May 13, 2019

Dear Committee Members:

As you may know, CCO Oregon is a membership-based nonprofit organization that convenes stakeholders from across the state engaged in the coordinated care model. We respectfully submit the following comment regarding the DHS foster child metric for your consideration. This document represents ongoing discussions that have taken place across our Dental and Oral Health and Behavioral Health workgroups.

Child health assessments across primary care, behavioral, and dental health are a priority, and CCO Oregon members understand the value and reasons for a metric focused on these assessments for foster children, arguably the most vulnerable of the child population. While each of the assessments -- oral, physical, and mental health -- is a challenge, the oral health assessment remains the most difficult to attain under the current 60-day timeline and there is considerable concern about that timeline shortening to 30-days in 2020.

While overall, our workgroup members would prefer no change in the days allotted, we are preparing for the truncated timeline in 2020 and offer the following as potential opportunities to better support this work:

- **Data Sharing and Fidelity:** Contact information regarding foster children received by coordinated care stakeholders is frequently incorrect, incomplete, or missing. Additionally, there is a lack of consistency in how the information is presented and transmitted to CCO/DCOs. Process alignment and consistency would improve controllable error rates and allow for more reliable care plans and provider work flows.

- **Enrollment Flags:** Enrollment data currently received in the Electronic Data Interchange (EDI) 834 file by coordinated care stakeholders from DHS/OHA does not specify whether new members are foster children. Adding a "flag" to the EDI form 834 transmissions will help CCO/DCOs quickly identify foster children in monthly enrollment reports.

- **First Visit and Assessment Coordination:** OAR 413-015-0465 calls for an intake nurse assessment to be performed by a DHS contracted nurse shortly after the child is placed in a foster home. Incorporating a dental hygienist or an expanded practice licensed practitioner in this visit would allow the dental health assessment to also be performed during the first visit. This step may take significant relationship building and maintenance between DHS and CCOs/DCOs but that initial investment would likely be outweighed by the health and timeline benefits.

- **Dental Care Organization Choice and Alignment:** Foster parents may have other children in the home assigned to a different dental care organization (DCO) than the new foster child; this may make scheduling, coordination, and transportation to appointments difficult, and the process to change the new child's DCO can be a challenge. Efforts to address this challenge may include the DHS case worker re-assigning the child to a new DCO based upon discussion with either the foster parent or, depending on the age of the child, the foster child.

- **Legal Guardianship:** CCO Oregon convenes workgroups across other topic areas besides Dental and Oral Health; our Behavioral Health partners identified the challenge of determining and navigating legal guardianship, which we presume impacts all health assessments. Specifically, if DHS is the legal guardian of the child, the foster parent may not be able to consent the child for appointments or assessments. Ensuring that the appointment is scheduled and approved by DHS prior to placing a child in a foster home may mitigate this challenge.

- **Trial Reunification Support:** When a child and biological parent(s) enter trial reunification, an additional layer of complexity needs to be worked through. An extended deadline for these assessments or, alternatively, an exception could be put into place for this specific population. Some CCOs/DCOs have been advised not to schedule assessments for children in trial reunification creating further confusion. Guardianship and consent issues also arise with this population.

- **Provider Education:** Educating providers on the time frame associated with this metric as well as incorporating any "flags" or other notes to facilitate the work helps providers and their staff understand the urgency of scheduling with this population.

- **Establishing and Maintaining Local DHS Relationships:** Developing and maintaining effective relationships with local DHS offices and case workers is critical to serving this population. CCOs and DCOs often work across counties and service areas, meaning there are many contacts to maintain across DHS offices with a staff and a population-served that has high turnover. CCOs/DCOs have seen gains with attending local foster parent association meetings and staying in contact with local DHS field offices, but this is also where a lot of resources are being spent. Ensuring contact lists are up-to-date at the state and local level for DHS with changes communicated proactively to the CCO/DCO would benefit all parties.

- **Coding Dental Assessments Performed by Primary Care Providers:** Dental assessments administered by primary care providers cannot be billed for children over the age of six. To promote further integration and achievement of the metric, the oral health assessment code, CDT code D0191, should be opened and expanded to include children over the age of six. CCO Oregon understands that this is currently being further explored by OHA staff.

We look forward to ongoing discussion and operational advancements to improve the health of this population that considers the most strategic use of health and human system resources.

Additionally, we're excited about the proposed Health Aspects of Kindergarten Readiness (HAKR) measurement strategy and the inclusion of a pediatric dental component. While this measure was presented with an age band capped at 5, with recently proposed changes to DQA specifications raising the sealant age band from age 6 to 7, we request the committees determining metrics for 2020 ensure that between these two measures age 6 children do not get left behind. Therefore, we recommend raising the HAKR age band upper limit from 5 to age 6.

Thank you for your consideration,
The CCO Oregon Dental and Oral Health Workgroup

For further information or discussion, please contact Samantha Shepherd, CCO Oregon Executive Director at samantha@ccooregon.org or 928-699-1343.