

Highlights from the Improving Timely Health Care for Children and Youth in Foster Care Affinity Group

Background

More than 600,000 children and youth were served by the foster care (FC) system in the United States in 2021.¹ Children² entering FC often do so with complex medical, mental health, developmental, and oral health issues, which have frequently been exacerbated by fragmented and sporadic health care.³ Along with new living and school arrangements, out-of-home foster placements often require new medical, mental health, and dental providers. Assuring continuous health care for children in FC is critical to their health and well-being.

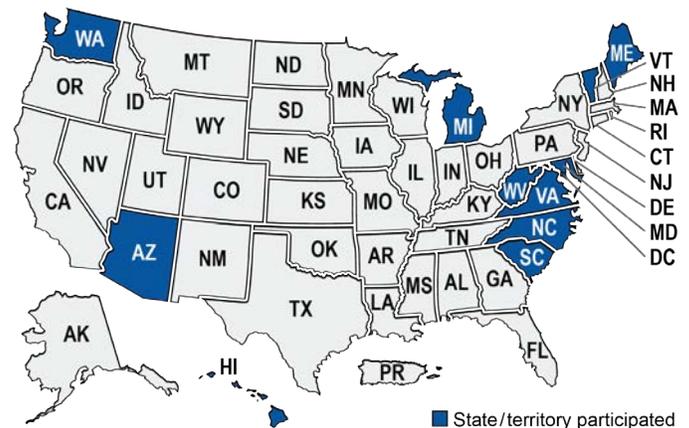
Children qualified for federal child welfare assistance under Title IV-E are automatically eligible for Medicaid. Recognizing that children in FC often have unmet health care needs, 48 states⁴ require a health assessment⁵ in at least one of the three health domains (physical, behavioral, and oral health). The purpose of health assessments is to identify possible physical health, mental health, and development needs of children entering FC, allowing their caregivers, caseworkers, and care teams to develop treatment plans. Timeframe requirements for these assessments vary, but the most common requirement is within 30 days of the child entering FC.⁶

Medicaid programs, in collaboration with their child welfare partners, play an important role in ensuring that children in FC receive timely health assessments. To aid states in improving care for children in FC, the Centers for Medicare & Medicaid Services (CMS), in collaboration with the Children’s Bureau within the Administration for Children and Families (ACF), convened the Improving Timely Health Care for

Children and Youth in Foster Care Affinity Group from July 2021 to August 2023.

The main objective of the affinity group was to support state Medicaid and CHIP programs and their child welfare agency partners in driving improvement in the timely completion of health assessments for children in FC. Eleven state teams participated in the affinity group (Figure 1).

Figure 1. State Participation in the Improving Timely Health Care for Children and Youth in Foster Care Affinity Group



¹ <https://www.acf.hhs.gov/cb/report/afcars-report-29>.

² The term “children” also includes youth.

³ <https://publications.aap.org/pediatrics/article/>.

⁴ The term “states” includes the 50 states, the District of Columbia, and U.S. territories.

⁵ States use various terms for these health assessments, including initial health exams and comprehensive health assessments. For clarity, this report will refer to health assessments.

⁶ <https://www.medicaid.gov/sites/default/files/2021-05/foster-care-webinar.pdf>.

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Identifying Barriers to Timely Health Assessments for Children in FC

CMS supported state teams in designing, testing, implementing, and assessing a quality improvement (QI) project to improve timely health assessments among children in FC. As a first step, state teams used QI tools such as process flow maps to identify barriers and opportunities for improvement (Box 2). While process flow maps varied from state to state, most included the key steps outlined in Figure 2.

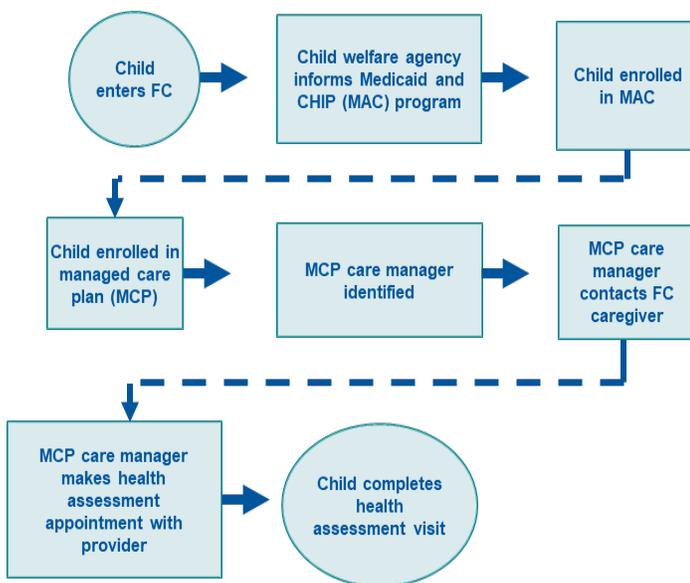
Box 2. Using Process Flow Maps to Improve Timely Health Assessments for Children in FC

