Improving Timely Health Care for Children and Youth in Foster Care Driver Diagram and Change Ideas

Background

A driver diagram shows the processes or systems that affect the aim of your quality improvement (QI) project and determine what you need to do to improve outcomes. Use the state Medicaid and CHIP improving timely health care for children and youth in foster care driver diagram on the next page to help plan your state foster care-related QI project. You may also want to develop your own driver diagram and change ideas. Here are some suggestions to begin:

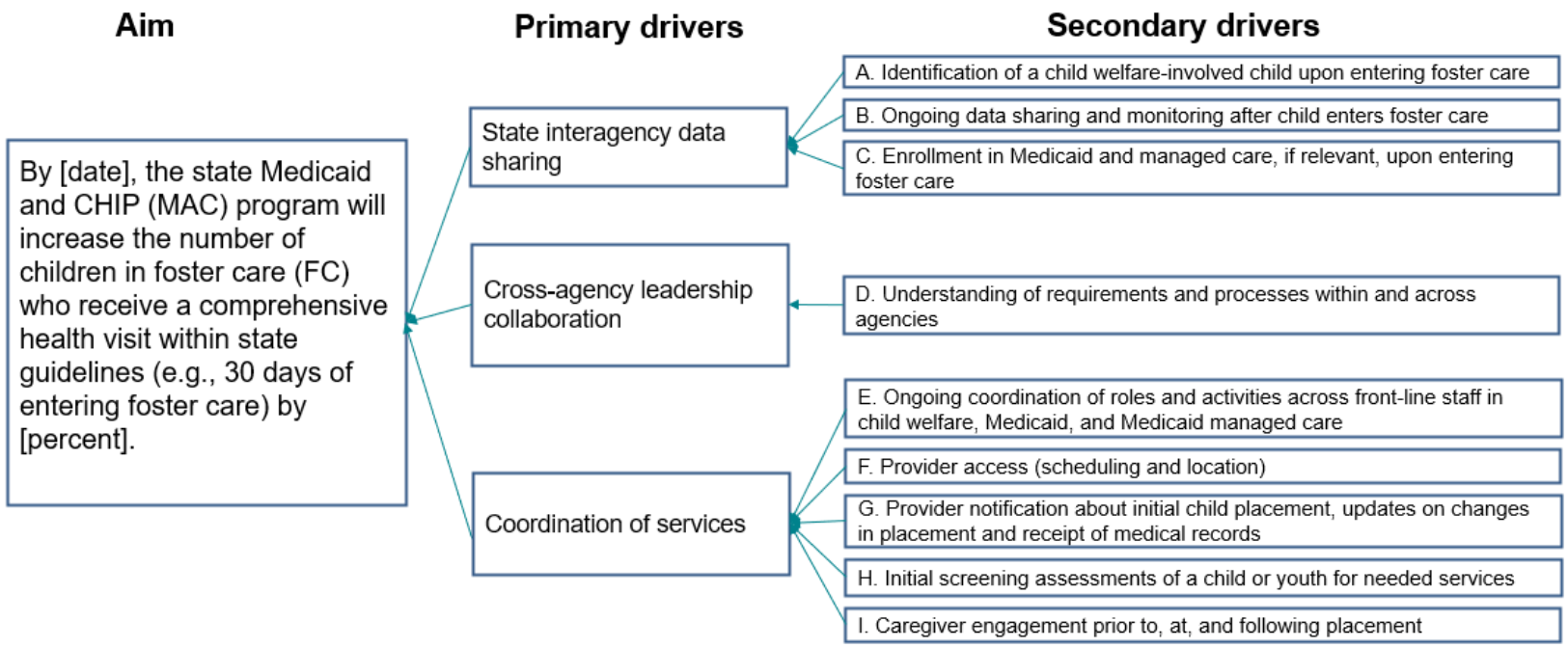
- Develop an aim statement. A good aim statement is specific, measurable, and answers the questions, "For whom, how much, and by when?" It should be brief, easy to understand, and should not include background or side issues. An example aim statement is given on the driver diagram.

