Appendix L

Health Aspects of Kindergarten Readiness Technical Workgroup
Summary of Metric Components of Measurement Strategy Proposal for the Metrics and Scoring Committee

The attached visual provides a high-level overview of thirteen priority metrics identified by the Health Aspect of Kindergarten Readiness Technical (HAKR) workgroup. From this list, four metrics were are then proposed for adoption by the CCO Metrics and Scoring Committee (M&S), the public body which chooses the measures included in the CCO Quality Incentive Program (https://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/Metrics-Scoring-Committee.aspx). Workgroup meeting dates at which specific measure were discussed are noted below; meeting materials, including audio recordings, are on the workgroup webpage (https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/KR-Health.aspx).

1) Preventive Dental Visits for Children Aged 1-5

Description: Percentage of children ages 1-5 on Medicaid who received preventive dental services from a dental provider in the year.
Measure Developer: CMS EPSDT – Form 416, Modified by OHA
Data Source: Medicaid claims
HAKR Workgroup Meeting at Which Measure Properties Described in Detail: May 25th, 2018
Mean Score on HAKR Measure Criteria When Assessed by Workgroup Members: 10.8 (out of 13)

Relevant Information Related to HAKR Measure Criteria:

- Evidence-Based or Aligned with Clinical Recommendations: Measures align with Bright Futures clinical recommendations.
- Actionable: CCOs can impact access to care, through physical health services and additional outreach.
- Outcome-Related: Poor oral health can significantly impact a child's ability to learn in school.
- Engages Health System: Promotes the health system's awareness, engagement, and role in ensuring children receive dental health care early in their life.
- Understandable to Families: Communicates to families the importance of oral health as part of child health.
- Addresses Social Determinant: Poor oral health linked to many poor long-term health and education outcomes.
- Promotes Cross-Sector Collaboration: Metric could promote collaboration across physical health care and dental care providers if primary care providers who see children more often are leveraged for education and outreach (and vice versa). Opportunities to engage early childhood settings on outreach as well.
- Able to Identify Inequities: The measure is able to be disaggregated by race, gender, geography or other child factors. Barriers to access to dental health providers has been noted in rural regions.

Additional Considerations:

- Fills gap in M&S measure set focused on dental service line within CCOs, and aligns with measure used by the Oregon Educators Benefit Board.
- 2nd highest HAKR workgroup measure criteria score. Of the metrics ready for adoption now, highest mean HAKR score.

Relevant Data:

- In 2015, 20.4% of children on Medicaid ages 0-2 received preventive dental services from a dental provider.
- In 2015, 52.6% of children on Medicaid ages 3-5 received preventive dental services from a dental provider.

Data About Need Derived from Early Learning Division Strategic Plan:

- 52% of children ages 6-9 in Oregon have tooth decay.
- Tooth decay is one of the most prevalent chronic conditions of childhood and can lead to problems with eating, speaking, playing, and learning.
- In 2013, Oregon ranked last out of 50 states regarding children having at least one preventive dental visit during the year.

2) Well-Child Visits for Children Ages 3-6

Description: Percentage of children ages 3-6 that had one or more well-child visits with a primary care provider (PCP) in the year.
Measure Developer: National Committee for Quality Assurance (NCQA)
Data Source: Medicaid claims
HAKR Workgroup Meeting at Which Measure Properties Described: May 25th, 2018
Mean Score on HAKR Measure Criteria When Assessed by Workgroup Members: 8.62 (out of 13)

Relevant Information Related to HAKR Measure Criteria:	**Additional Considerations:**
• Evidence-Based or Aligned with Clinical Recommendations: Measures align with Bright Futures clinical recommendations related to well-child visit periodicity. Addresses a gap in current metrics for care for children 3-6. • Actionable: Access to primary care is first step in ensuring access to developmental screening and follow-up supports needed to ensure children are ready for kindergarten. • Understandable to Families: Communicates to families that preventive care, received annually through age six, is important. That said, it may not be clear why well-child visits and the care provided in those visits impact kindergarten readiness. • Able to Identify Inequities: The measure is able to be disaggregated by race, gender, geography or other child factors.	• Fills gap in M&S measure set for population of children 3-6. • Metric is focused on access to well-visit, but the claim does not provide information that would allow for assessment of the quality of care provided in the visits. If adopted, opportunity to focus on the elements that should occur in well-child visits, including a focus on social-emotional health, through metric guidance document and other technical assistance. **Relevant Data:** • In 2017, 60% of children on Medicaid ages 3-6 received one or more well-child visits. • By comparison, 73% of children on commercial health insurance, 70% of children on insurance through OEBB, and 68% of children on insurance through PEBB received one or more well-child visits.

