CMS AFFINITY GROUP STATE SPOTLIGHT WEBINAR: IMPROVING TIMELY HEALTH CARE FOR CHILDREN AND YOUTHIN FOSTER CARE

Transcript

[Joe Zickafoose] Well, welcome, everyone. I'm sure we'll have many more joining us over the next minute or two; but we'd like to jump in. I'm Joe Zickafoose with Mathematica, and I've had the pleasure of being the Team Lead for the last two years for the CMS-sponsored state affinity group focused on improving timely health care for children and youth in foster care. We're very excited to share examples today of what the states who have participated in the group have worked on and the progress that they've made. Next slide, please.

Before we dive in, a few technical instructions. All participants have been muted to maintain good sound quality. Closed captioning is available by clicking on the "CC" icon in the lower left corner of your screen. You can also click Ctrl+Shift+A on your keyboard to enable the closed captioning.

We welcome audience questions throughout today's webinar through the Q&A panel, which is located at the bottom right corner of your screen. If you'd like to submit a question, please select "All Panelists" in the drop-down menu; and then click "Send" to submit the question or comments. We'll be monitoring the Q&A throughout the webinar and will address as many questions as possible. If you have any technical issues, please use that same Q&A window to reach out to us. Select "Derek Mitchell" in the drop-down menu and then click "Send" to let us know how we can help.

At the end of the webinar, there will be a survey pop up; and we're asking you to please respond as you're able to help provide feedback and improve future webinars. We also want to let everybody know that today's webinar is being recorded, and we'll send an e-mail to all meeting registrants when the slides and recordings are posted on Medicaid.gov. Next slide, please.

So, to get started today, I'll be handing off to Susan Ruiz with CMS to welcome everyone and briefly describe CMCS's approach to quality improvement affinity groups. Then I'll provide a brief overview of the affinity group as a whole and high-level summaries of the work that the states have been doing. Then we'll take deeper dives hearing from two of the states that participated, Michigan and Virginia. Then we'll open up for questions. We should have about 10 to 15 minutes at the end before wrapping up with a summary of some upcoming opportunities for QI technical assistance from CMS. Next slide, please.

With that, I'd like to hand it off to Susan Ruiz. Susan, it's all yours.

[Susan Ruiz] Thanks, Joe. Good afternoon, everyone. My name is Susan Ruiz and I'm with the Center for Medicaid and CHIP Services. I want to thank all of you for joining us today. I especially want to thank our participating states for their hard work and commitment to this work for the whole two years of our learning collaborative. This was a unique group that brought together Medicaid agencies and their partners in child welfare agencies, and we're really pleased to have had such great interest from states. Next slide, please.

I also want to tell you a little bit about how this work fits into our other portfolio of quality improvement affinity groups. The CMCS QI TA program supports state Medicaid and CHIP programs, as well as their QI partners, with all sorts of information tools and expertise to improve care and outcomes for Medicaid

and CHIP beneficiaries. For each part of the QI TA program, we convene action-oriented affinity groups like this one to help states build their QI knowledge and skills, develop their QI projects, and scale up, implement, and spread QI initiatives. Each affinity group is preceded by a webinar series that includes this information on QI success stories, which is what you'll be hearing today. Next slide, please.

With that, I'll pass it off to Joe again. Thank you again for being with us today.

[Joe Zickafoose] Great, thanks so much, Susan. Next slide, please.

While much of this information will probably be familiar to everyone in attendance today, we wanted to review why it's important to focus on the timeliness of health care for children and youth in foster care.

This group has a high rate of preexisting conditions, and the circumstances that lead to removal from their homes often contribute to additional needs, thus making them a group with an extremely high rate of physical and behavioral health care needs. Initiating timely health care after their placement in foster care is critical to identifying and meeting those needs. The American Academy of Pediatrics recommends all children and youth have a comprehensive health evaluation soon after placement in foster care; for example, within 30 days. And state child welfare agencies are expected to incorporate timely comprehensive evaluations into their health care and oversight coordination plans. But what is considered timely and how well it is monitored presents key opportunities for improving care for this group. Next slide, please.

To help address this opportunity, CMS convened the state affinity group from July 2021 through August 2023. So, we're just now wrapping up. There were 11 participating states, who we'll describe in just a moment; and the affinity group sought to support Medicaid programs to partner with their states' child welfare agency and other partners and design and implement data-driven quality improvement projects to improve the timeliness of health services for children and youth in foster care. Next slide, please.

As part of this overall goal of supporting state Medicaid and child welfare teams to improve the timeliness of comprehensive assessments for children and youth entering foster care, the affinity group sought to address several specific objectives. These included: expanding state teams' knowledge of evidence-informed practices; learning from other states' experiences using data-driven approaches to QI projects; supporting state strategies to coordinate across partners, especially between Medicaid, child welfare, and managed care as relevant in the states; and lastly, to improve general QI skills for all of the participating state teams. Next slide, please.

