# CHCS Center for Health Care Strategies, Inc.

Improving Outcomes for Children in Child Welfare:
A Medicaid Managed Care Toolkit

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The **Center for Health Care Strategies** is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries. Its program priorities are: enhancing access to coverage and services; improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity.

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I. Preface

Why Focus Medicaid Quality Improvement Efforts on Children in Child Welfare?

On any given day, there are close to half a million children in foster care in the U.S. Many more come to the attention of the child welfare system due to reports of suspected child abuse or neglect, but remain with their families.[1] Medicaid is already the dominant insurer for children involved in child welfare, and its role will expand as the Affordable Care Act[2] (ACA) extends Medicaid eligibility to former foster youth up to age 26, starting in 2014. More than 30 states now enroll foster care children in Medicaid managed care arrangements, and more are likely to do so amid ACA implementation.[3] Accordingly, Medicaid managed care organizations (MCOs) are uniquely positioned to play a key role in quality improvements for this population of children.

The ACA and other federal efforts to improve overall health – for children generally, and for children in foster care specifically – emphasize improvements in the quality and cost of care, particularly for populations with chronic physical and behavioral health conditions. These improvements are crucially important for children in child welfare, who have high rates of both physical and behavioral health needs and often face barriers to access to health care services. For example, research has shown that:

- Nearly 90 percent of children entering child welfare have physical health problems, and more than half have two or more chronic conditions;[4]

- One-quarter of children entering foster care have three or more chronic conditions;[5]

- Nearly half of children entering foster care have significant emotional and behavioral health conditions;[6] and

- Rates of psychotropic medication use for youth in foster care are significantly higher (ranging from 13-52 percent) than for the general youth population (four percent).[7]

Furthermore, children from racial and ethnic minority populations, who are disproportionately represented in child welfare, are at even higher risk for poor health status.[8]

Yet despite the complex needs and high health care costs of children in child welfare, states' requirements vary widely across the country for this population.[9] The federal Child and Family Services Review process,[10] which gauges the performance of state child welfare systems, has consistently documented the need for states to improve physical and behavioral health care access and services for children in child welfare. This need was also emphasized in the 2008 *Fostering Connections to Success and Increasing Adoptions Act*,[11] which requires state child welfare and Medicaid agencies to improve coordination of physical and behavioral health care; ensure appropriate screenings, assessments, and follow-up treatment; share critical information with appropriate providers; and provide oversight of medication use. The more recently enacted *2011 Child and Family Services*

Improvement and Innovations Act[12] reinforces this focus by requiring state child welfare systems to develop specific protocols on the appropriate use of psychotropic medications and a clearly delineated response to emotional trauma among children in foster care.

Children in child welfare also constitute a high-utilizing, high-cost Medicaid population. Medicaid costs for children in foster care are disproportionately high relative to their low share (three percent) of Medicaid enrollment. States spend about three times more for children in this population than for non-disabled children in Medicaid.[13] Cost disparities for behavioral health care[14] are even more dramatic: utilization rates and expenditures for children in foster care are comparable to those of children with disabilities.[15]

Improving the quality of physical and behavioral health care for children in child welfare poses unique challenges. These children often experience multiple changes in living arrangements, assigned child welfare workers, and Medicaid eligibility. Data regarding a child's address, program eligibility, and service history may reside in multiple systems – including child welfare, Medicaid, mental health, juvenile justice, and education – and thus may be different or difficult to locate, particularly in a timely fashion. Quality improvement efforts are often best carried out at a local or regional child welfare or Medicaid plan level, but those efforts require data – and sometimes policy changes – from state systems. Further, while partnerships between child welfare and Medicaid agencies are required, each of these systems has multiple, competing demands and privacy policies that can impede collaboration.

The nine MCOs in *Improving Outcomes for Children Involved in Child Welfare: A CHCS Quality Improvement Collaborative* navigated many of the complexities of improving care for the child welfare population. The plans built relationships with child welfare systems and state Medicaid agencies, and sometimes directly with families and caregivers, to improve: (1) timely access to screenings, assessments, and services; (2) coordination of care; (3) family and caregiver engagement; and (4) appropriate use of psychotropic medications. They employed strategies that are reflected in the national health reform discussion, including use of system navigators, electronic health records, medical homes, and evidence-informed practices.[16]

Two overriding lessons emerge from the pioneering work of these nine plans. First, improvements in physical and behavioral health care for the child welfare population are achievable, particularly if the important foundational work of building relationships between child welfare and Medicaid agencies is done. Second, the quality improvements made by MCOs are translatable to other plans. Within the context of national health reform, this toolkit is a particularly timely resource for state policymakers, MCOs, and others considering effective quality improvement approaches for a small, but significantly high-need, subset of the Medicaid child population.

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Children in child welfare in Medicaid have:

- Significant behavioral health and chronic physical health issues;
- Frequent disruptions in living situations and changes in caregivers;
- Fluctuating health care access and poorly coordinated care; and
- Substantially higher health care costs than children in Medicaid overall.

Efforts to improve their care must focus on:

- Access to health care services;
- Coordination of care; and
- Appropriate use and monitoring of psychotropic medications.

Working together, child welfare systems, state Medicaid agencies, managed care organizations, and caregivers can improve performance in these three areas. This toolkit details promising practices for improving care delivery for children in child welfare within Medicaid managed care arrangements.

II. Introduction

Children in the child welfare system have a unique set of health care needs often characterized by significant behavioral health needs and concomitant chronic physical health issues. Vulnerable to frequent disruptions in living situations and the inability of their caregivers to ensure their well-being, these children often experience fluctuating access to health care, little continuity of care, and poorly coordinated care, all of which lead to high health care costs. For these children, systems that better monitor the utilization of physical and behavioral health services are key to ensuring access to high-quality care and, ultimately, better outcomes.

To improve health care for children in child welfare, quality assessment and improvement is critically needed to enhance access to health care services, better coordinate care, and ensure appropriate use and monitoring of psychotropic medications. With the majority of Medicaid-insured children in child welfare currently in managed care arrangements – and the majority of children in child welfare being served in their homes, or ultimately returning home – the process of improving performance must be a collaboration between child welfare agencies, state Medicaid programs, caregivers, and MCOs.

This toolkit describes the efforts of the nine MCOs that participated in *Improving Outcomes for Children Involved in Child Welfare: A CHCS Quality Improvement Collaborative*, designed by the Center for Health Care Strategies (CHCS) and funded by the Annie E. Casey Foundation. The participating MCOs collaborated over a three-year period (January 2007 – December 2009) to identify and pilot ways to improve the process and outcomes of health care for children and youth who were involved in the child welfare system. The plans' interventions, described in this toolkit, addressed three categories: **(1) access to physical and behavioral health care; (2) coordination of care;** and **(3) appropriate use of psychotropic medications**.

Depending on circumstances, children entering the child welfare system either: (1) remain at home under the supervision of the child welfare agency; (2) are placed in out-of-home foster care, kinship care, or other residential programs; or (3) are placed in a subsidized adoption. In addition to having an understandably high level of psychosocial needs, these children are very likely to have chronic physical and behavioral health problems.[17, 18] Unfortunately, their access to physical and behavioral health services varies considerably across states, with some youth receiving inappropriate or disjointed care, and others receiving too little care. Expenditures for foster children in particular are disproportionately large relative to their share of Medicaid enrollment.[19]

When this initiative began, approximately 491,000 children were in foster care in the U.S., with an average length of stay of just over two years.[20] From 2007 to 2009, during the work of the Quality Improvement Collaborative (QIC), not a single child welfare agency in the nation achieved substantial conformity with the federal Child and Family Services Review, which assesses the extent to which child welfare agencies meet standards across three key domains.[21] In particular, states did not perform satisfactorily against the well-being outcomes standard that "children

receive services to meet their physical and mental health needs." In response, this initiative sought to: (1) improve the quality of care provided by the MCOs contracted to serve children in child welfare; and (2) engage child welfare agencies as critical partners – with a vested interest – in improving access to and use of care by this shared population. CHCS focused this initiative on MCOs for a number of reasons. First, the majority (73 percent) of Medicaid-enrolled children nationally are served by an MCO. Secondly, MCOs have leverage to modify administrative practices and directly impact the clinical practice of network providers through outreach and educational efforts. Lastly, states can leverage MCO contracts to drive quality improvement activities.

Under this initiative, participating plans devised quality improvement approaches to directly impact the care of a combined estimated 71,000 children in child welfare in their service areas. Each plan designed its efforts to focus on a particular subset of this population; most focused on children in foster care.

Key Successes and Challenges of the Quality Improvement Collaborative

The collaborative defined quality improvement (QI) as enhanced access to, appropriate use of, and coordination of care. Collectively, the plans had a measurable impact in all of these areas by improving:

- **Access** to physical and behavioral health screenings, assessments, and services; access to primary care; and provision of medical homes for targeted populations;
- **Coordination** between primary care and behavioral health providers, and between health plans and child welfare agencies;
- **Use of electronic health records** and provision of health information to child welfare caseworkers;
- **Information and support** for families and caregivers; and
- **Psychotropic medication monitoring** and appropriate use.

Most of the plans were able to institutionalize their QI initiatives, and some extended their efforts beyond their initial focus. As described herein, however, there were a few instances where plan initiatives did not succeed, reflecting the considerable challenges and complexities in addressing quality improvements for children in child welfare.

A fundamental challenge to improving quality of care for these children is the plans' inadequate access to accurate – and sufficiently specific – state Medicaid administrative data that can identify children based on their level of child welfare involvement. In most states, the Medicaid agency, directly or through its enrollment contractor, provides MCOs with enrollment data for the eligible population. These data typically only identify children in foster care or subsidized adoption, and often do not distinguish between the two. Other subcategories of

children served by the child welfare system, such as those remaining at home, are usually not identifiable through Medicaid data as child welfare-involved. In addition, MCOs may receive "new" enrollment data when a child in foster care changes placement, making it challenging to maintain accurate, unduplicated counts of children. Child welfare agencies typically have the most current status update and contact information for children in their care. Establishing positive and effective relationships between these state and local agencies is thus another important, but challenging, step in quality improvement efforts for this population.

In most states, the Medicaid agency, directly or through its enrollment contractor, provides MCOs with enrollment data for the eligible population. These data typically only identify children in foster care or subsidized adoption, and often do not distinguish between the two.

Additional challenges to improving the quality of care for children and youth involved in child welfare include:

- **Population size,** given the small proportion of children in child welfare in a state's overall Medicaid enrollment and within any one plan's membership.

- **Fragmented social services,** including the involvement of multiple, often uncoordinated systems such as behavioral health, child welfare, juvenile justice, education, and primary care; and limited resources and competing demands on plans, state Medicaid agencies and child welfare systems.

- **Information systems challenges,** including fragmented data sources for identifying and targeting high-need children; incomplete or inaccurate information regarding prior health service use and health-related needs; and limitations – perceived and actual – to data-sharing between Medicaid and child welfare agencies, as well as between these agencies and the plans.

- **Workforce issues,** such as a limited pool of providers with specialized training to work with the child welfare population; high turnover among caseworkers; caseworkers' lack of experience with and negative perceptions of managed care; and priority placed by caseworkers on safety and permanency before access to care.

- **Family disruptions,** including frequent changes in residence for some groups of children and youth; competing priorities among birth, foster, and/or kinship families; and lack of clarity about and/or restrictive policies in the child welfare system regarding communication with foster families about health-related issues.