- Add primary drivers. Primary drivers are the high-level processes, structures, or norms in the system that must change in order to achieve your aim. While all the primary drivers are necessary to achieve your aim, begin your QI project by just focusing on one or two primary drivers and then expand your activities over time to address the other drivers.

- Add secondary drivers. Secondary drivers expand an understanding of the primary drivers and are action oriented, addressing the places, steps in a process, time-bound moments, or norms where changes are made to bring about improvement. Secondary drivers will help lead you to testable change ideas.

- Develop change ideas. Change ideas describe the specific, testable actions that can be taken to impact the secondary driver, the related primary driver, and achieve your aim. Change ideas are activities supported by evidence, experience, or expert opinion The change ideas on the following tables were gathered from research, case studies, expert opinions, and other resources. Where available, the resources have been referenced. Short descriptions accompany Medicaid specific experiences. Where no reference has been provided, the change idea comes from subject matter experts consulted to develop this driver diagram.

Example State Medicaid and CHIP Improving Timely Health Care for Children and Youth in Foster Care Driver Diagram



The driver diagram has the following relationships:

- Aim Statement: By [date], the state Medicaid and CHIP program will increase the number of children and youth in foster care who receive a comprehensive health assessment within state guidelines by [percent]. The aim statement is affected by three primary drivers. Each primary driver is affected by several secondary drivers.

  - Primary Driver 1: State interagency data sharing. This primary driver is affected by three secondary drivers:
    - A. Identification of a child-welfare involved child upon entering foster care
    - B. Ongoing data sharing and monitoring after child enters foster care
    - C. Enrollment in Medicaid and managed care, if relevant, upon entering foster care

- Primary Driver 2: Cross-agency leadership collaboration. This primary driver is affected by one secondary driver:
  - D. Understanding of requirements and processes within and across agencies

- Primary Driver 3: Coordination of services. This primary driver is affected by five secondary drivers:
  - E. Ongoing coordination of roles and activities across front-lie staff in child welfare, Medicaid, and Medicaid managed care
  - F. Provider access (scheduling and location)
  - G. Provider notification about initial child placement, updates on changes in placement and receipt of medical records
  - H. Initial screening assessments of a child or youth for needed services
  - I. Caregiver engagement prior to, at, and following placement

Change Ideas for State Medicaid and CHIP Improving Timely Health Care for Children and Youth in Foster Care

Secondary Driver

A. Identification of a child welfare-involved child upon entering foster care. The ability of a state Medicaid agency to provide timely health services to children and youth in foster care is dependent on their ability to identify those children quickly and easily in administrative data.

Change Activity	Evidence, Resources, & Case Studies
A1. Enter child information into child welfare system within 24 hours (or other state guideline) of the child entering state custody	**West Virginia Bureau for Children and Families** (child welfare) requires that child welfare staff enter the child's information in their child welfare system within 24 hours of entering state custody. They review performance on this metric monthly to support quality improvement efforts.
A2. Develop common identifiers for children, youth, and families receiving services from both child welfare and Medicaid to support data matching and identification of a child welfare-involved child upon entering foster care	Recommended by subject matter experts. **Resources:** • **Improving Information Sharing for Youth in Foster Care** • **Toolkit: Data Sharing for Child Welfare Agencies and Medicaid**
A3. Automate system notifications to health plans when a child has entered state custody and needs a comprehensive health assessment conducted	The **Oregon Health Authority (Medicaid)** MMIS systematically generates an enrollment file that is sent daily to each of its Coordinated Care Organizations (managed care) that includes identifiers for foster children to support managed care staff in finding children that need to be scheduled for a comprehensive health assessment. **Resources:** • **Improving Information Sharing for Youth in Foster Care** • **Toolkit: Data Sharing for Child Welfare Agencies and Medicaid**

Secondary Driver

B. Ongoing data sharing and monitoring after child enters foster care. Children in foster care have high rates of physical and behavioral health care needs. Timely health care delivery is critical to the child's health and wellbeing. Data sharing facilitates improved health outcomes by supporting timely assessment of health care needs, ongoing care management, and continuity of care across placements.