On the next three slides, I'm going to be summarizing the work of the states at a very high level. As we mentioned, there were 11 states, two of which you'll hear about in more detail after I finish up. Throughout, you'll start to hear some common recurrent themes based on the focus of the affinity group; but you'll also see several of the unique ways that states sought to address these aims within the context of their own state.

Arizona sought to increase the number of children who received a comprehensive EPSDT visit within 30 days of entering foster care. To do this, they partnered with their state foster care-focused managed care organization to test using a new team of non-clinical care coordinators to outreach to caregivers for scheduling those visits.

Hawaii aimed to increase the number of children receiving a comprehensive visit within 45 days of placement, which was their state guideline. They tested having child welfare staff refer new foster children to their state's MCO's care managers to support scheduling.

Maine sought to increase the completion of comprehensive health assessment referrals, and they engaged with local child welfare staff and district offices to improve timely completion of referrals to providers and receipt of documentation after the comprehensive health assessments were conducted.

Similarly, Maryland sought to increase the number of children who received a comprehensive visit within 60 days of entering foster care, which was their state guideline; and they explored leveraging managed care organizations' special needs coordinators, which was an existing position, to support scheduling of the assessments. Next slide.

Michigan you'll hear about in detail in just a few minutes here. Next, North Carolina sought to improve timely initial health assessments within seven days and the comprehensive assessment within 30 days of entering foster care. They tested using updated timeliness targets for state staff to process Medicaid and enrollment, a step in the process that they identified as a key barrier.

South Carolina also aimed to increase comprehensive visits within 30 days of placement, and they implemented five of what they refer to as "health care quality improvement coordinators" at the state level to support scheduling and completion of the visit. These were new positions that were created specifically to help meet this goal.

Vermont also aimed to increase comprehensive visits within 30 days of placement, and they partnered with a program called Fostering Healthy Families, which was a quality improvement program already in place who had nurses that worked with the outreach to providers to confirm custody of the child and support timely scheduling. Next slide.

You'll also hear about Virginia in a few minutes after Michigan. For the last two states, Washington already had high rates of comprehensive visits after placement; so their team chose to focus on increasing the number of children who received a follow-up call from their foster care specific health plan, the goal of which was specifically to connect them to needed care that was identified during the comprehensive assessments. They partnered with the health plan to survey caregivers to better understand their experience with the follow-up calls and identify opportunities to improve.

West Virginia also sought to increase comprehensive visits within 30 days of placement. They identified key process steps leading to completion of the comprehensive health assessment at five different points along the way, defined timeliness targets for those steps, and tracked data to monitor performance. Next slide, please.

So now it's my pleasure to hand off to Shannon Baker from Michigan to talk more about the specific work that their team conducted during the affinity group. Shannon, all yours.

[Shannon Baker] Thank you. Hello, I'm Shannon Baker, the health analyst for Child Welfare Medical and Behavioral Health, which is under the Children's Services Administration and part of the Michigan Department of Health and Human Services (MDHHS).

Our team consists of myself, along with Mary Chaliman, Manager of the Child Welfare Medical and Behavioral Health; Dr. Jeanette Scheid, Medical Consultant with Child Welfare Medical and Behavioral Health; Matt Hambleton, Medicaid Policy Specialist for Behavioral and Physical Health and Aging Services Administration Program Policy Division with MDHSS; as well as Elizabeth Pitts, Medicaid Dental Policy Specialist with MDHSS, and Dr. Sandy Swarnavel, Department Specialist for the Healthy

Kids Dental Program with the Bureau of Medicaid Care Management and Customer Service for MDHSS. Next slide, please.

In Michigan, child welfare is state administered. 46% of the cases are supervised by local offices, and 54% are supervised by private foster care agencies. Children in foster care are categorically eligible for Medicaid, and most children are enrolled in one of the nine medical health plans and one of the two dental health plans we have in Michigan. Sometimes briefly when first coming into foster care or while a child is in a child caring institution, they will have fee-for-service Medicaid; otherwise, most are enrolled in a health plan. The Native American children may opt out of enrolling in the health plans. If a child in foster care has private insurance through their parent or guardian, that coverage continues, and the Medicaid is secondary insurance. Here in Michigan, children ages zero to 12 that initially were in out-of-home placement are required to receive all EPSDT or well-child visits until their foster care case is closed. Next slide, please.