Perhaps due to these challenges, there have not been extensive quality efforts targeted at public sector managed care plans and Medicaid providers of care for children in child welfare. The long-term goal of this initiative was to advance such efforts by contributing to the knowledge base of evidence-informed practices for improving access to care, coordination of care, and delivery of appropriate care to the child welfare population.

About this Toolkit

This toolkit is designed primarily for MCOs that want to improve administrative and clinical practices to support the delivery of services to children and youth involved in child welfare and their families or caregivers. In addition, purchasers of managed care services for this population (e.g., state Medicaid agencies and behavioral health authorities) can use the toolkit to identify promising approaches for their managed care programs serving this population. Child welfare agencies, as well, can draw on these approaches to coordinate physical and behavioral health care with state Medicaid agencies, and to ensure appropriate oversight of medication use (psychotropics in particular) – two key, health-related requirements of the *Fostering Connections to Success Act* and the *Child and Family Services Improvement and Innovations Act*. Providers can also learn from the activities described, and implement their own quality improvement processes at the practice level. Finally, families can use this toolkit to identify and advocate for programs focused on improved outcomes for their children and/or the children in their care.

The toolkit is organized in the following sections:

- **Project Overview:** Includes a brief introduction to the CHCS Quality Improvement Framework and its application to children involved in child welfare.

- **Overview and Impact:** Describes the data-driven approaches tested by workgroup participants to improve health outcomes for children in child welfare, including details of the quality enhancing initiatives that they undertook, as well as the impact of this work on access to care, care coordination, and patterns of prescribing and monitoring psychotropic medications.

- **Lessons Learned:** Synthesizes the challenges identified and addressed by the plans.

- **Conclusion:** Presents key takeaways from the three-year initiative and identifies opportunities for continued innovations in care for children in child welfare.

III. Project Overview

About the Workgroup

Following is an overview of the participating plans and their project goals:

Participating MCO	Service Area	Plan Type	Project Goal
ACCESS TO PHYSICAL AND BEHAVIORAL HEALTH CARE SERVICES			
Connecticut Behavioral Health Partnership (CTBHP)	Connecticut	Behavioral Health Organization (BHO) [22]	Improve access and reduce waiting times for behavioral health services for children entering the child welfare system.
Magellan Behavioral Health of Florida	Brevard County, Florida	BHO	Prevent kinship placement disruption due to behavioral health problems with the support of Kinship Navigators.
Mid Rogue Health Plan	Southwest Oregon	Independent Physician Association (IPA) [23]	Provide and coordinate health assessments to support medical homes for children newly placed in out-of-home care.
Priority Partners Managed Care Organization	Baltimore County, Maryland	MCO	Improve access to health care services among children living in foster care by ensuring adherence to the Code of Maryland (COMAR) requirements.
UPMC *for You*	Pittsburgh, Pennsylvania	MCO	Develop and send electronic health records to Allegheny County child welfare workers for all children in foster care. Improve rates of annual well-child visits, annual preventive dental visits, and access to behavioral health services for children new to foster care.
COORDINATION OF CARE			
Volunteer State Health Plan, Inc. (VSHP)	Tennessee	MCO	Increase provider use of electronic health records and review of the clinical health records of newly placed foster care children prior to their initial medical exam.
Wraparound Milwaukee	Milwaukee County, Wisconsin	BHO	Ensure that all children with child welfare involvement have an identified primary care provider (PCP) within three months of enrollment; and ensure that all children who are on three or more psychotropic medications and have not seen their PCP within the last year make and keep an appointment with their PCP.
UTILIZATION AND MONITORING OF PSYCHOTROPIC MEDICATIONS			
CareOregon	Oregon	MCO – Capitated Full	Improve medical record documentation of attention deficit/hyperactivity disorder (ADHD) using American Academy of Pediatrics best practice recommendations.
Massachusetts Behavioral Health Partnership (MBHP)	Massachusetts	BHO	Address outlier psychotropic provider prescribing patterns and simplify medication regimens for children who have been stable for at least six months.

Child Population Served by this Collaborative

Children in child welfare are predominantly low-income, similar to other children covered by Medicaid,[24] and they comprise a disproportionate number of children in racial and ethnic minority groups relative to national distributions.[25] Figure 1 compares demographic data across: (1) the population of children enrolled in child welfare who are served by the nine plans participating in the QIC; (2) the national child welfare population; and (3) U.S. children overall.

FIGURE 1: **Comparison of Children Enrolled in the QIC Plans with the National Child and Child Welfare Populations***

	QIC Plan Child Welfare	U.S. Child Welfare	U.S. Child Population
RACE/ETHNICITY			
African-American	3% – 67%	32%	14%
Hispanic-American	0% – 28%	19%	22%
White	18% – 80%	40%	56%
AGE			
0 – 5	28%	33%	32%
6 – 13	35%	33%	41%
14 or older	37%	33%	27%

* Data reflect year 2007.

Sources:
"Foster Care Statistics: Numbers and Trends." Child Welfare Information Gateway. 2009.
KIDS COUNT Data Center. Annie E. Casey Foundation. 2009.

The plans participating in the QIC are as diverse as the populations they serve. Three plans were operating in predominantly rural areas, and the populations served by those plans were predominantly white. The plans serving urban populations had a higher proportion of children and youth from racial and ethnic minority groups. This collaboration among plans from disparate regions of the country accounts for the large variation in race/ethnicity among the populations served.

Children in child welfare are also documented to have poorer physical, behavioral, and oral health outcomes compared to other children in Medicaid.[26] This holds true for children in child welfare in the QIC plans. The children served by the plans in the QIC experienced a range of levels of access to health care in these three domains. Figure 2 illustrates their level of utilization of key health services

compared to levels for all children in Medicaid. The plan-level data reflect all children enrolled in the plans, including those not touched by the specific interventions in the collaborative.

The plans in the collaborative had varying levels of access to data regarding access to care. This was due to the inclusion of different types of managed care plans in the project. For example, behavioral health carve-out plans did not have data on access to primary care, well-child visits, or dental visits. Similarly, in plans operating in carve-out arrangements, the physical health plans did not have access to data on behavioral health service use. For these reasons, the measures in Figure 2 could not be populated by all plans, and data were limited to the plans with access to those indicators.

The plans' specific quality initiatives focused on either their entire child welfare population or a subset based on geography, certain clinical characteristics, or placement status within the child welfare system, as discussed in Section IV.

Applying the CHCS Quality Framework to Children in Child Welfare

The QIC used the CHCS Quality Framework[27] to guide the creation of the individual teams' quality improvement strategies. This framework was created by CHCS to address the complexities of improving health care services and delivery for people covered under Medicaid managed care in a systematic, stepwise, and logical manner. It was based on the experiences of health plan medical directors and quality improvement staff across the country, and has been refined in work to date with more than 140 Medicaid managed care plans.

CHCS adopted some elements of the framework from existing learning models, including those developed by the Institute for Healthcare Improvement[28] and others focusing on chronic disease, such as the Robert Wood Johnson Foundation's Improving Chronic Illness Care program.[29] The following elements comprise the CHCS Quality Framework:

- **QI Typology**: Categorize, define, and quantify quality-improvement activities.
- **Rapid Cycle Improvement**: Test small changes, systematically analyze improvement processes, and refine approaches as necessary.
- **Measurement and Evaluation**: Enable health plans to measure short-term process changes and long-term outcomes, and to evaluate organizational capacity.
- **Sustainability and Diffusion**: Promote the institutionalization of identified best practices within organizations using the framework, extend the use of the framework across an organization, and introduce its use and extend its applicability to other organizations.

The CHCS Quality Framework provides a template for designing quality initiatives that can be customized for clinical and administrative improvement projects. It is a standardized improvement process that emphasizes the importance of incremental change and the use of frequent measurement to assess the impact of changes. The following typology categories provide a clear, stepwise approach to the design of a quality-improvement initiative:

Identification	How can the MCO or BHO identify its population of children who are involved in child welfare? How can it identify the providers it needs to engage in practice change?
Stratification	How can the identified population of children involved in child welfare be stratified by different levels of need or risk? How can the high-opportunity providers be targeted among all providers serving the population?
Outreach	How will health plan staff effectively reach the targeted children, their families, their providers, and/or child welfare workers?
Intervention	What clinical or administrative changes effectively improve health outcomes for children in child welfare?

Depending on the nature of the proposed activities, it may be appropriate to combine categories to allow flexibility in the design of new initiatives. This flexibility is particularly relevant when considering the health needs of children in child welfare. Efforts to identify the target population may include stratification strategies, and outreach activities may sometimes constitute interventions.

IV. Overview and Impact of Plans' Initiatives

This section describes the activities undertaken by the participating plans, their application of the CHCS Quality Framework typology categories, and the results of their quality improvement activities.

Access to Physical and Behavioral Health Care Services

Five of the plans in the collaborative focused interventions on improving access to physical and behavioral health care. Children in child welfare require customized approaches to ensure access to primary care, behavioral health care, and other health-related services. Effective systems of screening, assessment, and intervention are necessary to ensure this access and to improve long-term health outcomes for them. Although nationally recognized health care recommendations for this population exist,[30] challenges to access remain widespread.[31]

Although most children involved in child welfare are insured by Medicaid,[32] their health care utilization patterns vary considerably across states.[33] Inadequate access to both preventive and specialty care may result from inadequate availability of specialized providers, a lack of understanding about how to access needed services and supports, competing priorities within the family and among systems, and an emphasis on safety and permanency rather than on health care, particularly if a child is at immediate risk for harm. Further, feedback from QIC plans suggests a lack of clarity among health care providers, child welfare workers, and/or caregivers regarding required health-related services to be provided to children entering foster care.

> **Although nationally recognized health care recommendations for children in child welfare exist, challenges to access remain widespread.**

While the MCOs in the collaborative sought to address these access challenges in different ways, many were fundamentally reliant on partnerships with child welfare agencies. In some instances, these relationships were essential to the QI efforts because they enabled the MCOs to: (1) access relevant data; (2) identify strategies to improve timely screenings and assessments; (3) engage, educate, and support families; and/or (4) ensure adherence to state health assessment regulations. Following is a description of activities undertaken by the five QIC plans that focused on improving access to physical and behavioral health care.

CONNECTICUT BEHAVIORAL HEALTH PARTNERSHIP

Connecticut Behavioral Health Partnership (CTBHP), a behavioral health ValueOptions subsidiary, is a Medicaid behavioral health carve-out plan that serves approximately 260,000 children and youth, just under two percent (4,761) of whom are in foster care. The program is a partnership of the Connecticut State Medicaid Agency (Department of Social Services (DSS)), the state's Department of Children and Families (DCF), and ValueOptions. ValueOptions is also the

statewide Administrative Services Organization (ASO) for the Connecticut HUSKY program, which provides health coverage to Medicaid- and CHIP-enrolled children and their families or guardians. CTBHP's quality improvement initiative aimed to improve access and reduce waiting times for behavioral health services for children entering the child welfare system in the cities of and areas surrounding Bridgeport and Waterbury. The QI objectives were to:

- Increase by 25 percent the rate of connection to behavioral health services for children removed from their homes for the first time and identified as needing behavioral health services by the state's multidisciplinary exam process (MDE); and

- Reduce by 10 percent the average time to behavioral health appointments for these children.