A process flow map, or flow chart, is a visual display of the steps in a process. Developing process flows promoted a deeper understanding of the process of scheduling health assessments for children in FC and supported the state teams in identifying problems, gaps, and inefficiencies.

The process flow maps provided a basis for designing and testing new processes and helped build consensus among cross-agency staff responsible for implementing successful new processes. Finally, process flow maps enabled state teams to identify the resources and data needed to develop and monitor improved workflows.

More information on using process flow maps for QI is available at <https://www.ihl.org/resources/Pages/Tools/Flowchart>

Figure 2. Example Process Flow Map for Scheduling Health Assessments for Children in FC



Maryland developed a process flow map documenting key steps and associated timeframes between out-of-home foster placement and completion of a health assessment. The state team engaged staff from local child welfare agencies and managed care plans (MCP) that had high rates of timely health assessments for children in FC to understand their process. From these discussions, the state team identified promising practices for scheduling health assessments, such as using a spreadsheet to track health assessment deadlines.

Hawaii's process flow maps enabled the state team to identify sources for delays in scheduling health assessments, including FC placement changes and variations in enrollment notification processes across child welfare case management teams. The state team's QI project sought to (1) standardize data collection for the purposes of Medicaid enrollment and (2) coordinate referrals between child welfare staff and MCP staff to support scheduling health assessments.

Virginia's process flow maps enabled the state team to identify potential process improvements and eventually led them to test the use of "warm handoff" emails between child welfare agency staff and MCP staff for faster scheduling of the health assessment. Test results showed that warm handoff emails decreased the time between children entering FC and MCP's scheduling health assessments.

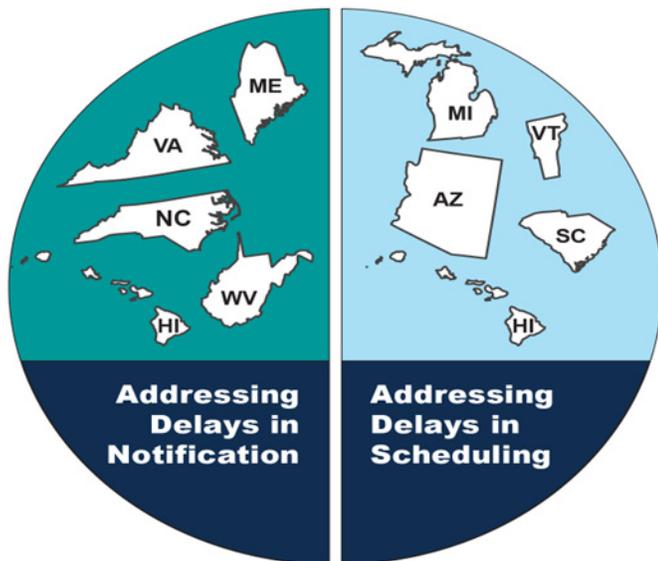
North Carolina used process flow maps to build consensus on the appropriate time to allot for each step of scheduling health assessments for children entering FC. After reviewing the process flow map with providers, the state team determined that the Medicaid Application Process (DSS-5120) for children in FC must be completed within 7 days of FC enrollment for the health assessment to be completed within 30 days of FC placement. The state team then focused its QI project on testing strategies that supported meeting the goal of completing Medicaid enrollment within 7 days of the child entering FC.

West Virginia used process flow maps to identify time allotments for key steps associated with completing health assessments and coordinating needed health services identified from the health assessments. For example, the state team set the goal that within 24 hours of the child entering FC, their information would be entered into the child welfare system. As the state team planned QI strategies, it continually monitored progress toward its goals.

Addressing Barriers to Improve Timely Health Assessments for Children in FC

The state teams' process flow maps highlighted two key steps contributing to delays in health assessments for children in FC: (1) notifying the Medicaid or CHIP program of the child's enrollment into FC and (2) scheduling health assessments with providers. With this understanding, state teams began testing QI strategies to address these barriers (see Figure 3).