Change Activity	Evidence, Resources, & Case Studies
B1. Develop and implement data sharing agreements including working with legal counsel from the beginning to identify legal and regulatory considerations for sharing data for child welfare-involved children (e.g., demographic information; placement status; caregiver information; social, physical, mental, clinical needs)	The **California Department of Social Services and the California Department of Health Care Services (Medicaid)** have a global memorandum of understanding to exchange confidential and non-confidential data as it pertains to children or youth receiving child welfare services and former foster youth. Data is exchanged for analysis and reporting to support ongoing oversight of health care services. **Rhode Island's Executive Office of Health and Human Services (Medicaid)** established an Inter-Agency Memorandum of Understanding documenting its shared vision, mission, and governance process and implemented data sharing agreements with each data provider (state agency) to allow data to flow into its Integrated Health and Human Services Data Ecosystem. **Resources:** • **Using Data in Multi-Agency Collaborations: Guiding Performance to Ensure Accountability and Improve Programs** • **Technical Bulletin #2: Data Sharing between CCWIS and Child Welfare Contributing Agencies** • **Toolkit: Data Sharing for Child Welfare Agencies and Medicaid**
B2. Develop processes for continuous information exchange between Medicaid and child welfare	**Oregon Health Care Authority (Medicaid)** and Oregon Department of Human Services (child welfare) has implemented a systematic, real-time data exchange between their agencies. When a child enters state custody, child welfare staff enter the child's information into its SACWIS (Statewide Automated Child Welfare Information System) and this information is then automatically fed into Oregon's MMIS (Medicaid Management Information System). **Washington's Research and Data and Analysis Division (RDA)** developed the Integrated Client Databases (ICDB) to integrate data on social and health services across agencies including Washington's Health Care Authority (Medicaid), Department of Children, Youth, and Families (child welfare), and Department of Social and Health Services. **Resources:** • **Toolkit: Data Sharing for Child Welfare Agencies and Medicaid** • **Technical Bulletin #2: Data Sharing between CCWIS and Child Welfare Contributing Agencies** • **Technical Bulletin #8: CCWIS Data Exchange Standards**

Secondary Driver

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Change Activity	Evidence, Resources, & Case Studies
	• **Using Data in Multi-Agency Collaborations: Guiding Performance to Ensure Accountability and Improve Programs**
B3. Formalize and facilitate regular communication between stakeholders by identifying data-sharing liaisons/champions or workgroups to support ongoing information exchange	**Rhode Island's Executive Office of Health and Human Services (Medicaid)** created interagency analytic teams which included executive leadership, data experts, State and community subject matter experts, and other operational staff to guide integration of data into its Integrated Health and Human Services Data Ecosystem. **New York Office of Children and Family Services (OCFS)** is in the process of developing and implementing a Comprehensive Child Welfare Information System (CCWIS) which includes establishing bidirectional data exchanges across eight areas, one of which is medical data including Medicaid claims. New York OCFS created a CCWIS data exchange/data quality workgroup that meets quarterly. **Resources:** • **Maximizing Linkages: A Policymaker's Guide to Data-Sharing** • **Using Data in Multi-Agency Collaborations: Guiding Performance to Ensure Accountability and Improve Programs** • **Inter-Organizational Collaboration in the Implementation of Evidence-based Practices Among Public Agencies Serving Abused and Neglected Youth**
B4. Leverage low effort but compliant systems (e.g., SharePoint) to share foster care data between agencies and/or MCOs	**South Carolina's Department of Health and Human Services (Medicaid)** and Department of Social Services (child welfare) established a memorandum of understanding that allows the state to manually share and link data between child welfare, Medicaid, and its Medicaid managed care plan via data extracts uploaded to a secure SharePoint site.
B5. Establish regular and frequent (e.g., via interoperability, daily data transfers) sharing of foster care data between Medicaid, child welfare, and, if relevant, MCOs	**Oregon Health Care Authority (Medicaid)** and Oregon Department of Human Services (child welfare) are working towards interoperability between the Medicaid system (MMIS) and the child welfare system (OR-KIDS) so that information is fed automatically and in-real time between the two. **Resources:** • **Toolkit: Data Sharing for Child Welfare Agencies and Medicaid** • **Improving Information Sharing for Youth in Foster Care**

