Establishing and Using Bidirectional Data Sharing

Recorded May 24, 2021

Laura Armistead:

Hello everyone. My name is Laura Armistead, and I'm an Analyst at Mathematica. Thank you for attending today's Foster Care Learning Collaborative, Improving Timely Health Care for Children and Youth in Foster Care Webinar Series. This is the final webinar in the series, titled, "Establishing and Using Bidirectional Data Sharing." Next slide, please.

Before we begin, we wanted to cover a few housekeeping items. All participants logged into this webinar have been muted for the best sound quality possible. If you have any technical issues, please use the Q&A window located at the bottom right corner of your screen. Please select "Host" in the dropdown menu, and then click "Send" to let us know how we can help.

We also welcome audience questions throughout today's webinar through the Q&A window. If you'd like to submit a question, please select "All Panelists" in the dropdown menu and click "Send." We will monitor the Q&A window throughout today's webinar, and we will address as many questions as possible at the end.

Lastly, we want to let everyone know that this meeting is being recorded. The recording will be posted on Medicaid.gov, along with a transcript and meeting slides after the event. Next slide, please.

Now I'd like to turn it over to Joe Zickafoose from Mathematica. Joe, you now have the floor.

Joe Zickafoose:

Thank you so much, Laura. It's my pleasure to serve as a moderator today. As we prepare for this webinar series in the Affinity Group to support states, the topic of data sharing came up over and over again as crucial to collaboration between state Medicaid and child welfare agencies to improve care for children in foster care and Medicaid. That was the driving impetus for today's webinar that focuses on the data sharing experiences of two states.

Today, first we'll hear from Deirdra Stockmann from CMS, who will provide a brief overview of the learning collaborative that support improving timely health care for children and youth in foster care. Then we'll hear from Lori Coyner and Rebecca Jones Gaston about Oregon's data sharing between their Medicaid and child welfare agencies, and they will be followed by Kathleen Donlin, Barbara Lucenko, and Barb Putnam about data sharing in Washington.

We've planned for about 15 minutes of questions at the end, but feel free to submit questions throughout, and we will reiterate them during the question period. With that, I'd like to hand off to Deirdra Stockmann from CMS.

Next slide, please.

Deirdra Stockmann:

Thank you so much, Joe. Hello and welcome again to today's webinar. As you may know, the webinar is part of a new learning collaborative focused on improving timely health care for children and youths

entering foster care. This learning collaborative is one of our many quality improvement initiatives at the Center for Medicaid and CHIP Services within CMS.

The goal of our quality improvement work is to support state Medicaid and CHIP agencies and their partners, such as other state agencies, health plans, and providers to drive measurable improvement and quality of care in health outcomes for Medicaid and CHIP beneficiaries. Next slide, please.

Over the past year or so, we've been working closely with colleagues at the Children's Bureau within the Administration for Children and Families to develop this learning collaborative, and through the webinar series and Affinity Group, we hope to provide state Medicaid and child welfare agencies with the support and tools you need to expand your understanding of data-driven interventions to improve timely access to care while learning about the science of quality improvement. To do this, we hope states will build and strengthen partnerships across agencies, including, of course, their data-sharing partnerships in order to provide the best care for children and youth in foster care. Next slide, please.

Briefly, before we move into the main content of today's webinar, I wanted to provide a few more details on the components of the learning collaborative. So, as you have heard, the webinar today is the second in a two-part series. Webinar #1 focused on the role for Medicaid in improving outcomes for children and youth and featured a wonderful presentation from the state of Virginia.

We also held an information session for the upcoming Affinity Group. State Medicaid and child welfare agency teams interested in working and take action to improve timely care for foster youth are invited to express interest in participating in the Affinity Group. This Affinity Group will be a more intensive technical assistance opportunity for states to expand their knowledge of policies, programs, promising practices, for getting more youth to health care they need in the most timely manner possible. Please note that the Expression of Interest forms are due this Friday, May 28th, for the Affinity Group, and we'll provide more information at the end of today's webinar.

If you're joining us for a second or third time today, welcome back to the learning collaborative. If you missed earlier sessions, recordings are now posted on Medicaid.gov. With that, thank you again for being with us today, and I'm very pleased to hand it over to our first state speakers, the team from Oregon to share their cross-agency approaches to data sharing and collaboration.