Figure 3. Key Strategies Tested by State Teams Participating in the Foster Care Affinity Group



Addressing Delays in Notifying Medicaid and CHIP Programs of FC Placement

Process flow maps showed that bottlenecks in the flow of information from the child welfare agency to the Medicaid and CHIP programs contributed to delayed health assessments. State teams sought to address this issue by strengthening cross-agency collaboration and, at times, removing steps so that information flowed directly from the child welfare agency to the MCP responsible for scheduling the child's health assessments.

Maine tested a process where staff from the child welfare agency met weekly with Medicaid program staff. The goal of these meetings was to improve the timeliness of referrals to providers – one of the key barriers the state team identified. During the meetings, the child welfare agency staff ensured that the Medicaid

program had been notified of children recently placed in FC and the Medicaid program updated the child welfare agency of children who had been referred for a health assessment. These weekly meetings enabled the state team and its partners to address impediments delaying care in real-time.

Hawaii identified delays in notifying the Medicaid program of a child entering FC were partially due to confusion and inconsistencies in how child welfare staff completed the Medicaid enrollment process. To address these issues, the state team developed a protocol document that outlines when and how to complete the application. The state team continually tested the protocol with child welfare staff, refining it based on feedback to improve usability.

Virginia collaborated with two local child welfare agencies to implement warm handoff emails to the child's assigned MCP. When a child entered FC, the child welfare staff sent secure emails with the child's information to the MCP to begin scheduling a health assessment. This approach removed delays associated with information having to flow from the child welfare agency to the Medicaid program to the MCP, allowing the MCP to initiate scheduling health assessments sooner.

Addressing Delays in Scheduling Health Assessments for Children in FC

State teams also sought to expedite health assessment scheduling by improving processes within the Medicaid and CHIP programs and, when relevant, their MCPs. States tested various strategies, including using care coordinators to streamline the scheduling process and adding steps for direct outreach to FC caregivers and providers.

Arizona created a non-clinical care coordinator role within the Medicaid program. The care coordinator was responsible for conducting outreach to caregivers of children newly enrolled in FC to schedule health assessments. The state team conducted several tests and found that 65 percent of health assessments were conducted in a timely manner for children in the pilot, compared to 46 percent statewide.

South Carolina created a health quality improvement coordinator position within the child welfare agency. The coordinator's primary responsibilities were to schedule and coordinate health assessments for children

in FC and act as a liaison between the FC caregiver and the MCP. Data collected by the state team showed that the 30-day health assessment completion rate improved dramatically following the establishment of this position, from 44 percent in 2021 to 100 percent in July 2023.

Michigan tested expanding the responsibilities of health liaison officers (HLOs) within the child welfare agency to include conducting outreach to FC caregivers. The HLOs made two calls, one two days after the child entered FC and one five days after the child entered FC. The first call was to notify the FC caregiver that they needed to schedule the child's health assessment, and the second call was to confirm scheduling or offer scheduling support if needed. Among children in FC whose caregivers received outreach from the HLO, more than 85 percent had timely health assessments. Due to these promising results, the state team is considering scaling their efforts to statewide implementation.

Vermont tested having nurses from the child welfare agency send custody notification fax alerts to primary care providers (PCPs). These alerts notified the PCP of a child's FC placement and prompted them to contact the child's caregiver to schedule a health assessment within 30 days. Additionally, in one county, the state team tested having the nurse call the PCP practice to ensure the health assessment was scheduled before the 30-day deadline. Results showed PCP practices that received the fax alerts combined with the follow-up phone call had higher rates of timely health assessments for children in FC.

For More Information

More information about the Foster Care Learning Collaborative is available at <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/foster-care-learning-collaborative/index.html>. Technical assistance resources are available to help states develop their own foster care QI projects, including background materials, a driver diagram, a change idea table, and a measurement strategy.

More information about other Medicaid and CHIP QI initiatives is available at <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/index.html>.

To obtain technical assistance, please email MedicaidCHIPQI@cms.hhs.gov.

About the CMS Medicaid and CHIP Quality Improvement (QI) Program

The CMS Medicaid and CHIP QI program provides state Medicaid and CHIP programs and their QI partners with the information, tools, and expert support they need to improve care and outcomes for Medicaid and CHIP beneficiaries. Technical assistance is available to help states build QI knowledge and skills; develop QI projects; and implement, spread, and scale up QI initiatives. Participation is voluntary and involves collaboration between Medicaid and CHIP program leaders and other partners, including MCPs and public health agencies.