Secondary Driver

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Change Activity	Evidence, Resources, & Case Studies
B6. Implement systematic notifications to Medicaid and MCO(s) when child placement information and/or caregiver contact information is added or updated in the child welfare system	Recommended by subject matter experts. **Resources:** **Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit**

Secondary Driver

C. Enrollment in Medicaid and managed care, if relevant, upon entering foster care. Children and youth eligible for Title IV-E foster care supports are automatically eligible for Medicaid. Efficient enrollment in Medicaid and, if relevant, managed care are needed to ensure timely receipt of needed services to meet the often complex health care needs of this population

Change Activity	Evidence, Resources, & Case Studies
C1. Synchronize smooth and efficient Medicaid enrollment upon entering foster care, such as through process flow mapping and identification of barriers and inefficiencies	**North Carolina Department of Health and Human Services (Medicaid)** began leveraging an existing workgroup in 2023 to review its foster care Medicaid enrollment process after receiving feedback from providers about delays in processing Medicaid eligibility for this population. North Carolina's workgroup is reviewing process steps to identify barriers to timely processing and will be testing use of updated timeliness targets for staff to complete specific steps. **Tennessee's Division of TennCare (Medicaid) and Department of Child Services** (child welfare) established an interagency agreement to coordinate the enrollment and ongoing provision of health services for all children in state custody. After a child enters state custody, child welfare notifies the state's Medicaid managed care plan serving children and youth in foster care, TennCare Select, so that the child can be quickly enrolled and assigned a primary care practitioner (PCP) to serve as their medical home. **Resources:** • **Health-Care Coverage for Children and Youth in Foster Care—and After** • **Medicaid and Children in Foster Care**

Secondary Driver

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Change Activity	Evidence, Resources, & Case Studies
C2. Maintain same health plan and/or PCP after child enters custody to expedite scheduling of health assessments and ensure receipt of continuous, comprehensive, coordinated health care	Recommended by subject matter experts. **Resources:** • **Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit** • **Health Care Issues for Children and Adolescents in Foster Care and Kinship Care**

Secondary Driver

D. Understanding of requirements and processes within and across agencies. Providing health services to children and youth in foster care requires coordination between Medicaid and child welfare agencies. Awareness and alignment of related requirements and processes can enable greater inter-agency coordination and ultimately support improved service delivery for this population.

Change Activity	Evidence, Resources, & Case Studies
D1. Share existing relevant timeliness guidelines (e.g., guidelines for completion of Medicaid enrollment, completion of comprehensive health assessment), and notify when updates are made	Recommended by subject matter experts. **Resources:** • **Inter-Organizational Collaboration in the Implementation of Evidence-based Practices Among Public Agencies Serving Abused and Neglected Youth** • **Health Care Issues for Children and Adolescents in Foster Care and Kinship Care**
D2. Develop the Health Care Oversight and Coordination Plan, as part of the Child and Family Services Plan, with coordination between the child welfare and Medicaid agency	Recommended by subject matter experts. **Resources:** • **Title IV-B Plan Health Oversight and Coordination Plan Requirements** • **Health Care Issues for Children and Adolescents in Foster Care and Kinship Care**

Secondary Driver

D. Understanding of requirements and processes within and across agencies. Providing health services to children and youth in foster care requires coordination between Medicaid and child welfare agencies. Awareness and alignment of related requirements and processes can enable greater inter-agency coordination and ultimately support improved service delivery for this population.