Identification

CTBHP aimed to identify:

1. One hundred percent of children in the Bridgeport and Waterbury DCF Areas who were removed from their homes for the first time and who received an MDE (the "target population");

2. One hundred percent of the target population who were found by the MDE to need behavioral health services; and

3. One hundred percent of those who then received needed behavioral health services (need determined by the MDE) within 60 days.

To identify the above, CTBHP supplemented Medicaid claims data with information from the DCF Statewide Automated Child Welfare Information System (SACWIS), which captured treatment purchased through a separate DCF-managed (non-Medicaid) fund. Linking these data allowed for a robust identification strategy that enabled CTBHP to accurately assess the extent to which children were receiving services, whether paid through the plan under Medicaid or through the child welfare system.

Stratification

CTBHP stratified the identified population by the child welfare area offices serving the two target regions. The plan used these stratification data to identify differences between the two offices in order to customize subsequent outreach and potential intervention strategies. CTBHP also stratified data by age, refining the target population to exclude children ages three or younger, whose referrals are made to the state's Early Intervention or Head Start program rather than to CTBHP.

Outreach

CTBHP's outreach goal was to share the stratified data with the state child welfare agency and the program directors and staff of each child welfare area office and engage them to interpret and address the findings. These data indicated that 100 percent of the children assessed by the MDEs in one of the regions were found to need behavioral health services, driving the state to revisit the MDE assessment tool and the training around its use. The data also showed that in one of the area

offices, children with potentially urgent needs experienced unacceptably long waiting times to access services. Sharing these data with the local offices allowed CTBHP to engage them in problem-solving.

Intervention

CTBHP's primary intervention strategy was to work with each of the area offices and the central DCF office to address issues raised by the data. The plan made the DCF central office aware of the MDE shortcomings and suggested that those findings inform efforts to improve the MDE process. In addition, to address delays in securing appointments from Medicaid providers, CTBHP focused on the state's Enhanced Care Clinics (ECCs), which are paid an enhanced Medicaid rate to see children in a timely manner. CTBHP used these performance incentives to improve the rate at which the ECCs met the 14-day standard for routine appointments.

State data provided by DCF indicated that children continued to access services outside of CTBHP's network primarily as a result of DCF staff preference for maintaining established provider relationships and ongoing concern regarding staff turnover at ECCs. CTBHP subsequently worked with key stakeholders and the ECCs to address these issues. One such strategy was to implement training for network clinicians in Trauma-Focused Cognitive Behavioral Therapy, an evidence-based treatment approach shown to help children, adolescents, and their caregivers overcome trauma-related difficulties and reduce negative emotional and behavioral responses following traumatic events.[34]

Impact

Following are CTBHP's overall aim measures and results for its quality improvement initiative, as shown in Figures 3 and 4:

- **Overall Aim Measure #1:** Increase by 25 percent the rate of connection to behavioral health services for children removed from their homes for the first time and identified as needing behavioral health services by the MDE.

  Result: The percentage of children in the target population who had a behavioral health claim within 60 days of being found by the MDE to need behavioral health care increased from 45 percent to 72 percent (an improvement of nearly 60 percent).

- **Overall Aim Measure #2:** Reduce by 10 percent the average wait time to behavioral health appointments for these children.

  Result: The average time to an appointment for behavioral health services following MDE identification of need decreased from 22.5 days to 6.5 days (a 71 percent improvement).

Furthermore, by the initiative's end, more than 96 percent of the network ECCs provided appointments to children needing services in less than 14 days, up from a baseline rate of 79 percent.

Sustainability

CTBHP continues to work with its network of ECCs to reduce wait times for behavioral health care appointments. This clinic-focused strategy allows for continued monitoring of population-specific, evidence-based treatment provision. DCF's lack of an electronic data collections process (as of 2010) with regard to identifying those foster children who received services outside the CTBHP network hindered subsequent expansion of the project to other DCF area offices. However, DCF leadership is considering the benefits of the pilot and invited CTBHP to present its results to the Office of Foster Care & Adoption Services and DCF clinical leadership.

FIGURE 3: Utilization of Behavioral Health Services among CTBHP's Target Children Identified by the Multidisciplinary Exam Process as Needing Services Upon Removal from Home

Percent of Children in Target Population Who Had a Behavioral Health Claim within 60 Days of Being Found to Need Services

- Baseline: **45%**
- Post-Intervention: **72%**
- Goal **56%**
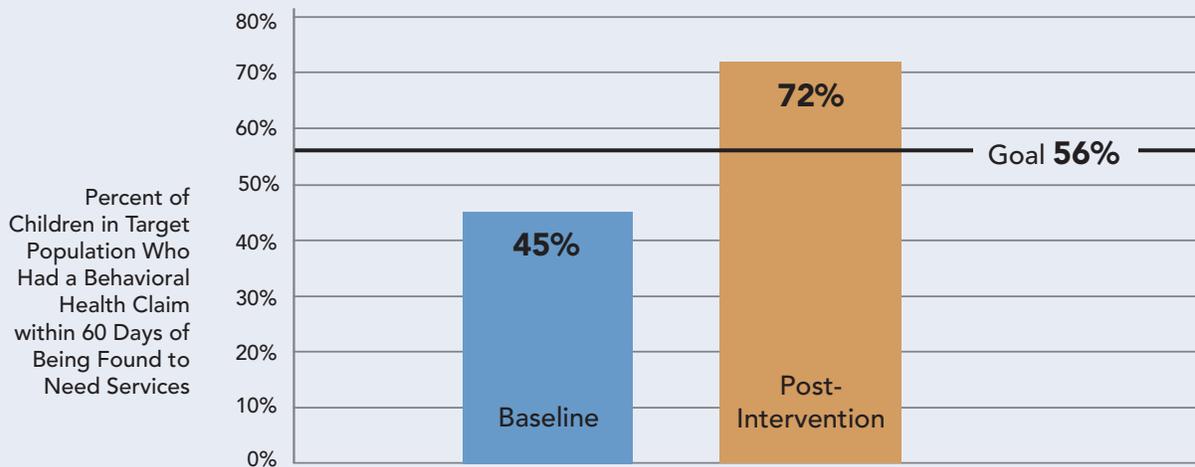
FIGURE 4: Average Time to Behavioral Health Appointment for Children in CTBHP Identified by the Multidisciplinary Exam Process as Needing Services Upon Removal from Home

Average Number of Days to an Appointment for a Behavioral Health Service

- Baseline: **22.5**
- Post-Intervention: **6.5**
- Goal **20** Days
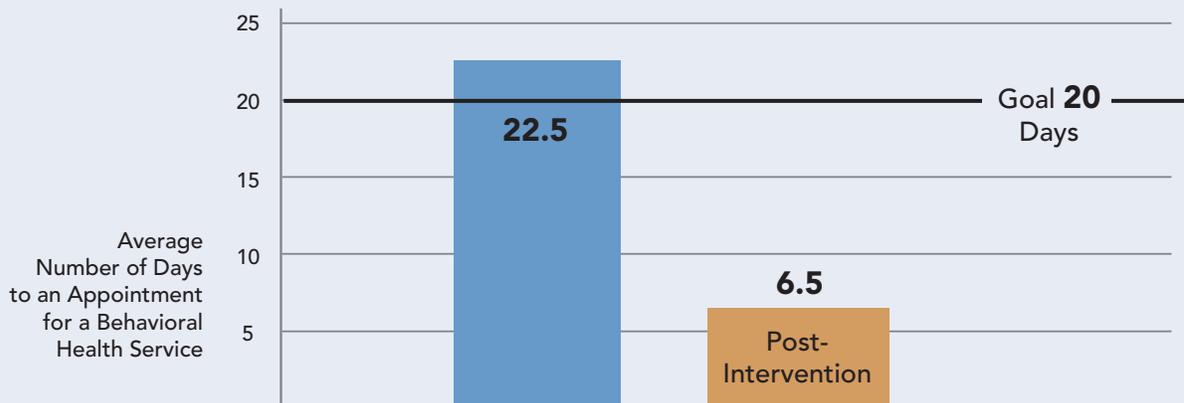
MAGELLAN BEHAVIORAL HEALTH OF FLORIDA

Magellan Behavioral Health of Florida, Inc. (Magellan) and the Community-Based Care (CBC) agencies in 58 of Florida's 67 counties formed a limited partnership in 2006 that successfully bid on the state's procurement for a specialty Medicaid health plan. The specialty plan, titled the Child Welfare Prepaid Mental Health Plan (CW PMHP), was designed to meet the behavioral health needs of children involved in Florida's child welfare system. Florida's CBC agencies are responsible for meeting the safety, permanency, and well-being needs of children in the child welfare system. Through the CW PMHP, Magellan provides utilization management of behavioral health services and other managed care services. Magellan is an integral part of the permanency planning process coordinated by the CBC agencies. To be eligible for the CW PMHP services, a child must have a serious emotional disturbance that: (a) is a defined mental health disorder, or (b) requires two or more coordinated mental health services to enable the child to live in the community.

Magellan's role as a partner in the CW PMHP enabled them to develop a joint project with the CBC of Brevard County and the Florida Kinship Center. This quality improvement initiative targeted children involved in child welfare who met the above criteria for serious emotional disturbance, resided in Brevard County, and were in a kinship relative placement. This population represented two percent of the 21,000 Medicaid enrollees in child welfare in Magellan's statewide membership. The initiative's overall goals were to maintain family preservation, either in a kinship family or home of origin, by preventing placement disruption due to behavioral health problems for more than 90 percent of children in kinship care. To do so, the plan initiated the Kinship Navigator program, which pairs experienced relative caregivers ("kinship navigators") with new kinship care families. Interested kinship families received peer support to help them understand, navigate, and access behavioral health services.

Identification

The initiative's goals were to identify:

1. One hundred percent of the children enrolled in the CW PMHP who reside in Brevard County; and
2. One hundred percent of the children enrolled in the CW PMHP in Brevard County who reside with relative caregivers.

Magellan employed a two-step identification process to achieve these goals. First, the plan used Medicaid eligibility/enrollment data from the Florida Agency for Health Care Administration (AHCA) to identify Brevard County children eligible for services by virtue of their child welfare involvement. Second, the plan relied on the CBC of Brevard County to identify and inform it as to which of those children were in kinship placements.

Magellan identified 592 children in the first category. From among those, the plan initially identified an average of 34 newly placed, eligible children per month who resided with relatives. As resources were available to work with many more

children and families, Magellan expanded the target group in December 2008 to include children living with relative caregivers prior to the project's launch (rather than just newly placed children). This approach increased the number of children eligible for the Kinship Navigator program from 34 to 270.

Stratification

Since the entire population of children in kinship care in Brevard County was included, Magellan determined that there was no need to further stratify the project data beyond the above identified target population.

Outreach

Magellan worked with kinship navigators to contact relative caregivers and provide them with information about the Kinship Navigator program. The plan's initial outreach goal was to contact 100 percent of relative caregivers of children newly enrolled in child welfare in Brevard County who were identified and referred to the Kinship Navigator program.

At the start of its project (June 2007), Magellan utilized kinship navigators in its employ who lived in the community, in order to test protocols established with the CBC prior to contracting to hire navigators through a community agency. In early 2008, kinship navigators from the Florida Kinship Center at the University of South Florida in Tampa assumed those responsibilities. Magellan found that using kinship navigators with ties to the community was effective at creating local support for the program.

The kinship navigators reached the kinship caregivers of 220 children – an average of 80 percent of children living with relative caregivers – through the program's outreach efforts.