Lori Coyner:

Good morning everyone. This is Lori Coyner the Medicaid Director for the state of Oregon and the Oregon Health Authority, and I am joined by my counterpart over in child welfare, and I will let her introduce herself.

Rebecca Jones Gaston:

Good morning everyone. I am Rebecca Jones Gaston, Child Welfare Director for Oregon's Department of Human Services. Happy to be here.

Lori Coyner:

And before I move on to the next slide, I just want to call out an important piece around the bidirectional data sharing. You can't have good or excellent data sharing and cross-agency collaboration unless you have people collaborating. And Rebecca has been in her role in the last year, and even though we haven't met in person because of COVID, I've just been really happy with her willingness and ability to collaborate with Medicaid, and we have staff that are working together on a daily basis to make all this

happen. I can't say enough how, you know, having staff that are committed and from across the agencies who are all working in the same direction makes a huge different, and you need to have that before you can have the data-sharing flow. So, I'm just going to call that out at the beginning, and then we'll move to the next slide.

I'm going to give a little context about Oregon and how we have our delivery system set up for Medicaid and for children and youth in custody of child welfare and then I'll turn it over to Rebecca to talk a little more deeply about some of the work that we've done together.

So, we have managed care organizations. We call them Coordinated Care Organizations or CCOs, and they are responsible for physical, oral, and behavioral health services, so we don't have those services carved out. They're all under a CCO, and at any one time, about 90 percent of our Oregon Health Plan members are enrolled in a CCO. We have about 10 percent Fee for Service, so it's pretty small, and, by and large, our members are enrolled in a CCO, and these CCOs are unique to Oregon in that they tend to be small, regional. We don't have large national plans. We have one in the entire state, and so that makes some of the work that happened across the agencies a bit more challenging, and we'll talk about that in the next slide.

Our Oregon Health Plan, once a child or youth is in custody of child welfare, we identify them as being in a priority population. This is important, because it allows those children to receive intensive care coordination (ICC) services, and these ICC services include navigating the health system, help with accessing a particular needed service, that can be in child welfare and behavioral health and physical health or dental visits that are needed. And the intensive care coordination also provides follow up, so when these initial services are accessed then, any treatment recommendations are followed through and fulfilled.

We also have a very robust network of community partners around the state who provide support on the ground with communities of color, different parts of our state, rural, urban, and they really support eligibility and enrollment, and how that occurs, both for kids in child welfare, but also members and people who want to be enrolled in Oregon Health Plan across the state. Next slide.

So I'm going to give a little bit more context by the numbers since I know there are people from all over the country on this webinar, and just so you have some context for Oregon, our current population is about four million people. We cover approximately a little bit more right now with COVID, but 25 percent of Oregonians are covered on the Oregon Health Plan, and about 40 percent are children, and 60 percent are adults. As I mentioned, over 90 percent are enrolled in a Coordinated Care Organization. Of the 450,000 or so children who are enrolled, we have, at any point time, about 5,800, so just a little under 6,000 kids in foster care. The numbers that I'm showing right now are as of April 2021, and certainly that fluctuates. We also have, of in-home services for the kids in child welfare, about 1,000 receive additional in-home services. Next slide.

Here's a map of Oregon. This just shows where all of our Coordinated Care Organizations are. We actually have about 15 Coordinated Care Organizations operating right now. You'll see they really vary in region. The orange region on the right is rural frontier Oregon. There are 12 counties operated altogether under Eastern Oregon's CCO. The total population is much, much smaller than many of the other CCOs. You'll also see the kind of half shading in some areas of the state is where there is more than one CCO. But many parts of our state only have one, so Portland Metro area, which is the most populated and in the upper middle part of the state has two CCOs, and there's about 350,000 members just in that area, for example. I think the key point for everyone here is, number one, there's lots of different CCOs for child

welfare to work with, and the other piece is that they're regional and local and so we do not have a single CCO that is across the entire state. Next slide.

I'm going to start by giving some background and really what were the catalysts for our agencies to get involved in data sharing. And just to give you a little more background, the Medicaid and Behavioral Health units are in Oregon Health Authority, and child welfare sits in Oregon Department of Health and Human Services, so it requires cross-collaboration between different agencies. And as many of you know, that's not something that we typically do in government and can be challenging, and so there were a few things that happened that really drove this initial data sharing.