Change Activity	Evidence, Resources, & Case Studies
D3. Align agency timeliness guidelines and managed care contractual obligations	Recommended by subject matter experts. **Resources:** • Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit • Health Care Issues for Children and Adolescents in Foster Care and Kinship Care

Secondary Driver

E. Ongoing coordination of roles and activities across child welfare, Medicaid, and Medicaid managed care. Medicaid and child welfare agencies have a shared responsibility to provide children and youth in foster care with timely health services that meet their unique health needs. This requires coordination between child welfare, Medicaid, and, in some cases, managed care organizations to support access to health services.

Change Activity	Evidence, Resources, & Case Studies
E1. Implementing designated staff (either by bringing on new roles or leveraging existing related roles) to coordinate comprehensive health assessments	**Hawaii's Med-QUEST (Medicaid) and Social Services Division (child welfare)** are leveraging care managers within their health plans to conduct outreach to caregivers and support scheduling of comprehensive health visits. These care managers are responsible for engaging with caregivers to support coordination of care for needed services upon enrollment in the managed care plan. South Carolina Department of Social Services (child welfare) created a new health care quality improvement coordinator position and hired four staff to support scheduling of initial and comprehensive well-child visits and dental visits as well as interface with health plan care coordinators to support foster children in accessing needed services and addressing barriers to care. Michigan Department of Health and Human Services (Medicaid and child welfare) maintains a cadre of Health Liaison Officers (HLOs) to support child welfare staff in meeting the health needs of children in foster care. In addition to supporting efforts to address coverage issues, they also provide support to caregivers in scheduling initial and comprehensive health assessments.

Secondary Driver

E. Ongoing coordination of roles and activities across child welfare, Medicaid, and Medicaid managed care. Medicaid and child welfare agencies have a shared responsibility to provide children and youth in foster care with timely health services that meet their unique health needs. This requires coordination between child welfare, Medicaid, and, in some cases, managed care organizations to support access to health services.

Change Activity	Evidence, Resources, & Case Studies
E2. Implement a checklist for staff responsible for referring or scheduling children for the comprehensive health assessment	**Hawaii's Med-QUEST (Medicaid) and Social Services Division (child welfare)** created a procedure document detailing the steps for child welfare support staff to complete and submit forms for Medicaid enrollment and notify MCO care managers to reach out to schedule the comprehensive health assessment. This also included key contact information for each health plan.
E3. Establish timeliness targets for key steps needed to complete the comprehensive health assessment (e.g., outreach to caregiver within 5 days of child entering foster care)	**Michigan Department of Health and Human Services working with** (Medicaid and child welfare) is using updated timeliness targets including having HLOs reach out to caregivers within 5 days of placement to ensure they have scheduled the comprehensive health assessment. This has resulted in improved performance on timely completion of the comprehensive health assessment.
E4. Determine standard method of proof for health care providers (e.g., placement letter) to confirm that the child is in state custody and has Medicaid coverage	**North Carolina Department of Health and Human Services** (Medicaid) developed a standard custody verification letter to provide to caregivers within 24 hours of placement which identifies that the child is in child welfare custody that caregivers can share with providers and the child's school. The letter also includes the name and contact information of the child's caseworker as well as language outlining state statute for medical consent.

Secondary Driver

F. Provider access (scheduling and location). Access to primary care and specialty providers is necessary for timely, high-quality care for children and youth in foster care.

Change Activity	Evidence, Resources, & Case Studies
F1. Develop a network of primary care and other providers (including establishing dedicated sites in regions with less accessible primary care) willing to complete comprehensive health assessments	Recommended by subject matter experts. **Resources:** • **Health Care Issues for Children and Adolescents in Foster Care and Kinship Care** • **Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit**

Secondary Driver

F. Provider access (scheduling and location). Access to primary care and specialty providers is necessary for timely, high-quality care for children and youth in foster care.