FIGURE 5: **Enrollment, Satisfaction, and Family Preservation in Magellan's Kinship Navigator Intervention**

CHILD REMOVED FROM HOME/ PLACED WITH KINSHIP FAMILY

FAMILIES CONTACTED BY KINSHIP NAVIGATOR

Behavioral health issues can exacerbate the frequency and severity of placement disruptions

KINSHIP NAVIGATOR

74%

Of those contacted, 74% enrolled

Of those enrolled, 97% satisfied

97%

100%

Placement maintained or family reunified for all of those enrolled
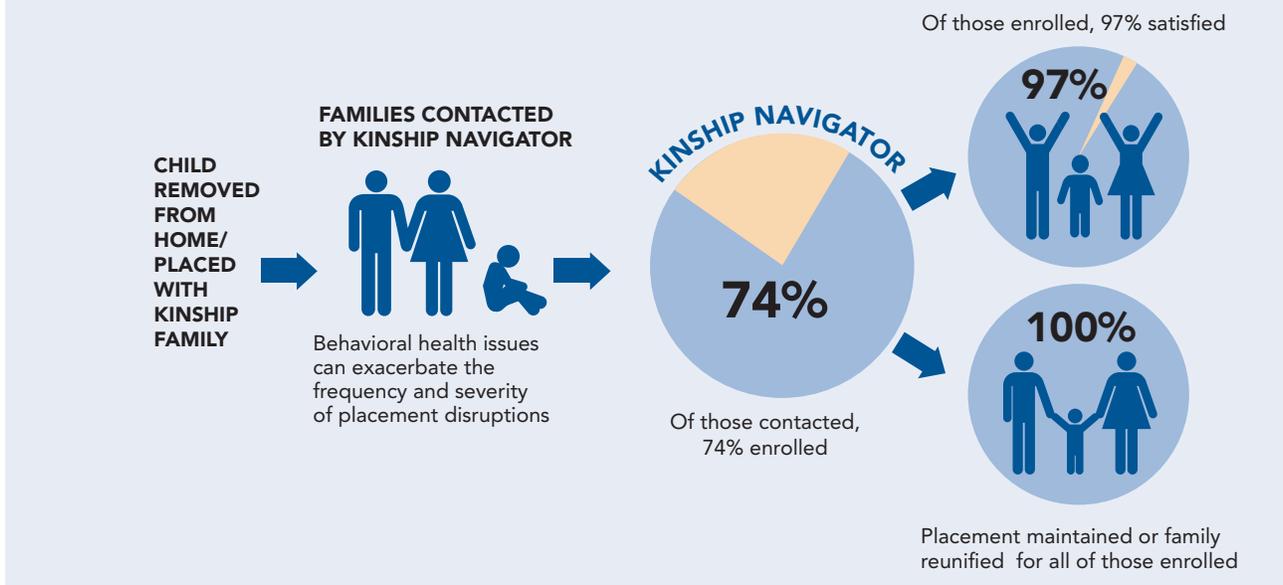
Intervention

Through telephone contact, Magellan referred caregiver families to Kinship Navigator services. Families could enroll to receive all of the program's services, or use services on an ad hoc, non-enrolled basis. Families with children newly placed in child welfare were more likely to enroll in the program than to use services on an ad hoc basis; families contacted within 30 days of placement were more than twice as likely to enroll in the program as families not newly enrolled or not contacted within 30 days. Early intervention made it easier to contact families and offer services: navigators reached 79 percent of families within 30 days of placement; after 30 days, they reached 48 percent of families. Forty-six percent of families that did not enroll still used some Kinship Navigator services.

Impact

Following are Magellan's overall aim measures and results for its quality improvement initiative, as shown in Figure 5:

- **Overall Aim Measure #1:** Have seventy-five percent of the children residing with kinship caregivers who were contacted and referred to the Kinship Navigator program utilize Kinship Navigator services.

    Result: During the course of the project, 161 children (73 percent) residing with contacted and referred kinship caregivers used Kinship Navigator services.

- **Overall Aim Measure #2:** Enroll 75 percent of eligible children's families in Kinship Navigator services.

    Result: Enrollment in the Kinship Navigator program was more likely when family outreach and successful contact occurred for new kinship placements. Initially, only families of newly placed children were invited to enroll in the Kinship Navigator program, yielding an enrollment rate of 74 percent. This rate dropped to 58 percent when the program expanded to include established kinship family placements, presumably because many of these families had already settled into a sustainable routine, had mastered the nuances of a complex service system, and/or were no longer in crisis, and consequently had less need for navigator supports.

- **Overall Aim Measure #3:** Either prevent placement disruption or support reunification for 90 percent of children whose caregivers were enrolled in the Kinship Navigator program.

    Result: Maintenance of kinship placement or reunification was achieved for 100 percent of the targeted children.

- **Overall Aim Measure #4:** Achieve satisfaction with Kinship Navigator services among 80 percent of families utilizing the program.

    Result: Ninety-seven percent of families interviewed reported satisfaction or high satisfaction with the Kinship Navigator program.

Return on Investment

Though the collection and reporting of expenditure data were not required under this initiative, Magellan found savings arising from changes in the type and amount of service utilization. Program enrollees had no inpatient claims and used fewer high-cost services on average than children in kinship families not enrolled in the Kinship Navigator program. In efforts to replicate this program, implementers may expect that the greatest potential savings will accrue from the avoidance of residential treatment for children placed in kinship care for whom crises can be avoided and family stability can be maintained.

Sustainability

Throughout and following the initiative, Magellan encouraged community stakeholders to shape policy and identify opportunities for expanding resources related to kinship care. In an era of diminishing resources and competing demands on time and program funds, securing ongoing financial support proved challenging. This experience highlights the need for financing strategies and incentives (e.g., contractual reimbursements for navigator and peer services) to support Kinship Navigator services. Magellan hopes to introduce the kinship model into other programs with local resources to support and sustain this type of initiative.

> **In an era of diminishing resources and competing demands on time and program funds, securing ongoing financial support proved challenging.**

MID ROGUE HEALTH PLAN

Mid Rogue Health Plan (Mid Rogue), located in rural southwestern Oregon, is a full-risk, fully capitated health plan contracted by the State of Oregon to administer medical benefits to Medicaid recipients in Josephine and Jackson Counties. The health plan serves nearly 13,000 individuals, more than half (7,089) of whom are children. Within these two counties, more than three percent of Mid Rogue child members are in foster care, representing about two percent of overall plan enrollment.

The goals of Mid Rogue's quality improvement initiative were to provide 50 percent of foster care children newly placed in out-of-home settings with the following state-required services and supports: (1) assignment of a PCP within 14 days of health plan enrollment; (2) a primary care health assessment within 30 days of placement; and (3) a mental health assessment within 60 days of placement. For the purposes of this project, Mid Rogue determined that provision and coordination of all three of these services would define a "medical home" for a child.

Identification

Mid Rogue had two identification goals:

1. Identify 100 percent of the children in Department of Human Services (DHS) out-of-home placements and enrolled in the Mid Rogue health plan; and

2. Identify 100 percent of Mid Rogue PCPs in Josephine County (the pilot county) willing to see new and established patients ages 1-18.

To achieve the first goal, the plan first tried using enrollment data from the state Medicaid agency to determine the type of child welfare involvement, but information on placement status and date of entry into the child welfare system were unreliable. Mid Rogue then pursued and established a successful relationship with local child welfare staff to accurately identify each child's placement status and date of entry. Mid Rogue analyzed data from its internal provider database to achieve its second goal, identifying an average of 24-34 PCPs able to see new and established patients, representing about 25 percent of its child-serving PCPs.

Stratification

Stratification was directed at both the target child population and the PCPs available to serve them. Mid Rogue stratified children in out-of-home placement based on their counties of residence, targeting the population in Josephine County. Over eight months, the plan found a total of 68 such children (ranging from three to 18 children each month) enrolled in the plan and residing in Josephine County.

In any given month, Mid Rogue identified between 10 and 17 PCPs available to serve new and established patients in Josephine County. The plan deemed this number of providers adequate to serve the target population.

Outreach

Mid Rogue's outreach strategy was predicated on providing a child's foster family with: (1) contact information for the assigned PCP; (2) information about required health screenings; and (3) an introduction to the services available to families through Mid Rogue.

Unfortunately, incomplete foster parent contact information made it difficult to reach these families. To address this challenge, Mid Rogue:

• Engaged the Josephine County Foster Parent Association (JCFPA) to help raise awareness about the initiative;

• Instituted a stipend for interested foster parents to attend monthly support meetings; and

• Provided educational information for and produced the JCFPA newsletter.

Although Mid Rogue manages only physical health services, the plan reached out to the local mental health service agency – Jefferson Behavioral Health – to develop a relationship that would support coordination of care by providing Mid

Rogue with information regarding mental health service utilization among its members. Working with the Foster Parent Association and the local mental health agency improved the effectiveness of Mid Rogue's identification and outreach efforts. In addition, the project produced processes for sharing information between the local child welfare offices and Mid Rogue staff – processes that are now standard for both organizations.

Mid Rogue's outreach goal was to reach 75 percent of all the targeted children's foster families. However, the actual rate of direct contact varied from 33 percent to 100 percent in a given month and did not show sequential improvements.

Intervention

Building on the above outreach strategy, Mid Rogue care managers made follow-up calls to foster care families when the plan identified gaps in required services. When the care managers were unable to contact the foster care families, they were able to engage the child welfare agency's foster parent trainer to facilitate follow-up. The successful follow-up rate varied by month, but reached 100 percent in the last month of the project and continues at this level.

Impact

Following are Mid Rogue's overall aim measures and results for its quality improvement initiative, as shown in Figure 6:

- **Overall Aim Measure #1:** Ensure that 75 percent of the target population was assigned a PCP within 14 days of enrollment.

  Result: At baseline, 40 percent of target children were assigned a PCP within 14 days; this rate improved to 100 percent by the project's completion, surpassing the goal.

- **Overall Aim Measure #2:** Ensure that 50 percent of the target group received a primary care assessment within 30 days of placement.

  Result: Mid Rogue met this goal by the project's midpoint, up from a baseline of 22 percent, and achieved a 100 percent completion rate by the project's end.

- **Overall Aim Measure #3:** Ensure that 50 percent of the target children had a behavioral health assessment within 60 days of placement.

  Result: Mid Rogue exceeded this goal by the end of the project, reporting that 88 percent of the children received a behavioral health assessment within 60 days, compared to a baseline rate of 33 percent.

- **Overall Aim Measure #4:** Ensure a medical home for 50 percent of the target population, defined by achievement of the above three aim measures.

  Result: By the project's end, 88 percent of the target group received all three services.