There are approximately 10,000 children in Michigan's foster care system at this time. So far for 2023, an average of 312 children enter foster care monthly. The expectation is that at least 85% of the children will have an initial medical health examination within 30 days of the child's entry into foster care. At least 90% of the children shall have an initial dental examination within 90 days of the child's entry into care unless the child had a dental exam within the three months prior to placement or the child is less than one year of age. As we are able to use a dental exam that occurred up to 90 days prior to out-of-home placement for that initial dental, the HLO, that we'll talk about briefly in a moment, needs to verify that a new dental exam is required for each child over age one year. Next slide, please.

Here's our aim statement. By the end of 2023, we will improve the timeliness of initial medical and dental exams that occur for children in foster care by, one, increasing the percentage of initial comprehensive medical visits received within 30 days of place into foster care from 72% to 85%; and second, increasing the percentage of initial dental visits received within 90 days of placement into foster care from 67% to 90%. Next slide, please.

In Michigan, we have 34 health liaison officers or HLOs. This is not a new role for us. It has been around for some time. The HLOs are assigned to local county offices throughout the state. This current test is a reboot for us. Our initial test was of a different process. Our early attempts involved the HLO coordinating with the foster care case manager. That initial process was more detailed and required more time and documentation of the work on the part of the HLO. It was too indirect, and it did not work well. So, we went back to our lean process improvement that was developed eight-ish years ago.
For this Plan-Do-Study-Act (PDSA) we refocused on one region in the state that is made up of the larger counties with higher populations. This time, we made contact with that region's leadership to get their buy-in. Also at the same time, our state's Children Services Administration began focusing more on the issue of timely initial well-child exams. That led us to having leadership support for this project.

Our current test is to see if an initial medical visit will be timelier if the HLO makes contact directly with the caregiver within two business days of initial out-of-home placement. Then, the HLO contacts the caregiver again at five business days to ensure that the exam is scheduled. The same process is simultaneously being tested for the dental exams for our PDSA #5 since March.

Basically, the HLOs are making contact with the caregiver on Day 2 to discuss the medical and dental exams and their due dates, and then they will make contact again on Day 5 if the appointment was not made prior. Next slide, please.

The question we wanted answered was if scheduling the medical and dental exams as early as possible would facilitate a timelier exam. I'll pause for a minute so you can read that slide because there's more. [Pause] Okay, next slide, please.

We started this current test for initial medical exams in January of 2023. We are focusing on the four counties in one region of the state. This slide shows the four test counties in blue and the statewide numbers in orange. Because we are limited in size of the graph that we can use for this slide, we are only showing the data for the two months prior to beginning this new test and the four months of data we had available prior to submitting for our presentation.

If we had room to share all of the data from 2022, you would see pretty much what you're seeing for November and December of 2022. The test counties were in about the 40% to 80% range, and the statewide numbers were around 60% to just over 80%. You can see in January 2023 when we implemented this test for the four counties, they had a major improvement from the year before. Also, the region is surpassing the statewide numbers where before they were consistently below the statewide numbers. Also, we would like to make note that these four counties are pulling up the statewide numbers, as you can see that the orange bars are higher than prior to implementing the PDSA. Next slide, please.

Throughout this process, we have had to make slight tweaks in what and how we are tracking. For this slide we are using February 2023 through May 2023 data. We are testing the two- and five-day contacts, but there are weekends and oftentimes vacation and sick times for the HLOs during that five-business-day time frame. Therefore, the contact within five business days is sometimes not feasible. So, our team decided that as long as a contact was made within 10 days, it is being counted as a successful early contact for this slide.

This slide shows for those children that had that early contact in February, 95% of them had a successful visit and so on, as you can see the rest of the numbers listed. We also looked at those incidences where an early contact was not made; it was outside of the 10 days, or no contact was made at all. In those situations, we see only 55% to 67% of the time, the exam was completed timely. We are seeing that when the PDSA is followed and early contact is made, the exam is more likely to be completed timely than if it is not. Next slide, please.

This is our data for initial well-child exams for all of 2022 through May of 2023. The green line is the goal of 85%. The yellow bar is when we had the change in process. The blue line is the data for the four test counties, and the orange line is the median. You can see how the four counties were performing prior to the test change and the improvement once we implemented this new PDSA.

I wanted to note at this point that COVID had a large impact on our initial well-child exam numbers, as I'm sure it did for everyone else. Prior to COVID, our numbers for the initial well-child exams were generally in the high 70s and low 80s percent. In three years, our numbers were back almost to the levels pre-COVID. Next slide, please.

Here's our data on the initial dental exams. We have the dental data for all of 2022 and through March of 2023. The dental data comes in a little bit slower, since we have those 90 days to complete the dental exams. Our requirement for initial dental exams is 90% of children ages one and over will receive a dental exam within 90 days of initial out-of-home placement unless the exam was completed within the previous 90 days.

