?
    - Are there any gaps in services by region?
- How many PCPCH sites attested to 3.C.3, but those providers don't serve children birth - 5?
- Examine the rows describing the integrated behavioral health:
    - For each characteristic consider where there are opportunities for discussion and reflection in Attestation Component #3 when engaging community based providers.
    - Consider opportunities for training and coaching of integrated behavioral health staff?

Appendix C: Sample Asset Map Form

Year 3: Early learning providers and **other community-based Social-Emotional services** identified in Attestation Component #3 in Years 1 and 2.

Below is a draft or example asset map template to capture these Social-Emotional services that exist within early learning and other settings. The table below is a draft of the Year 3 potential providers

Year 3 Asset Map: Early Learning, Family Support Services, and Other Community Based Services **with specific expertise and training on infant and early childhood mental health.** (*Potential Examples Below*)	**Community-Based Social Emotional Services**							
	What social-emotional services are provided? ***(Drop down of evidence-based modalities)***	**Are there eligibility requirements impacting access for publicly insured children?**	**Do they have openings for more children to be served by this program?**	**Counties in which these services available?**	**Is there a focus on populations with inequitable outcomes?**	**Can this provider do screenings and assessments of Social-Emotional health?**	**Could the provider submit a claim for these services?**	**Does the CCO provide supports or investments to the program?**
3.1. Home visiting providers								
3.2. Early Head Start/Head Start								
3.3. Early Intervention/Early Childhood Special Education staff								
3.4. Evidence-based/ evidence informed parenting classes with a specific focus on attachment and Social-Emotional health.								
3.5. Children's Relief Nurseries								
3.6. Other Services Identified								

Year 3: Key Considerations and Reflections for Early Learning and other Community-Based Social-Emotional Health Services and Providers

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

Appendix D: Sample Action Plan Template

Target Area 1 Identified for Improvement: (Align with Drop Down Required in 4.1)						
Aim Statement/Desired Outcome (Ensure that is a SMART Aim):						
Improvement Strategies or Action Steps	***Responsible Person/Party***	***Community-Level Partners Engaged***	***Deadline***	***Resources Needed***	***Methods that will be used to track progress and impact***	***Status/Update***
1.						
2.						
3.						

Target Area 2 Identified for Improvement: (Align with Drop Down Required in 4.1)						
Aim Statement/Desired Outcome (Ensure that is a SMART Aim):						
Improvement Strategies or Action Steps	***Responsible Person/Party***	***Community-Level Partners Engaged***	***Deadline***	***Resources Needed***	***Methods that will be used to track progress and impact***	***Status/Update***
1.						
2.						
3.						

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

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