FIGURE 6: **Access to and Coordination of Care for Mid Rogue Children Newly Enrolled in Foster Care**

100% of children assigned a PCP
Goal 75%
40% of children assigned a PCP
WITHIN 14 DAYS

100% of children have a PCP visit
Goal 50%
22% of children have a PCP visit
WITHIN 30 DAYS

88% of children have a behavioral health assessment
Goal 50%
33% of children have a behavioral health assessment
WITHIN 60 DAYS

88% of children ensured a medical home (all three goals)
Goal 50%
GOAL

● End of project
● Baseline
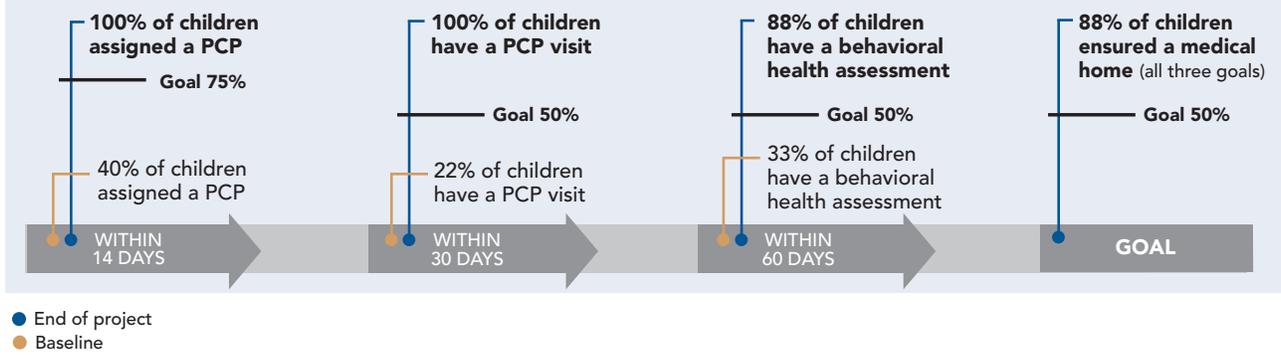
Sustainability

Mid Rogue team members noted that their successful community partnerships will continue to support ongoing coordination for the target group of children in Josephine County. In January 2010, the plan expanded this model to Jackson County, where Mid Rogue staff cultivated similar partnerships with local officials and advocates, and key child welfare employees have become liaisons to Mid Rogue care managers. Efforts are currently underway to extend the model into Oregon's Curry County.

PRIORITY PARTNERS MANAGED CARE ORGANIZATION

Priority Partners Managed Care Organization (PPMCO) is a partnership between Johns Hopkins HealthCare LLC and Maryland Community Health Systems (MCHS), a group of eight Federally Qualified Health Centers (FQHCs) in Maryland. PPMCO's 2007 Medicaid enrollment was almost 112,000 individuals, including 74 percent (82,880) under age 21. About five percent (4,144) of PPMCO child members were in foster care at the start of the plan's quality improvement initiative in 2007, representing about four percent of overall plan enrollment.

PPMCO's initiative aimed to improve the health and well-being of its newly enrolled child members who were in foster care by ensuring adherence to Maryland state health screening requirements (Code of Maryland Regulations – COMAR) for children in foster care. The state mandates that children entering foster care receive an initial health screening within five days, a comprehensive health screening exam within 60 days, and a comprehensive mental health screening exam within 60 days.

Identification

Using the state Medicaid agency's enrollment files, PPMCO sought to identify 100 percent of newly enrolled member children who were in foster care. This identification strategy proved challenging because: (1) state data did not distinguish between children in foster care and children who are currently eligible for Medicaid through subsidized adoption; (2) state data updates were often incomplete or not current; (3) data on date of entry and exit from foster care were unreliable; and (4) reconciliation of Medicaid enrollment data with PPMCO eligibility data was time-consuming. Ultimately, the files were manually reviewed by the PPMCO special needs coordinator and corrected in the system.

Stratification

PPMCO stratified children in foster care who were newly enrolled in PPMCO into either an enhanced intervention group (no fewer than 20 percent of the target population) or a comparison group. The initial plan was that up to 10 children could be newly assigned to the intervention group each week; in practice, the weekly number fluctuated between five and 20 children, depending upon staff resources and PPMCO enrollment that week.

Outreach

PPMCO's outreach strategy was to contact DSS workers and/or foster care families for 75 percent of children in the enhanced intervention group to ensure that workers and families were aware of: (1) the child's enrollment in PPMCO; (2) the child's PCP; (3) health screening and exam requirements; and (4) PPMCO support services available to DSS caseworkers and families.

Initially, PPMCO targeted the Baltimore City DSS office, with which the majority of PPMCO foster care children were affiliated, though with marginal success. The plan's special needs coordinators used face-to-face meetings, letters, and telephone outreach to determine appropriate DSS point personnel for the initiative. However, DSS staff turnover, changes in caseload assignments and child placement, and competing DSS priorities hampered this effort. Midway through the QIC, PPMCO joined a multi-stakeholder taskforce charged with improving health outcomes for Baltimore City children in foster care, through which PPMCO partnered with the newly established DSS nurse case management program, Making All the Children Healthy (MATCH).

Initially, PPMCO special needs coordinators contacted and oriented foster families to PPMCO health protocols required by COMAR.[35] The coordinators also convened focus groups with foster families to better understand their foster children's health care needs and the families' concerns. Once the MATCH unit was established, primary contact with foster families subsequently shifted to MATCH nurse case managers, who provided coordination among health care providers, social services, and families.

Ultimately, the outreach goal of 75 percent of intervention group families reached was not met; however, the contact rate for that group greatly exceeded that of comparison families, with 44 percent of intervention families being contacted versus 17 percent of comparison families.

Intervention

PPMCO's intervention was designed to provide enhanced support and assistance to foster care families navigating a complex health care system by dedicating PPMCO special needs coordinators to provide enhanced outreach and service linkage to DSS foster care staff and foster care families. The plan's special needs coordinators provided all of the 353 contacted families with assistance that included: (1) a PPMCO enrollment packet; (2) Medicaid and plan membership cards; (3) timely service authorizations; (4) interpreter services; and (5) behavioral health care referrals. They also provided updated child health histories to DSS.

Impact

Following are PPMCO's overall aim measures and results for its quality improvement initiative:

- **Overall Aim Measure #1:** Ensure that 75 percent of children in the intervention group whose families and/or DSS workers were contacted received a comprehensive health care screening within 60 days of entering foster care.

  Result: While the goal was not met, improvements were achieved, as 64 percent of those contacted received the screening.

- **Overall Aim Measure #2:** Children included in the intervention group whose DSS workers or families were contacted would be more likely to receive a comprehensive health care screening than children in the comparison group.

  Result: As shown in Figure 7, children in the intervention (30 percent) were slightly more likely to receive the required screening than children in the comparison group (23 percent).

FIGURE 7: **Effect of Priority Partners' Intervention on Children's Likelihood of Receiving Required Comprehensive Health Care Screening**
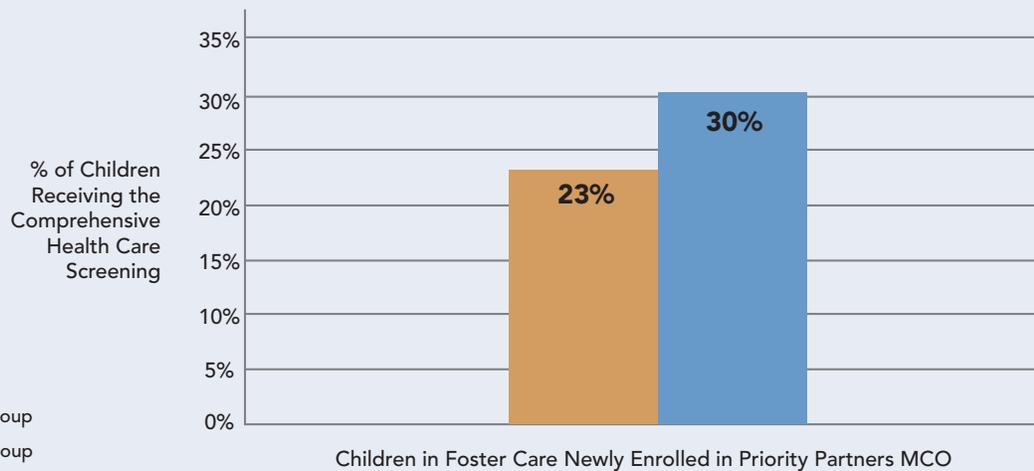
Sustainability

The partnership between the Baltimore City DSS and PPMCO yielded a new collaborative relationship integral to addressing health-related issues confronting children in foster care in the Baltimore region. Through their efforts for this population, PPMCO has been identified as the "MCO of choice" for any unassigned child in foster care in Baltimore City. PPMCO network community clinics have been identified as medical homes for the foster care children of Baltimore City; and, through the MATCH program, foster families have continued access to enhanced outreach services from PPMCO's special need coordinators. These critical relationships were built during this project, and remain in place to provide ongoing support to families. PPMCO has plans to expand this model statewide.

UPMC *FOR YOU*

UPMC *for You* (UPMC) is one of three MCOs that provide physical health care services to Medicaid beneficiaries in Pennsylvania's Allegheny County through the HealthChoices program. In Pennsylvania, HealthChoices Medicaid behavioral health benefits are carved out from physical health benefits and managed by separate behavioral health managed care organizations in each county. Community Care Behavioral Health Organization, part of the larger UPMC Insurance Division, provides behavioral health benefits to Medicaid-eligible individuals in Allegheny and 35 other counties in Pennsylvania. UPMC *for You* is also part of the larger UPMC Insurance Division and serves 14 counties in Pennsylvania.

As UPMC's quality improvement initiative began in 2007, approximately 75,200 child Medicaid beneficiaries resided in Allegheny County. Approximately 2,000 (three percent) of these children – including 400 UPMC members – were in foster care at any given time. UPMC focused its quality improvement initiative on the physical and behavioral health care needs of these 400 children.

UPMC designed a three-pronged initiative to:

- Develop and send an electronic health record (EHR) to the Allegheny County Office of Children, Youth and Families (CYF) for all children in foster care in UPMC's membership;
- Achieve a 10 percent improvement over baseline for completion of an annual well-child visit and an annual preventive dental visit; and
- Increase by 10 percent over baseline the rate at which children newly placed in foster care received needed behavioral health services.

Identification

UPMC sought to identify: (1) all child members in foster care; and (2) among them, those who were in need of behavioral health services.

Initially, UPMC attempted to use Medicaid enrollment files to identify its member children in foster care. However, those data lacked the coding to distinguish between children in child welfare generally and those in foster care specifically. In response, UPMC engaged the project's liaison at CYF to establish a protocol for weekly cross-referencing of CYF membership files identifying children in foster care with UPMC membership data.

Community Care used three criteria to identify children in need of behavioral health services: (1) a child enrolled in UPMC and involved with CYF who had previously used behavioral health services; (2) a child with an open authorization for behavioral health services based on previous authorizations within the past six months; or (3) a child for whom a foster parent, caseworker, or the youth him/herself requested behavioral health services from Community Care.

Stratification

UPMC reviewed its own and Community Care's claims data to determine which foster care members lacked the following: (1) an annual well-child or primary care visit; (2) an annual dental visit; or (3) receipt of needed behavioral health services. Additionally, if any needs or gaps in either physical or behavioral health care were identified by any means, the child and family would be prioritized for outreach and intervention.

Outreach

The success of this initiative rested on the development of important stakeholder relationships within CYF and the community at large to facilitate outreach, as illustrated by the following:

- UPMC and Community Care established a Foster Pilot Workgroup and created a Weekly Issues/Accountability Log to identify cases needing assistance from the CYF project liaison. The workgroup held weekly meetings (attended by the CYF liaison) to address any concerns or potential barriers. The plans also held project training seminars for CYF foster care caseworkers and providers.

- UPMC and Community Care, in partnership with CYF, developed a brochure describing the quality improvement initiative and how to access available services that was given to CYF caseworkers and to the CYF contracted agencies and distributed at CYF resource fairs. In addition, in 2010, Community Care highlighted this innovative project at their annual Recovery Conference for behavioral health providers, consumers, family members and other stakeholders. Over 400 conference attendees received detailed information about the project during the conference, as well as copies of the brochures developed for CYF.