We began the process of having the HLOs reach out to the caregivers and provide the due dates and offer assistance with scheduling for the initial well-child exams in January 2023. We began having the HLOs track the contact through the initial dental exams as well in March of 2023. As you see, the contact to the caregiver began having a positive impact on timely dental exams as early as January. The green line on this slide is our goal. The yellow bar is the date we started the refocus with the initial medical PDSA, and the blue is the monthly performance of our four test counties for 2022 through March of 2023. You can see that our test counties were typically between 50% and 70% timely initial dental exams. Once we began this new process, the numbers improved significantly. The orange line is the median of just over 60%. The numbers we are seeing now are higher than we saw in all of 2022 and much above the median.

For the dentals, we are asking that they attempt to have the exam scheduled within 30 days but know that it may take longer and require assistance from the dental health plan. We did see a dip in March 2023 numbers; however, due to our data lag, we do not have the April 2023 dental numbers available yet. We're looking forward to seeing if this was a one-time dip. If the numbers remain lower than our goal, we will use the PDSA process to work towards our goal. I will note that the March 2023 numbers are still above our median for what was in 2022. Next slide, please.

Our successes with PDSAs #4 and 5 are that we selected a region that is comprised of the most-populated counties in the state, which led to a greater impact. We met and exceeded our goal of 85% for initial medical exams, which also increased the number of the entire state by 12%. We pivoted from having HLOs work with the case managers to having them working directly with foster parents. This also provided a relief for the case managers. Next slide, please.

Our challenges were that much of the data collection was handled by one or two members. Also, obtaining accurate two- and five-day contacts was challenging. Also, identifying the relationship between the contacts or our process to the timely medical exams, which was our outcome, was difficult. In the beginning, a challenge was that the information being asked of the HLOs was too much and consumed too much of their time. Challenges for us specific to the children was the young adult voluntary foster care population, hospitalizations, and delayed out-of-home placements due to initial placement with non-offending parents. Challenges for us specific to the primary outcomes datapoints was the lag in entry into our system. The lag is about two months for medical exams and up to five months for our dental exams. Next slide, please.

Our plan for sustainability is to have our group meet internally at least biweekly. We plan to continue to collect data for 6 to 12 more months. We recognize that more data is needed to show the correlation between the early contacts and increased percentages of timely visits. We're going to collect and track the data to ensure that we are not slipping but that this is sustainable. We will recommend expanding statewide to leadership once we have enough data to justify the expansion.

Our recommendation will be for HLOs to incorporate the two- and five-day contacts into their own tracking documents or spreadsheets so that they can continuously track and monitor this on their own. I do want to say it was a pleasure to work with CMS, Center for Health Care Strategies, and Mathematica on this process. We really appreciate the support and guidance that we received throughout. Thank you.

[Joe Zickafoose] Great, thanks so much, Shannon. I want to remind folks that you are welcome to submit questions in the Q&A panel. If it's not popping up for you directly, you can click on the little three dots in the bottom right-hand corner; and it should give you the option. All right, next slide, please.

With that, I'd be happy to hand off to Lora Smith Hughes and Christine Minnick with Virginia.

[Lora Smith Hughes] Good afternoon, everyone. I'm Lora Smith Hughes, and I'm the Foster Care Program Manager with the Virginia Department of Social Services. Then in just a moment, you're going to hear from Christine Minnick, who's with the Virginia Department of Medical Assistance Services. Next slide.

We wanted to start off with some brief information on Virginia's foster care population and an overview of our delivery systems. You'll see on this slide that in July of 2023, there were 6,136 children enrolled in Medicaid through foster care in Virginia. I do want to note that these numbers are somewhat inflated compared to the actual number of kids in foster care because as most of you know, during the pandemic coverage was not being terminated for members even after they left foster care.

The Department of Medical Assistance Services, or DMAS, is Virginia's Medicaid program and provides oversight of Medicaid policy and benefits. DMAS contracts with five managed care organizations, three of which were part of our affinity group team; and they cover approximately 95% of Medicaid members. The other 5% of Medicaid members remains in fee-for-service due to just having been enrolled in Medicaid or just having been placed in residential settings. The Virginia Department of Social Services, or VDSS, is our state child welfare agency. We are state-supervised and locally-administered, and we have 120 localities around the state. The challenge with this is that while each of the 120 local DSS agencies conduct Medicaid eligibility based on DMAS policy, the process of doing so differs from one agency to another. Next slide, please.

Our state aim statement was similar to Michigan's in that we aim to increase the percentage of children that receive their initial medical exam within 30 days of entering care. Virginia DSS policy, as well as our Administrative Code, states that the service worker shall ensure that the child receives a medical examination no later than 30 days after the initial placement.