Change Activity	Evidence, Resources, & Case Studies
within the state's required timeframe	
F2. Conduct education with providers (e.g., text notifications, association newsletters, grand rounds) to communicate AAP/state guidance related to completion of the comprehensive health assessment	South Carolina Department of Health and Human Services (Medicaid) and South Carolina Select Health, the Medicaid managed care plan that serves South Carolina's children and youth in foster care, sent targeted education via flyers and text messages to providers about the enhanced rate available for completing a comprehensive health assessment with foster care patients. They also developed an informational flyer summarizing billing guidance and describing AAP guidelines for treating foster children. The Vermont Child Health Improvement Program, working with the Department of Vermont Health Access (Medicaid), provided a presentation to pediatricians in Grand Rounds on AAP guidelines for providing timely health services for children and youth in foster care and how to bill for these services. This included providing state data on timeliness to raise awareness on opportunities for improvements.
F3. Implement enhanced payment rates for PCPs that provide an initial timely visit to children in foster care	Washington Health Care Authority (Medicaid) provides an enhanced rate for providers completing EPSDT well-child visits with children in foster care. Additionally, Washington does not limit use of the enhanced rate to children in foster care; they may be used without regard to the periodicity schedule. **Arizona Mercy Care**, the Medicaid managed care plan that serves Arizona's foster care population, implemented an enhanced rate for EPSDT visits with foster children who require a visit within a specific time to meet policy requirements. Providers are instructed to bill using a specific set of codes with a TJ modifier to receive an enhanced rate at 200% of the Mercy Care fee schedule. **Resources:** • Health Care Issues for Children and Adolescents in Foster Care and Kinship Care

Secondary Driver

G. Provider notification about initial child placement, updates on changes in placement and receipt of medical records. To prevent delays in completion of health assessments and subsequent services, it is important for child welfare and Medicaid agency staff to work closely with the child's provider(s) to share health history information and updates on child placement information as needed.

Change Activity	Evidence, Resources, & Case Studies
G1. Notify MCO or designated practice/provider within 5 days (or other state guideline) that child has entered foster care and needs a comprehensive health assessment scheduled	**Virginia Department of Medical Assistance Services (Medicaid)** sends a weekly enrollment file to its health plans with new members including those who are foster children. Care managers at select health plans review these weekly enrollment files to identify children that have recently entered state custody and outreach to their caregivers to schedule the comprehensive health assessment. **Resources:** • **Health Care Issues for Children and Adolescents in Foster Care and Kinship Care** • **Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit**
G2. Expedite sharing of child's medical record to provider if the provider is new for the child	Recommended by subject matter experts. **Resources:** • **Health Care Issues for Children and Adolescents in Foster Care and Kinship Care** • **Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit**

Secondary Driver

H. Initial screening assessments of a child or youth for needed services. The **American Academy of Pediatrics (AAP)** recommends, and most states require, all children and youth entering foster care have an initial health assessment completed soon after placement (e.g., 72 hours). These initial health assessments can be used to promote a timely, follow-up comprehensive health assessment.

Change Activity	Evidence, Resources, & Case Studies
H1. Establish timeliness standards for completion of initial health assessment/screening after entering foster care	**Maryland Department of Human Services'** (child welfare) policy stipulates that the local child welfare office must ensure that a child or youth entering out of home placement has an initial health care screening to identify any immediate medical, urgent mental health, or dental needs within 5 business days of placement. **Resources:** • **Health Care Issues for Children and Adolescents in Foster Care and Kinship Care** • **Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit**

Secondary Driver **I. Caregiver engagement prior to, at, and following placement.** Foster caregivers play a critical role in supporting access to health services. Engagement and coordination with caregivers is a necessary part of supporting foster children in accessing required health screenings and receipt of subsequent services.	
Change Activity	**Evidence, Resources, & Case Studies**
I1. Send follow-up reminders to caregivers at least 2 days (or other state timeliness guideline) before the date of the appointment for the comprehensive health assessment	Recommended by subject matter experts.
I2. Provide caregivers with checklists and information on the comprehensive health assessment (including timeliness guidelines) at the time of placement	Recommended by subject matter experts.

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