- UPMC and Community Care made CYF shelter providers aware of benefits available for children in their care.

- When a child was identified as having UPMC/Community Care coverage, CYF staff notified the birth parents about available coverage and services. CYF then engaged the birth parents in the child's care, facilitating service continuity for children who return home.

Intervention

UPMC's aims were as follows:

1. **Create EHRs and send to CYF.** UPMC developed an EHR – a summary of a child's physical, behavioral, and oral health services – to transmit monthly to CYF for all children newly placed in foster care that month. Quarterly summaries were also transmitted for all children previously placed and continuing in foster care in order to provide periodic updates. These health histories become a part of the child's agency file and are available to foster parents, placement planning staff, and other health care providers. In late 2010, CYF developed a policy and training curriculum regarding the use and

delivery of the EHR to contracted agencies, and distributed a confidential survey to all CYF caseworkers to ascertain the current utility of the EHR. The survey explored caseworker training needs and the perceived challenges of sharing personal health information across state systems.

2. **Utilize care coordination to improve access to care.** The sharing of information – including provider and immunization histories – between UPMC and child welfare caseworkers promoted access to needed services and the maintenance of child health. During weekly reviews of newly enrolled children, UPMC designated a primary health plan contact for children whose health needs were largely physical, or a contact at Community Care for those whose needs were primarily behavioral. The assigned caseworker contacted the CYF caseworker to discuss gaps in care and the current needs of the child, and offered related assistance.

Impact

Following are UPMC's overall aim measures and results from its quality improvement initiative, as shown in Figure 8:

- **Overall Aim Measure #1:** Develop and send an EHR to CYF for all children in foster care in UPMC's membership.

    Result: EHRs were created for 100 percent of children in foster care and sent to CYF.

- **Overall Aim Measure #2:** Achieve a 10 percent improvement over baseline for completion of an annual well-child visit and an annual preventive dental visit.

    Result:
    – The percentage of target foster care children with an annual well visit increased from 53 percent to 78.5 percent (a 48 percent increase); and
    – The percentage of target foster care children, ages 3 or older, with an annual dental visit increased from 60 percent to 75 percent (a 25 percent increase).

- **Overall Aim Measure #3:** Increase by 10 percent over baseline the rate at which children newly placed in foster care receive needed behavioral health services.

    Result: The percentage of newly placed foster care children, ages 5 or older, receiving needed behavioral health services within 60 days increased from 56 percent to 58 percent (a 3.6 percent increase). This relatively static rate may have been due to a reliance on prior authorizations dating back up to six months, during which time children's need for behavioral health services may have changed or been addressed outside Community Care.

A significant related outcome of this initiative was the establishment of a mutually beneficial and collaborative relationship between CYF and the two plans. Local CYF caseworkers – who initially questioned the value of the partnership – came to view UPMC and Community Care as valuable resources for best serving children in their care. In turn, the plans can access current and accurate contact information about their members through CYF, ensuring continuity of care amid placement changes. Foster parents benefit from up-to-date information about the health needs of their foster children, and from the support provided by the plans to ensure access to services.

FIGURE 8: **Utilization of Health Services among UPMC's Target Population**

Utilization Rates Among Target Population

Annual Well Visit: 53%, 78.5%, GOAL 58%
Preventive Dental Visit: 60%, 75%, GOAL 66%
Behavioral Health Visit: 56%, 58%, GOAL 62%

Baseline
Post-Intervention
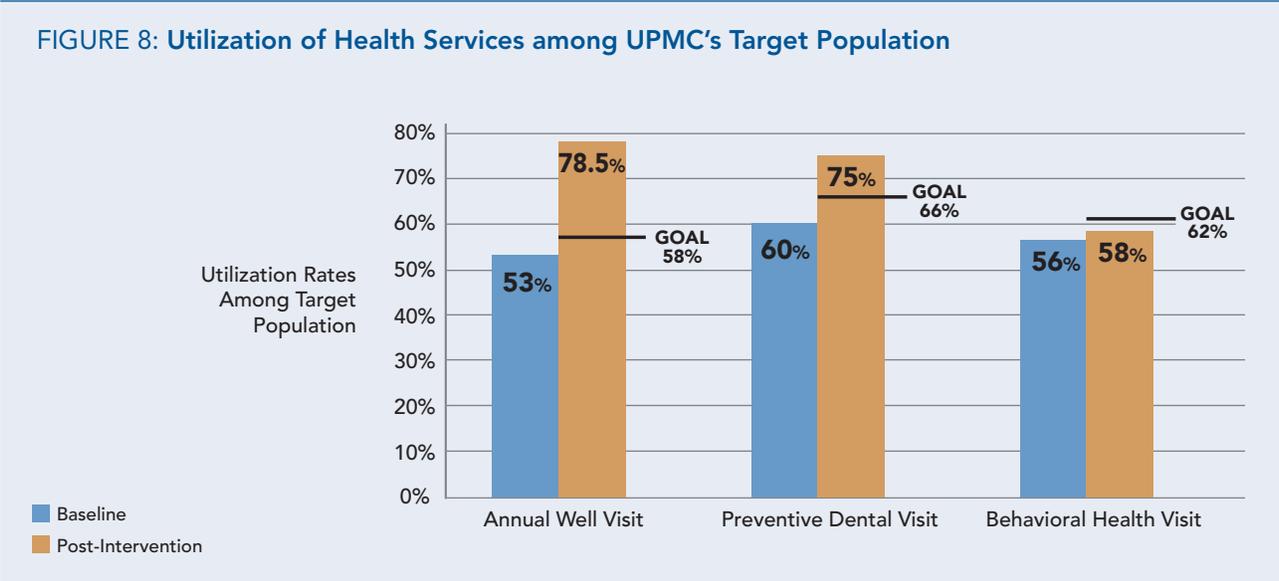
Sustainability

UPMC's project continues in Allegheny County. The plan is also expanding the model of shared health information and care coordination to people with developmental disabilities; UPMC expects this to begin in early 2012. UPMC also continues to explore the possibility of expanding the foster program to other counties.

Another outgrowth of this project is an agreement between CYF and Community Care to support continuity of care. Under this arrangement, CYF contacts the Community Care assigned care manager within 24 hours of a child's or adolescent's discharge from inpatient services. CYF will report the child's shelter placement – which may be within or outside the Allegheny County area – and the Community Care care manager will expeditiously coordinate the required supportive behavioral health services to ensure that the child is stabilized.

Coordination of Care

Two of the plans in the QIC focused on coordination of care through their quality initiatives. Children in child welfare typically face family disruption and changes in placement that affect their access to health services. Integrated and coordinated health care is critical to ensuring their well-being, particularly if they are in foster care and living in out-of-home placements.[36] Coordinated behavioral and medical care for children in child welfare requires a cross-system approach – including effective mechanisms for data-sharing and communication – to ensure successful health care delivery that is tailored to this population's unique needs.[37]

MCOs across the country have used a variety of care management models to coordinate services, information, and resources for people with complex health needs. Effective models of collaborative care include medical homes and a wraparound approach, both of which are child- and family-centered and provide structures for oversight and coordination of physical health, behavioral health, and social services in the context of managed care.[38] Timely availability of a child's health history is also critical to supporting well-being: care continuity and coordination are enhanced and duplication of services is reduced or eliminated when providers, families, and health system partners effectively and appropriately share health information. However, collecting, storing, and sharing this information – including immunization histories and screenings (e.g., developmental and emotional, dental, blood lead levels) can be challenging. As described below, a number of the participating MCOs effectively employed EHRs to improve communication among providers, case managers, and families so as to most effectively meet children's health needs.

> Coordinated behavioral and medical care for children in child welfare requires a cross-system approach – including effective mechanisms for data-sharing and communication – to ensure successful health care delivery that is tailored to this population's unique needs.

The participating health plans support the flow of health information within a fragmented health system in different ways. One specialty BHO sought to coordinate proactively with primary care for children in child welfare by first identifying a PCP and then ensuring an annual visit. Another plan aggressively sought to provide access to and encourage use of an EHR to enable its specialty PCP network and child welfare personnel to review health histories prior to initial comprehensive health assessments. Both plans' strategies provided a foundation for more coordinated care.

VOLUNTEER STATE HEALTH PLAN, INC.

Volunteer State Health Plan, Inc. (VSHP), a subsidiary of BlueCross BlueShield of Tennessee (BCBST), works with the Bureau of TennCare (Medicaid) and the State Department of Children's Services (DCS) to administer a statewide managed care program for children in foster care. VSHP's overall child membership includes almost 178,000 Medicaid beneficiaries, four percent (7,500) of whom are in foster care.

Through its quality improvement initiative, VSHP sought to increase the frequency with which providers review an Electronic Clinical Health Record (CHR) for children in foster care prior to the initial Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening visit exam that is required upon entry into the child welfare system. The CHR was developed by Shared Health, Tennessee's largest public/private health information exchange. Supporting the flow of medical information, the CHR contains comprehensive patient information such as past medical diagnoses, procedures, medications, immunizations, and allergies. Initially, VSHP's project focused on its Best Practice Network (BPN) – a group of primary care providers who have agreed to serve as the medical home for children in foster care – and later expanded to include DCS and local health department staff as well.

VSHP aimed to have the CHRs of newly assigned children reviewed prior to their initial medical exam by:

- BPN providers, for 60 percent of newly assigned children;
- DCS staff, for 50 percent of newly assigned children; and
- Local health department staff, for 10 percent of newly assigned children.

Identification

VSHP's goal was to identify 100 percent of the BPN providers, and 100 percent of children in its membership who were in foster care. Using data from BCBST and the state child welfare agency, VSHP tracked both groups quarterly, finding that while the number of BPN providers decreased from 767 in 2007 to 737 in 2009, the number of children newly enrolled into VSHP by virtue of their entry into foster care increased from almost 1,400 to about 2,150 over the same period.

Stratification

Using data from Shared Health, VSHP determined that 94 percent of its BPN providers had access to CHRs for the target population. However, the analysis also revealed that BPN providers were not the only users of the CHRs for child welfare members; DCS staff and the local health departments were also accessing the CHR, though at low levels, to obtain data on the health services provided to and needed by children in foster care. VSHP accordingly modified its project goals to include increasing review of the CHR by health department providers and DCS staff, as well as by BPN providers.

Outreach

VSHP provided information related to use of the CHR to all of its BPN providers through the plan's *Blue Alert Provider Newsletter*. As shown in Figure 9, targeted outreach to these providers included a letter explaining the Quality Improvement Collaborative and encouraging use of the CHR for children in child welfare. In addition, Shared Health outreach workers contacted BPN provider offices to ensure the providers' registration and access to the CHRs, provide hands-on training where needed, and reiterate the tool's importance in managing the health of children in foster care. Shared Health also conducted an orientation for DCS staff on the benefits and use of the CHR. DCS staff valued the training (particularly in light of staff turnover) and reported that they could access the child's health history, identify gaps in care, and better support appropriate referrals and services thanks to the CHR. Because some foster children were initially seen by health department providers, those providers were also oriented to the CHR.

Intervention

VSHP developed a letter to BPN physicians to notify them of children newly enrolled in foster care who were being assigned to their practices. These letters were created and mailed to providers on a weekly basis. The BPN providers were also encouraged to review each child's medical history in the CHR prior to the initial comprehensive exam mandated for children entering foster care.