We wanted to note while we were developing this aim statement at the beginning of the project, one of the first important moments of learning for our team was that the DSS and DMAS data systems don't really talk well to each other; and the date of custody isn't shared with DMAS. And the DSS case management system is antiquated, to be honest; so that led to unreliable data regarding the date of the medical exam. Because of that, we had to do our best to estimate the baseline rate of 89% by using the earliest data that the MCOs became aware of the member entering foster care. We'd be happy to talk a little bit more about how we got to that if anybody has questions.

I'm going to go ahead and turn it over to Christine. Next slide too.

[Christine Minnick] Hi, everyone. I am Christine Minnick. Like Lora said, I'm with the Department of Medical Assistance Services in Virginia. I'm the Child Welfare Program Specialist and co-led the Virginia team with Lora. I'm going to pick up where she left off and just share some information about our team strategies and interventions as we began this project.

In Virginia, DMAS or Medicaid hosts a statewide foster care stakeholder group called the Foster Care Partnership. At the beginning of this project, we were able to utilize feedback from stakeholders from local and state DSS staff as well as DMAS and MCO representatives during some of those meetings to develop a timeline of steps. Like Lora mentioned, each agency does things a little bit differently; but we mapped out generally each step from a child entering foster care to their assigned managed care organization being notified and through outreach and initiation of services.

We can see here on this condensed flowchart that once custody is transferred, the local DSS foster care worker submits the Medicaid application to the DSS eligibility worker. Then the eligibility worker completes the eligibility determination in the DSS data system, and that transfers over to the DMAS system. At that time, the DMAS system processes the enrollment changes only once per month for category changes for the upcoming months of eligibility. Then, a few days later after the 18th, the MCOs then receive their enrollment report for the upcoming months. At that time, they're officially aware that foster care eligibility has started for the member.

This was a really helpful first step in kind of determining how our system is set up. We learned that because of the way that our system and our data sharing is set up and the various opportunities for delays, the foster care enrollment and MCO outreach was often occurring too late to be able to make an impact on anything within those first 30 days of custody. We can go to the next slide.

Because of this learning that we had from developing our process flow map, we knew that our first area of focus was going to be the timely notification of the MCO when a youth entered foster care. Our hypothesis here was that if the MCO was notified sooner, then the care coordinator would be able to reach out to assist with scheduling the medical exam within that first 30 days of custody. Two of the tests that we'll be sharing data from today with you all were different variations of warm handoffs between the Department of Social Services, the Department of Medical Assistance Services or DMAS, and the MCOs.

For the first test that we're going to talk about, we worked with one of our 120 localities, Bedford County DSS, because they were involved in our Foster Care Partnership stakeholder group and shared with us at the beginning of the project that their intake process already included a secure e-mail notifying necessary parties that a child had entered custody. So, they were able to include the DMAS foster care inbox e-mail in that secure notification for that test. Because that sample size for that test for the one county was relatively small, in order to try to learn more, we developed a second warm handoff where Virginia DSS sent a secure list to DMAS twice per month with all Medicaid-eligible youth in the state who had entered custody in that time frame. So that was twice per month, while the Bedford was a daily notification on the day that the youth entered custody. Then for both of these warm handoff tests, after receiving the member information and the date of custody, DMAS would be able to identify the assigned MCO and notify them that the member had entered DSS custody. The MCO care coordinator would be able to outreach to the foster family or the local DSS worker to ensure that the medical exam was scheduled and completed within 30 days of placement. Next slide.

We will look at some data from our first Bedford e-mail warm handoff PDSA. Our two main process measures that we were collecting data on for these tests were the timeliness of the MCO notification after a youth entered custody and then the timeliness of MCO contact with the member after that. Then, of course, our outcome measure that we were looking at was the rate of those initial medical exams being completed within 30 days of DSS custody.

This slide is looking at one of those process measures, the improvement and the timeliness of the MCO contact with the foster care member from before we started the test to after we started the test. So, this is similar to Michigan's chart, where we have our red line as our data; and we have our vertical gray dashed lines – the first one is when we started the first iteration of the warm handoff test, and the second one is when we adapted that test to improve it, hopefully, to reach out directly to the foster parents when possible. Also, just for some context, Bedford is a relatively small county. As of last month, there were 75 children total in foster care in Bedford; and that's about 1.5% of the state's total.

So, we started the warm handoff test, you can see here, in October of 2022, and then we adapted it in January of 2023. We can see here on the y axis we have the number of days. We can see that when we started the test, we decreased the number of days significantly, which is a significant improvement between the date of custody and MCO contact with the member in order to assess. We'll go to the next slide to see the outcome measure for this test.