5) Follow-up to Developmental Screening

Description: Percentage of children screened with a standardized developmental screening tool and identified at-risk for developmental, behavioral and social delays who received follow-up steps to address delays identified. Three versions of the metric are available that vary according to what follow-up counts based on level and type of risk identified.
Measure Developer: Oregon Pediatric Improvement Partnership
Data Source for Version Presented: Medicaid charts, Electronic Health Record reported metric
HAKR Workgroup Meeting at Which Measure Properties Described: July 27th, 2018
Mean Score on HAKR Measure Criteria When Assessed by Workgroup Members: 11.5 (out of 13)

Relevant Information Related to HAKR Measure Criteria:	**Additional Considerations:**
• Evidence-Based or Aligned with Clinical Recommendation: Bright Futures recommends screening and follow-up. • Outcome-Related: Some evidence that early intervention services can address delays before kindergarten entry. • Engages Health System & Engages Families: Work would be needed to contextualize and message, but the metric could help explain the value of follow-up to screening, the need for services to address delays	• Fills gap in M&S measure set for metrics that address follow-up services. • Highest HAKR workgroup measure criteria score. • M&S and HPQMC have already identified desire for metric on this topic. • Includes a focus on **social-emotional health** and children identified with self-regulation and problem solving delays. • Could replace current developmental screening metric.

identified early, and the role the health system plays in connecting families to needed services. • Family Priority: Developmental screening and follow-up to screening were identified by families in focus groups. • Promotes Cross-Sector Collaboration: Given a number of the follow-up services are not within primary care, would require extensive collaborative work across the sectors in which follow-up services exist. • Supports Equity: Within quality improvement work and within Early Intervention data, observed disparities in screening and follow-up by race/ethnicity.	• Concerns about development work needed, burden of an EHR-based metric, and consideration of timing of when this would be proposed. **Relevant Data:** • Medicaid Performance Improvement Project within eight Medicaid Managed Care Organizations in OR: Overall, only **40%** of children identified at-risk received follow-up; large variation in rates by Managed Care Organization: 0-63%. • Practice-Level Data Collection: Medical chart reviews as part of quality improvement projects; collected in seven practices (*currently in process with five more*) with varied characteristics, electronic medical records, and patient populations: Baseline ranges: **30-68**% received follow-up. For a majority of the practices the rates were between **29-40**% that received follow-up.
HAKR Staff Team High-Level Summary of Work Needed to Develop the Metric as a CCO Incentive Metric	
Technical properties of the metric that need to be addressed: • Confirm version to use for the CCO incentive metric. • Develop EHR reported specifications based on medical chart review specifications. • Develop standardized specifications for what counts as follow-up (numerator for the metric). • Develop specifications for other developmental screenings tools that are not the ASQ. **Addressing feasibility of collecting the metric:** • CCOs will need to work with practices on documentation in their medical charts about the screen result (used to identify the denominator) AND the follow-up (numerator). • Practice-level outreach and training on follow-up aligned with the metric. **Degree to which the policies and payments are aligned with the metric:** • Bright Futures recommendations only clearly specify referrals to Early Intervention (EI) and to a developmental behavioral pediatrician for evaluation. • Current work with Oregon Department of Education to clarify EI referrals relative to ASQ score. • Variation in availability and capacity of services included in the follow-up metric.	

8) CCO Attestation Metric

This metric would be based on CCO reporting (e.g., via an attestation form) and demonstration of specific transformative tasks such as cross-sector activities, policy and payment changes, and system- and practice-improvements to impact the health aspects of kindergarten readiness. An integral component of the attestation metric would be the examination of data and development of systems, measurement methods, and processes that would allow for future feasible quality measurement focused on cross-sector activities and kindergarten readiness.

Based on input and direction from the HAKR workgroup, the proposed CCO attestation metric would include a priority focus on the factors and systems needed to address **social emotional health in young children.** The metric would be composed of three overarching components focused on: 1) Examining and expand screening for and identifying factors that impact social-emotional health (including social determinants of health); 2) Assessing capacity and utilization of behavioral health services for children 0-5 and their families; 3) Addressing policies, and payment for behavioral health services (within primary care and specialty behavioral health care) for children 0-5 and their families**.** Examples of specific activities that could be included in the attestation metric are detailed below. However, these are only examples, and substantial development work is needed to further develop and refine the items that would be included in the metric, determine how CCOs would demonstrate or attest to the items, and determine the scoring for the metric.

Example components of a CCO-level attestation metric focused on social-emotional (SE) health:

1. **Examine and expand screening for and identifying factors that impact SE health (including social determinants of health).**
    a) Conduct cross-sector training on identifying delays in social-emotional health that include follow-up pathways to address delays.
    b) Develop and implement specific pilots meant to address family-centered access of these services.
        - Pilot enhanced assessment of a child's social emotional health and/or family factors that impact social emotional development and evaluate whether enhanced assessments result in increased access of behavioral health services.
        - For those that access behavioral health services, assess the impact on child and family well-being.
2. **Assess capacity and utilization of behavioral health services for children 0-5 and their families.**
    a) Assess the specific number of trained providers and their capacity to provide behavioral health services for children 0-5. This assessment should include:
        - Map of providers and services available across the CCO region, including location, languages in which these services are available, and race/ethnicity of the provider. Include behavioral health services within primary care and specialty mental health care.
        - Capacity of these providers (existing "case load" and potential for expansion).
        - Comparison of this capacity to the full population of children 0-5 in the CCO region, including how this capacity will meet the cultural and linguistic needs of families.
    b) Examine claims data, using behavioral health penetration metric (to be provided), for utilization of behavioral health services for children 0-5. Assess for disparities in the full population, by race and ethnicity, and by geography within the CCO region.
3. **Address policies and payment for behavioral health services (within primary care and specialty behavioral health care) for children 0-5 and their families.**
    a) Address payment policies that limit access to services. For example, those that limit access to integrated behavioral health services within primary care including:
        - Prior authorization requirements for behavioral health services for children 0-5.
        - Prior-authorization requirements for behavioral health services in an integrated primary care clinic.
        - Requirements for specific diagnostic codes to be provided for behavioral health services based on the location of the provision of the service.