Impact

Following are BPN's overall aim measures and results for its quality improvement initiative, as shown in Figure 9:

- **Overall Aim Measure #1:** Have BPN providers review the CHR for 60 percent of newly assigned children prior to their initial medical exam.

    Result: BPN providers were found to review the CHR for 52 percent of children, compared to a baseline rate of 27 percent.

- **Overall Aim Measure #2:** Have DCS staff review the CHR for 50 percent of newly assigned children.

    Result: DCS staff reviewed CHRs for 9 to 10 percent of children.

- **Overall Aim Measure #3:** Have local health department staff review the CHR for 10 percent of newly assigned children.

    Result: Local health department staff reviewed CHRs for one to 3.5 percent of children.

The rate of review for both the DCS staff and the health department staff remained steady over the life of the project, reflecting the need to revisit and refine the outreach and education to those groups. Feedback from DCS indicated that staffing

constraints precluded staff reviewing the CHR when information regarding a child's health status was available through its internal information-gathering process. It is worth noting, however, that when review of the Shared Health data revealed that other (non-BPN) providers were accessing health history information, VSHP expanded its analysis to measure review by any network provider or support staff member involved in the child's care. Using this approach, VSHP found that 100 percent of the newly enrolled foster children had their records reviewed by a BPN provider, other TennCare provider, DCS staff, or health department staff prior to their initial visit, surpassing the project goal of 80 percent.

FIGURE 9: **VSHP Intervention and Outcomes for Children Newly Enrolled in Foster Care**

Only 27% of children's electronic health records reviewed by BPN providers

Child placed in foster care and assigned to VSHP

Health provider, DCS caseworker, or health department staff trained to use electronic record

VSHP sends letter to BPN provider notifying of assignment of foster child, encouraging use of shared health record

52% of children have electronic record reviewed by BPN providers

AND

100% of children have electronic health record reviewed by a provider or caseworker

BASELINE ——————— INTERVENTION ——————— OUTCOMES

Sustainability

VSHP is sustaining timely provider review of the CHR by making the provider notification system standard operating procedure. The plan began sending out letters on a daily basis to BPN providers regarding the assignment of children newly enrolled in foster care, encouraging use of the CHR. DCS has also institutionalized efforts begun during the project by incorporating the CHR into its intake process. DCS accesses the CHR to supplement information gathered through its Well Being Information and History form, which is reviewed by a DCS well-being nurse and psychologist to provide an initial review within 72 hours for the determination of physical and behavioral health needs for all children entering foster care.

To further improve communication and documentation of health histories for children involved in the child welfare system, VSHP, DCS, and foster family advocates are piloting a Medical Home Notebook in two of the DCS regions. The notebook contains information about: (1) health insurance benefits (medical and behavioral); (2) contact information for various agency liaison and support staff; (3) a list of the BPN network providers; and (4) community health resources and care standards. VSHP plans to survey these "pilot" families to determine ways to improve the tool; initial results have been favorable, and there are plans to provide Medical Home Notebooks to foster families statewide.

WRAPAROUND MILWAUKEE

Wraparound Milwaukee (WAM) is a specialty behavioral health carve-out serving high-utilizing populations of children with serious behavioral health challenges – including children and families involved in child welfare who are at risk for residential treatment. At the time of the initiative, WAM annually served approximately 1,000 children, roughly one-third of whom were involved with the Bureau of Milwaukee Child Welfare (BMCW).

The integration of primary care and behavioral health care for children involved in the child welfare system is challenging, particularly for children who are prescribed psychotropic medications. Accordingly, WAM's quality improvement initiative aimed to ensure that: (1) at least 80 percent of BMCW-involved children enrolled in WAM had an identified PCP within three months of enrollment; and (2) 100 percent of BMCW-involved children who are on three or more psychotropic medications and have not seen their PCP within the last year made and kept an appointment with their PCP.

Identification

WAM sought to identify the following:

1. One hundred percent of BMCW-involved children in WAM's overall enrollment. WAM identified these children through its management information system, Synthesis.

2. One hundred percent of BMCW-involved children who are using psychotropic medications. WAM identified these children through their electronic clinical records, in which the plan's care coordinators must document medications given.

3. One hundred percent of BMCW-involved children who have not seen their PCP in the last year. WAM identified these children based on the "date last seen" noted in the child's record, obtained by its care coordinators from the child's caregiver upon entry into the program. (If the date is unavailable, it is assumed that the child has not seen a PCP within the last year).

Stratification

WAM's stratification aims were threefold, seeking to categorize:

- **One hundred percent of BMCW-involved children with an identified PCP.** WAM care coordinators are trained to work with families to identify a child's PCP, and/or help families to locate a PCP for children without one. Identification of the PCP is required before the plan of care is approved administratively.

- **One hundred percent of BMCW-involved children using three or more psychotropic medications.** WAM derived this information from the children's plans of care.

- **One hundred percent of BMCW-involved children who are using three or more psychotropic medications and have not seen their PCP in the last year.** WAM obtained this information from the "date last seen" recorded in a child's plan of care. Data showed that this rate fluctuated between 23 percent and 7 percent, but did not demonstrate a trend over the course of the project.

Outreach

WAM's outreach strategy aimed to ensure that: (1) every child in the plan has an identified PCP; and (2) 100 percent of plans of care for BMCW-involved children include the above-mentioned PCP and medications information. To achieve this, WAM:

- Established a relationship with a local community health center that agreed to serve as the PCP for any child identified as not having a PCP; and

- Trained care coordinators on the importance of recording PCP and medication data and how to obtain it from families; and withheld approval of plans of care that lacked PCP and medication information.

Intervention

The project intervention aims were twofold:

- Early in the initiative, train WAM care coordinators to ensure that at least 80 percent of plans of care for BMCW-involved children resolved issues of lack of identified PCP or date last seen; and

- By the project's end, send letters to 100 percent of caregivers of BMCW-involved children who were using three or more psychotropic medications and had not seen their PCP in the last year.

Impact

Following are WAM's overall aim measures and results for its quality improvement initiative, as shown in Figure 10:

- **Overall Aim Measure #1:** Ensure that at least 80 percent of BMCW-involved children enrolled in WAM have an identified PCP within three months of health plan enrollment.

  Result: By the fourth quarter of the project, and for its duration, 94 percent of BMCW-involved children had an identified PCP, compared to 60 percent at baseline.

- **Overall Aim Measure #2:** Ensure that 100 percent of BMCW-involved children who are on three or more psychotropic medications and have not seen their PCP within the last year make and keep an appointment with their PCP.

  Result: By the end of the project, eighty-five percent of children on three or more psychotropic medications who had not seen their PCP in the last year made and kept appointments with their providers.

WAM also achieved the following:

- WAM established a process to contact the families of children on multiple medications who had not seen their PCP in the last year. By the end of the project, they were consistently contacting 100 percent of the families of those children and informing them of the need for a visit.

- The percentage of BMCW-involved children on two or more psychotropic medications who had not seen their PCP in the last year decreased from 35

percent to 19 percent, and those on three or more psychotropic medications who had not seen their PCP in the last year decreased from 18 percent to 12 percent.

- As a result of effective medications monitoring, at the project's end, the number of BMCW-involved children with an identified PCP using three or more psychotropic medications had dropped from 87 percent at baseline to 39 percent.

Return on Investment

While WAM did not collect expenditure data for this initiative, based on the above improvements, it is likely that savings accrued through reduced pharmacy costs for psychotropic medications. Other outcomes resulting from active relationships with PCPs extended the reach of WAM, fostered coordinated care for children, and encouraged the development of a medical home leading to increased oversight of psychotropic medication prescribing. Reports from WAM clinical staff also suggest that clinical and functional outcomes improved for these children due to better coordination between primary care and behavioral health.[39]

FIGURE 10: **Outcomes among WAM Children in Foster Care on Multiple Psychotropic Medications**

Measure	Baseline	At Completion
Children with a PCP identified and documented in care plan	60%	94%
Children on two or more psychotropic medications who saw their PCP in the last year	65%	81%
Children taking three or more psychotropic medications	87%	39%

Sustainability

The key elements of WAM's quality improvement project have been institutionalized as standard operating procedures for care coordinators. WAM does not grant administrative approval (authorizing service) unless the required PCP and medications information is included in plans of care. Lessons from this initiative will inform state and county deliberations around improved coordination of behavioral health and medical care for children involved in child welfare.

Utilization and Monitoring of Psychotropic Medications

Through their quality initiatives, two of the plans participating in the QIC focused on the use of psychotropic medications. Psychotropic medications are one important tool for treating behavioral health problems in children. However, inappropriate use of these medications, especially among children and youth in the care of public systems, is a growing concern among families, child advocates, mental health clinicians and policymakers. Potentially inappropriate use was defined for this initiative as: (1) specific types of polypharmacy (such as off-label use, concomitant drug use, or the use of too many psychotropic medications); (2) for too long; and/or (3) among those deemed too young. These potential "red flags" were first articulated by the Medicaid Medical Directors Learning Network.[40] States acknowledge that children involved in child welfare are particularly vulnerable to misuse of these medications, with rates of use as high as 50 percent.[41] Accordingly, 26 states provide written guidance regarding use of psychotropic medications for children in foster care, and 13 others are developing such policies.[42] Providing additional guidance, the American Academy of Child and Adolescent Psychiatry (AACAP) advises implementing prescribing practices that include careful assessment, family-centered treatment planning, medication monitoring, and taking a "judicious" approach to prescribing these drugs.

Quality improvement efforts focused on the use of psychotropic medications primarily involve provider-level interventions. Implementing provider-level quality improvement efforts requires provider education, incentives for behavior change, and systems for tracking changes at the practice level. In this Quality Improvement Collaborative, one participating health plan addressed pharmacotherapy by directly targeting individual clinicians, while another pursued improvement in medical record documentation among providers.

> **Inappropriate use of psychotropic medications among children and youth in public systems is a growing concern among families, child advocates, mental health clinics, and policy makers.**

CAREOREGON

CareOregon, a non-profit, medical MCO, serves more than 100,000 beneficiaries of the Oregon Health Plan (OHP), the state's Medicaid program. Seventy-six percent of CareOregon members are under age 18; about five percent (4,570) of these children and youth are also served by the Oregon Division of Children, Adults and Families, the state child welfare agency.

The plan's quality improvement initiative sought to improve the rate of medical record documentation of ADHD pharmacotherapy management among providers by 50 percent in at least two of the top-prescribing PCP practices that treat child members involved in child welfare who have ADHD. This was deemed an important improvement goal because of the frequency with which children were prescribed psychotropic medications with a corresponding lack of clinical rationale documented in their medical records. To achieve its goal, the plan supported adoption of best practice recommendations[43] for:

- Documentation of core ADHD symptoms;

- Use of behavior ratings scales;

- Documentation of objective treatment goals; and

- Follow-up within 30 days of initiating or changing ADHD medications, and completion of at least two follow-up visits between 31 and 270 days of initiating these medications.

CareOregon worked with clinicians and stakeholders to create a provider ADHD Prescriber Toolkit and an EHR ADHD encounter form in order to encourage adoption of these practices among targeted providers.

Identification

CareOregon's quality improvement initiative aimed to identify:

1. One hundred percent of child members involved in child welfare, age 18 or younger, who had an ADHD pharmacy claim during a given three-month period, as identified through Medicaid eligibility data and MCO pharmacy data; and

2. One hundred percent of the PCP clinics/practices that serve the above population, as identified through Medicaid pharmacy claims data and the MCO provider database.