This chart shows the percentage of youth in Bedford County who received their initial medical exam within 30 days of entering foster care each month from before to after beginning the test. So, with a small sample size in Bedford, the baseline rate from the month before the test began fluctuated quite a bit. We had a few months reaching 100% compliance, and then we had some dip down as low as 25%. I imagine that month may have been a month with four members or eight members entering care.
So, during our first testing month in October of 2022 where the first gray vertical dashed line is, we gathered data on six youths who entered custody; and four of those six had their initial medical exams completed. Then we can see from there, starting in January, that after we adopted that PDSA to have the MCOs outreach directly to foster parents to help schedule the appointment, 100% of those medical exams were being completed within 30 days for March through July of this year.

We can go to the next slide and see our second warm handoff test which we developed, which was as a reminder, this was our state DSS Office sending DMAS a list of Medicaid-eligible youth who had entered custody in the state twice per month. So, this chart shows the improvement in the process measure of timeliness of MCO notification of a member entering foster care from before to after we started the test. You can see here where the gray vertical dashed line is that we started in April of this year and began to see some improvement from fluctuating between 40 and 100 days down to our median, which is right around – it looks like 20-22 (days). Of course it doesn't reach our goal, and we want to note that because we were only able to get this list twice a month. So that obviously was not the same significant amount of improvement that our Bedford test was, but we were able to have a larger sample population and look at most of the state in this test. Let me see, okay, so next slide.

We have our final data to share, which is our outcome measure for the second warm handoff test, where we were outreaching with a list of new members twice per month. We were looking at the rate of comprehensive medical exams completed within 30 days of custody. We can see that we saw some improvement in this test as well, with several recent weeks reaching 100% compliance after beginning the test in April of 2023, getting up above our goal for four of the six months that we have been collecting data.

So that's the data that we wanted to share today. I'm just going to turn it back over to Lora now to just share some of our reflections and next steps with you all. Next slide

[Lora Smith Hughes] Thank you, Christine.

As we reflected on the project, we wanted to note that an important learning moment for our team was when we engaged all the relevant stakeholders in mapping our process flow. We found this to be a really important piece in helping us realize that the timeliness of Medicaid enrollment and MCO notification and outreach to new foster care members was a significant barrier to making improvement towards our aim statement.

It's also clear that our work with the affinity group enhanced coordination and collaboration among our Medicaid and child welfare agencies. The warm handoff secure information removed information silos among agencies involved with the youth. It allowed MCOs to collaborate directly with the local DSS agencies around a common goal for members. That collaboration has improved local DSS agencies'

understanding of care coordination. Also, participating MCOs have had the opportunity to develop relationships, share ideas, identify barriers to successful care coordination, and brainstorm possible solutions. Next slide, please.

As we're thinking about next steps, though we don't believe our data has demonstrated a direct correlation yet between the improvement in our process measures and our outcome measure, the Virginia team plans to continue to explore and test current and new ideas for reducing MCO notification and outreach time when a member enters the custody of DSS. We believe that continuing to improve the efficient and timely collaboration and communication among our agencies will improve the timeliness of initial service coordination for these children.

One innovative effort recently underway is that Anthem HealthKeepers, one of the MCOs on our affinity group, started a pilot partnership with a local Department of Social Services agency where an MCO care coordinator is on-site at the locate DSS Office several days per week to be available for care coordination assistance related to services for Anthem members in foster care within that county.
In addition to testing these ideas to improve communication among our agencies, we also plan to utilize our monthly interagency workgroups through our Foster Care Partnership Collaborative with DSS, DMAS, and the MCOs. We will continue to utilize the quality improvement tools provided by this affinity group to work toward improved collaboration, information sharing, and timely medical services for youth in DSS custody.

With that, I'm going to turn it back over to Joe. Thank you.

[Joe Zickafoose] Thank you very much to the Virginia team and to Shannon with the Michigan team as well. We're going to transition into question and answer time now. We've got a lot of great questions coming in that I'm going to work on summarizing and combining. But to get started, one of our first questions was about the role of dental evaluation in the comprehensive assessments. I think the Michigan team has largely addressed that with their dental work, but I wanted to see if the Virginia team could comment about expectations for dental evaluation and if and how you all have been thinking about opportunities for improvement there.

[Christine Minnick] I'm happy to address that; and then if Lora wants to jump in, she can.
Our initial comprehensive medical visits are within the first 30 days and our dental guidelines are within the first 60 days. Then similar to Michigan, unless they've had one within I believe it's 90 days prior to coming into care – I should have that pulled up but, Lora, feel free to correct me if I'm wrong – but it's kind of a similar thought process in terms of wanting the MCOs to assist with scheduling but needing to get the outreach and the notification about the custody on a more timely schedule first.

[Lora Smith Hughes] I think you covered it.

[Joe Zickafoose] Great, thank you, Christine and Lora. I can say across the entire affinity group, most of the states had an expectation for dental visits in addition to the comprehensive medical visits; and many of the states considered incorporating that into their quality improvement work. But in the end, most of those states decided to focus in on the medical assessment just as a first place to start; and then a few, as you saw with Michigan, decided ultimately to take some of the lessons they were learning and apply that to dental evaluations as well.

Okay, so we've got a bunch of great questions for Michigan about the role of the HLOs, the health liaison officers. So, Shannon, I wanted to see if you could say more about the HLOs, particularly around what kind of training they have; what resources they have and that they can provide to caregivers; how

many children are in their caseloads; and how they were notified about new out-of-home placements. That's a bunch of questions packed together, so I'll let you get started. Then, let me know – I can give you a refresher on the specifics.

[Shannon Baker] Okay, so it is our procedure that CPS workers notify certain people in the county at the time of removal, within 24 hours is the goal. So that's how the HLOs were notified of the removals was in that process. A health liaison officer is tasked with at the local county level ensuring the health and well-being for the children in foster care for the county or counties that they are assigned to. There are 83 counties in Michigan, I believe, so some counties have multiple, but some HLOs have multiple counties. As far as their training, they are trained by myself or someone in my position – one of my predecessors – in the systems that we have access to. We have our system CHAMPS (The Community Health Automated Medicaid Processing System), and then we have our Child Welfare Information System as well as some other systems. They read up a lot of policy; they are the policy expert in their county. I could go on for a great deal. I can go on in detail, but I think that kind of sums it up.

[Joe Zickafoose] Thanks, Shannon. Could you say a little bit more about caseloads and some of the additional ways that they can provide resources to help support families?

[Shannon Baker] Yes, so their caseloads vary from around 200 to over 500 children per health liaison officer, depending on where they are located in the state. They're considered to be the content experts in their local offices; so quarterly, we have trainings that are three hours long to pass on information. Then monthly, in between those quarterly trainings, we have check-in calls to pass on other information. So it comes from somewhere in the state – some other services, some other specialties – through myself and then to each of the HLOs at one of the various meetings that we have. They kind of get on-the-job training. Many are previous child services workers or specialists – so foster care worker, case managers. Some do work in benefits, so they would have more of a Medicaid experience.

[Joe Zickafoose] Great, thanks so much. We've got a couple questions about challenges early in the process of getting children who have been placed in foster care enrolled in Medicaid and then, as applicable, enrolled in MCOs. So just wondering if both states could say a little bit about how you go about determining which MCO a child should be assigned to, particularly if they weren't already assigned to one of them, and how you work in that period of time as children are getting enrolled and engaging providers, particularly those who might be hesitant to schedule before they can confirm enrollment in Medicaid. Virginia, would you be willing to kick off with that?

[Christine Minnick] Sure, yeah, this was definitely tricky for us to figure out as well in the beginning. What we learned as part of our process – because we shared briefly that when youth are first enrolled in Medicaid for the first time, for the first 30 to 45 to 60-ish days, will be in fee-for-service and then will be enrolled into an MCO at the next enrollment date.

So we weren't sure for new Medicaid members how we would incorporate any of our tests or assigning the MCO in those first 30 days before they had an MCO. But we found in looking at our data that – and this isn't official, but this is just in the data that we looked at – that about 75% of children entering foster care were already enrolled in Medicaid and in an MCO in another aid category. So, it was really just a matter of the aid category changing from the child's family to the foster care aid category. They would stay with their same MCO.

So, we were able to see even if they weren't moved over into the foster care aid category yet, we were able to, when we got that warm handoff information and looked them up, we were able to see what MCO [they were enrolled in] because they continue in the same MCO when they switch aid categories

to foster care. I hope that helps that kind of question about which MCO, and we focused on our tests and our sample populations on only MCO-enrolled members so that there was that continuity of the care coordination to engage in the test.

[Joe Zickafoose] Thanks, Christine. I think the second piece of that that folks were asking about is did you face any challenges with getting providers to schedule visits, depending on where the child was in the process of enrollment.

[Christine Minnick] Yeah, I think because we focused our tests on members that were already enrolled and already in MCOs, we didn't – to my knowledge – we did not experience any issues in that sense because we were only working with youths in foster care who were already enrolled in Medicaid.

[Joe Zickafoose] Great, thank you. Then, Shannon, do you have more that you can say about Michigan's approach and experience?

[Shannon Baker] I don't know the exact information, but I want to say it's probably pretty close to Virginia's number for youth that are already active with Medicaid. Then, the vast majority of them are also enrolled in one of the health plans in Michigan. So, I want to say it's probably similar to the 75%. I just don't know that number off the top of my head.

As far as providers, I think that providers that are willing to work with any of the Medicaid health plans – it's a struggle sometimes. That is one of the major job duties of the health liaison officer is they are tasked with liaising with providers in their areas. That's why they're housed and supervised at the local county office, so that they can reach out to those local providers and develop relationships and be somebody to troubleshoot for any insurance issues. But it is often a struggle to be able to locate providers that are willing to accept the fee-for-service Medicaid. It is always a push for us to have the children enrolled in one of the health plans as soon as we can though.