CareOregon met both of the above aims, identifying and matching 565 target children to their PCPs. The 10 highest-volume practices and/or clinic prescribers were found to account for 82 percent of the overall target population's pharmacy claims.

Stratification

The plan stratified the target child members by provider assignment and ranked PCP clinics/practices by the proportion of the target population served. The 10 PCP clinics/practices that served the largest proportion of children in the target group were identified through Medicaid pharmacy claims data and the MCO provider database. Providers were further stratified by their willingness to participate in the project.

Outreach

CareOregon staff created the ADHD Prescriber Toolkit using AAP guidelines.[44] They solicited feedback on the toolkit from clinicians and stakeholders, 40 percent of whom offered suggestions, which were then adopted. CareOregon worked with the targeted clinics/practices in the initiative to embed fundamental tenets of the toolkit into the clinics' EHR encounter forms. Initially, two of the 10 clinics agreed to do so, accounting for 99 physicians.

Intervention

The program's primary intervention was to distribute the toolkit via a provider-focused educational program that emphasized the importance of medical record documentation in the treatment of ADHD. The intervention was expanded to focus on implementation of EHR encounter forms in partner practices that would enable providers to capture initial and follow-up information reflecting best practice medical record documentation for ADHD.

Impact

CareOregon had two overall goals for its initiative. The first was to improve best practice medical record documentation over low pre-intervention rates, specifically to increase documentation of: (1) core ADHD symptoms; (2) parent and teacher behavior rating scales; and (3) objective treatment goals. For example, at baseline, only seven percent of records (two records) showed evidence of all three chart elements; rates of parent and teacher behavior rating scales and documentation of objective treatment goals were very low as well. Other evidence showed that only 25 percent of records documented the core ADHD symptoms.

CareOregon's second goal was to increase the rate of follow-up within 30 days, from a baseline of 20 percent, and the rate at which children on ADHD medication had at least two additional follow-up visits between 31 and 270 days of initiating or changing ADHD medications, from a baseline of nine percent. Overall, the baseline findings for both medical record documentation and follow-up care indicated that there was substantial room for improvement.

However, engaging clinics/practices proved to be challenging. Competing priorities within the target clinics indefinitely postponed implementation of the medical record documentation initiative. This was in spite of active outreach to multiple provider partners and service sites (clinics, practices, residential treatment centers, and school nurses) over the course of 12 months and those sites' avid interest in embedding the toolkit encounter form into clinic EHRs.

Looking Ahead

CareOregon continues to consider alternative approaches to engage providers to improve medical record documentation. For example, in one county, several health department clinics are considering integration of the ADHD toolkit components into their EHR.

MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP

The Massachusetts Behavioral Health Partnership (MBHP) manages mental health and substance abuse services for more than 350,000 MassHealth (Massachusetts Medicaid) members across the Commonwealth. Approximately 181,000 of those members are children – 10 percent of whom are involved in the child welfare system.

The overall goal of MBHP's initiative was to identify the parameters of outlier psychotropic provider prescribing patterns for children and intervene so that care would meet peer-review standards as defined by the clinical guidelines of the AACAP.[45]

Identification

MBHP aimed to identify all of its child members who were involved with the Department of Children and Families (DCF) and the Department of Youth Services (DYS) and who had also been taking psychotropic medications for more than 60 days in a calendar quarter. The percentage of children found to be prescribed *any* psychotropic medications ranged from 22 percent to 30 percent over the course of the identification period.

Stratification

MBHP initially intended to stratify the identified population into five groups based on outlier prescribing patterns in a given quarter. However, early work suggested focusing on the most prevalent prescribing problems, which resulted in MBHP ultimately using only two outlier categories:

- Children prescribed more than two psychotropic medications (polypharmacy); and

- Children prescribed duplicate psychotropic medications ("duplication of therapy"), defined as use of two medications in the same therapeutic class.

Over the course of the project, MBHP found that roughly 27 percent of the target population was prescribed more than two psychotropic medications and nearly four percent of the group was prescribed duplicate therapy.

Outreach

MBHP did not have an outreach goal distinct from the overall aims of its intervention.

Intervention

MBHP chose random samples of: (1) 40 medical records from 1,510 children involved with DCF who had been prescribed polypharmacy; and (2) 42 charts from 210 children involved with DCF who had duplication of therapy (a total of 82 records). When reviewed, these medical records indicated that prescribing of polypharmacy or duplication of therapy met peer-review standards for all the children involved.

However, during the course of the records review, MBHP noted that significant numbers of youth had been on the same course of psychotropic medication treatment for more than six months without any provider attempt to simplify the regimen. This evidence argued for a provider-based intervention not to change prescribing patterns in isolation, but to encourage more effective monitoring of the medication use among the population in the context of their treatment needs as indicated by their symptomatology. MBHP adopted this approach to drive efforts to reduce unnecessary prescribing. Forty-nine MBHP youth with stable polypharmacy for at least six months and their high-volume prescribers were identified and chosen for the intervention. Following discussion with the providers, 19 of 49 children involved with DCF were identified as candidates for an intervention to simplify their regimen by at least one medication.

Impact

Following are MBHP's overall aim measures and results for its quality improvement initiative, as shown in Figure 11:

- **Overall Aim Measure #1:** Successfully reduce the medication regimen of 80 percent of the youth eligible for simplification by one medication (Figure 11).

    Result: Sixteen (84 percent) of the 19 children involved with DCF eligible for medication simplification had their psychotropic polypharmacy regimen simplified by at least one medication.

- **Overall Aim Measure #2:** By simplifying the medication regimen of eligible youth, achieve lower average medication-related expenditures per child per month.

    Result: Simplification accounted for an average cost savings of $422.00 per child per month.

FIGURE 11: **Reduction in Polypharmacy Among Children in MBHP Pilot on More than Two Psychotropic Medications**

100% of children on more than two psychotropic medications who were candidates to receive the intervention

38% of those children were targeted by the intervention

84% of children targeted for intervention had medication regimen reduced by at least one medication

Sustainability

MBHP has engaged in preliminary discussions with other high-volume prescribers of psychotropic medications to children involved with DCF, and has found an eagerness to receive data to inform medication simplification. This provider-based intervention – communicating with providers and encouraging them to consider simplifying medication regimens – demonstrated both clinical improvement and a reduction in spending on inappropriate and unnecessary treatment. Furthermore, as a result of this initiative, in June 2011, MBHP began sending an automated quarterly report to prescribers listing their child members who had been on a stable psychotropic regimen for six months and detailing the prescription history for those members. The report was accompanied by a cover letter outlining the history of this project and requesting that the prescriber consider simplifying each child's regimen. Results are being tracked and are pending.

V. Quality Enhancing Initiatives: Lessons Learned

The MCOs participating in this Quality Improvement Collaborative faced a number of challenges to improve access, coordination, and appropriateness of care for children involved with child welfare. Common obstacles arose in a number of areas, including:

- Accurately identifying children newly placed in foster care arrangements using Medicaid eligibility data;

- Accurately determining the date of a child's entry into care;

- Engaging providers in practice change efforts;

- Developing effective communications directly with child welfare caseworkers, foster families, birth parents, and kinship caregivers;

- Developing protocols for data-sharing, which was resource-intensive;

- Overcoming initial reticence on the part of child welfare caseworkers who did not understand the plans' potential as valuable resources; and

- Maintaining plans' relationships with local child welfare agencies once cultivated, in light of high turnover among caseworkers or designated liaisons.

However, in spite of the challenges, and in light of the ultimate successes, a number of key takeaways emerged from this work:

- Data must be available to demonstrate baseline performance and quality of care, and to identify areas for improvement;

- Access to reliable data related to placement, residence, and service utilization is critical;

- Effective partnerships with state and local child welfare agencies must be cultivated, both at the administrator's level and with front-line workers;

- The role and responsibility of the MCO, and how it complements that of the child welfare agency, must be clearly understood and articulated;

- Efforts to engage providers must be informed by provider input, address provider needs, and be adaptable to practice workflows; and

- Efforts to engage families must be informed by the families themselves through partnerships with family organizations.

VI. Conclusion

Improving access, coordinating care, and ensuring the appropriateness of care that is provided are important goals across the nation's health care system and are particularly salient for the population of children involved in child welfare. The MCOs that participated in the Child Welfare Quality Improvement Collaborative undertook a daunting task. Their limited access to data, the time required to develop partnerships with other key players, and the need to tailor outreach and services to a high-need and high-cost population combined to create significant challenges to the attainment of these goals.

For those plans focused on improving access, success varied. However, on balance, the children and youth served by their programs overall were able to more quickly get appointments, access care, benefit from electronic health records, and have medical homes established. The plans' partnerships with child welfare were critical in identifying the population in need, successfully reaching out to the children, their caregivers and caseworkers, and developing an accurate history of care for each child. Provision of information to families and caregivers, whether through the child welfare agency or directly by the MCOs, also proved critical.

The plans in the QIC demonstrated that systems to support care coordination can be developed and implemented within both mainstream managed care plans and behavioral health carve-outs.

The importance of coordinating behavioral and physical health services is widely accepted, and particularly important for populations with complex needs. The plans working in this area demonstrated that systems to support coordination can be developed and implemented within both mainstream managed care plans and behavioral health carve-outs. When effective, these systems positively impact the process of care for children in child welfare, and are likely to result in better outcomes for them. Non-financial incentives were implemented in Wraparound Milwaukee, and partnerships – with physical health and child welfare health units – were keys to success for the plans that focused their interventions on coordination of care.

Significant attention is clearly warranted to the use of drugs to treat children – particularly children in child welfare – who have behavioral health issues, and the MCOs that implemented interventions in this area undertook complex clinical and policy challenges. The critical partners in these efforts are the providers who prescribe and monitor the effects of psychotropic medications among this

population of children. They must be engaged with data regarding their prescribing patterns, have information about the duration and characteristics of psychotropic medication use among their patient population, and have the ability to determine which among those children and youth are appropriate candidates for the reduction of medication and/or alternative therapies. As large purchasers of psychotropic medications, public agencies such as Medicaid and child welfare are focusing more attention on this issue; the ability to safely and appropriately reduce unnecessary psychotropic medication use – as was demonstrated by MBHP – is a valuable case study.

On the whole, the QIC was a successful initiative, achieving measureable and, in most instances, significant improvements over baseline across a range of indicators. Two of the participating MCOs, however, were largely unable to achieve their goals, due primarily to an inability to engage providers in one case, and a change in the system within which the MCO was operating in another. Yet even in these plans, changes were implemented, data were collected, and some positive impacts were achieved.

As a result of the efforts undertaken by these nine MCOs and their improvements in access, coordination, and appropriate use of care, there is new information in the pages of this toolkit that state Medicaid, behavioral health and child welfare agencies, providers, families, family advocates, and other MCOs can use to improve the experience and outcomes of care for children in child welfare and their families. The partnerships that were developed between the MCOs and their colleagues in child welfare can serve as models for effective cross-system engagement and collaboration, in which each entity is better able – and enables the other – to live up to its responsibilities to the children and youth in its care.

The work of this QIC demonstrates that expansion of access and better coordination of care for complex-need populations – two goals at the cornerstones of the ACA – can be achieved within a relatively short time frame and with cost efficiencies if strategies to improve quality are thoughtfully tailored to the population in question.

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