[Joe Zickafoose] Great, thank you. We had a question here about challenges with shortages of providers. So, I think you touched on that. I wanted to see if you had anything else to say about shortages of providers and how you might address it, Shannon, and then going back to the Virginia team on that question.

[Shannon Baker] Yeah, that is definitely something that I think everybody is facing at this time is shortage of providers, shortage of providers that will accept Medicaid, and then just short of appointments. They're stretched very thing. So that is something that we work with constantly. We, in Michigan, we bring in the health plans. So, all of the health plans have similar to like an HLO, like a counterpart that works with the HLO to ensure that the needs of the foster children are being met. But we still do have some areas in the state, particularly our upper peninsula where it's less populated, in locating providers. That is something that we're constantly doing – trying to work very hard to be a good partner in that relationship to be able to not wear them out and burn them out, which can happen. So, yeah, that's a struggle for us.

[Joe Zickafoose] Thank you. Anything to add from the Virginia team?

[Christine Minnick] I would just say about the same. I think we do have some provider shortages, particularly around dental providers. But we didn't particularly specifically encounter that issue during this project in scheduling.

[Joe Zickafoose] Great, okay. So, I think we're going to try to squeeze in just two more questions here. One I think – yes, I think is fairly connected to what we've been talking about. Someone from another state mentions that they often have a lot of placement movement within the first 30 days, and that makes it extremely challenging to get children in for that 30-day exam. They were curious if your state has struggled with that and any approaches that you've found to be helpful.

[Shannon Baker] We've definitely struggled with that in Michigan. That was an issue particularly during our first couple of PDSAs. During this next one, because the HLO was making contact within those first couple of days, we were trying to encourage getting an appointment scheduled and then maybe we could just work out transportation and how to get the child to that appointment later. We felt as though early outreach was going to address that as well.

[Lora Smith Hughes] As far as Virginia, we don't have emergency shelters or those sort of really temporary placements for kids when they come into foster care. So typically, as with any agency, we're working really hard for their first placement to be their only placement. But since we don't have those emergency-type facilities, more than likely kids are not moving around within the first 30 days.

[Joe Zickafoose] Okay, all right, well, let's wrap up with just one more question. This fits with a lot of what folks have been asking about; but if your state would have the opportunity – which we do right now – to give advice to other state teams that are thinking about starting a QI project, what would your advice be? We could start with Virginia.

[Christine Minnick] We have talked about this a lot. We have a lot of advice that we want to give ourselves from two years ago and to other teams. But really, our main one would be just that collaborative expertise – getting the expertise at the table. Particularly for us, the expertise around the data and the systems working together was really important because we didn't know in the beginning that we would need such detailed level of understanding of the systems and the sources of all the data that we needed. We felt like we were playing catch-up a little bit in the beginning, like we kind of talked about even figuring out our aim statement to get our baseline rates. So, I think from us would just be to have all your experts at your table working together; particularly the systems and data folks are helpful.

[Lora Smith Hughes] I would just add to that, Christine, I think we were fortunate enough to already have our foster care collaborative group. So, a lot of those relationships were built. But I think for us, really looking at the process mapping – nobody wants to do all that because it's not all that fun, but that was really eye-opening for us. I think I would really recommend really taking the time to go through that process to really drive the work that you're going to move forward with.

[Joe Zickafoose] Anything that you would like to add, Shannon?

[Shannon Baker] I think our advice would be on see where you're at and what you have, and build from what you already have naturally built into your system – such as we had the HLOs and that lean process improvement that we brought back. Then also, get the buy-in from leadership – county leadership or higher up leadership. Then that way you get the support that is needed for big process changes.

[Joe Zickafoose] Great. Well, thank you all so much. We've just got a couple pieces of information. We know we're right up at time, but we wanted to give a couple pieces of contact information. I'll hand it off to Laura Armistead with Mathematica to wrap up here.

[Laura Armistead] Thanks, Joe. Next slide. We briefly wanted to highlight that CMS is now offering a variety of on-demand QI TA resources on Medicaid.gov. These include videos on how to get started on

quality improvement projects and other resources from our affinity groups and previously-recorded topical webinars. As you can see, they cover a range of topic areas; and more will be added in the coming weeks. You're also welcome to reach out to the Medicaid and CHIP QI mailbox for one-on-one support. Next slide.

Just a reminder that the slides from today's webinar will be posted. We'll send an e-mail to all of our attendees letting you know when those are available. But we wanted to just thank you all. Thank you to our speakers, and thank you to our attendees for participating in today's webinar. We ask that you please complete the evaluation survey as you exit.

That's all. Thank you so much for joining us today.