Our Coordinated Care Organizations were established in 2012 through an 1115 waiver authority, and one of the big pieces of that was a collection of incentive metrics. We promised, essentially, the federal government that we would hold our Medicaid costs down to a sustainable rate of growth, and that our focus is to have regional Coordinated Care Organizations that manage all the services for individuals, and focused on quality and outcomes. And part of the outcomes were focused in what we call incentive metrics.

There were 17 incentive metrics established in 2012, and those 17 are overseen by an independent body called the Metrics and Scoring Committee, and the Metrics and Scoring Committee reviews metrics every year and decides what's going to be in the collection. The CCOs, right now, are paid 4.5 percent of their total operating expenses are paid in incentive metrics, so it's significant dollars. And I will say that whatever metrics we do incentivize, we really see movement in the needle on that, because of the dollar amounts that are tied to them.

And one of the metrics that was initially established was for children and youth entering foster care, and that metric required that children entering foster care had a physical, oral, and behavioral health screening within 60 days of entering the system. That required us to start to share data between the two agencies in terms of which kids were being entered into the foster care system, and then measuring for 60 days whether they got these screenings, and so it required data sharing there.

The other big piece where we came together on data sharing was this manual switch for CCO enrollment by child welfare. So, up until 2018, when a child was in a CCO, there had to be a manual switch by child welfare, and after 2018, that became a systematic enrollment, so we automated the system. This improved time to enrollment, it decreased delays in service, reduced a lot of errors that were occurring in manual processes, and provided a lot more clarity in terms of background enrollment status of the child so that if there were questions about the child's enrollment, you could go back and look in the systems and understand that.

So I'm going to turn – we're going to switch to the next slide, and then I'm happy to turn this over to Rebecca.

Rebecca Jones Gaston:

Thanks, Lori. And I would just really just reiterate what Lori started out, is that I think some of our success in the data sharing and being able to ensure that there's some continuity of care and that access to Medicaid eligibility isn't a hold up, is really been dependent on having a team that is working across agencies with each other and really doing day-to-day problem solving and continuing to look for some program improvement.

So I'm going to walk through a little bit of a description of what our data sharing looks like and how it works from the child welfare lens, and I will probably insert a little bit of some of the things where I think we've got some opportunities for just continued growth and progress.

So, child welfare's SACWIS (Statewide Automated Child Welfare Information System), our official information system, we call OR-KIDS. And when a child is placed in foster care, we enter information into OR-KIDS, and it automatically sends the information to our Medicaid Management Information System, MMIS. And we get information back from MMIS, and so sometimes that might be where a child might be enrolled already under the Oregon Health Plan, and we need to do a change to the CCO identified. But the important piece here is that it is an automatic and systemic real-time data exchange that happens, and, as Lori indicated, that's been a huge step in our improvement in meeting timelines and timeframes.

The CCOs are responsible for the service delivery and the care coordination, as Lori indicated. The intensive care coordinator differs from each of the CCOs, but the main function of that role really remains to predominantly assist with access to services, and the annual assessment of incentive measures really is a way for us to continue to kind of mark how are we progressing and where do we stand around timeliness, and I'll have a slide about that shortly. Next slide.

So, our promising practices that really drive this, our enrollment file is generated from our OR-KIDS data for youth that are in child welfare, and the report does include other priority populations, but, again, this is also dependent on my child welfare team getting the information into our OR-KIDS system to trigger that data exchange. The expectation is that we've got the 60-day period for the assessments, and where I think we're still learning is the 60-day, for my federal reporting requirements, starts the moment we are engaged with a young person and have to make the decision to place the child into foster care. Depending on how long it takes us to get that information into our OR-KIDS system then plays into the CCOs needing to get that data in order for their 60-day clock to kick in. And so that's one of the areas that I think we continue to look at, how do we get those to be closer and closer aligned so that both our child welfare measure is in alignment with the 60-day clock that is going for the CCOs.

The CCO funding includes a medical liaison that's housed in our child welfare offices, and we're testing that out currently in three of our counties, and required assignment of the intensive care coordination or wraparound services for all youth in foster care is another critical piece. Again, Lori called out the incentive metric assessments, and we have actually improved, and in the next slide, you'll be able to see it visually, but really improved pretty dramatically since 2015 to 2019, really with a marked 30 percent increase. And we're also tracking the use of psychotropic medications. Next slide.

And so here you'll see, really, what the dramatic increase has been over the last several years around hitting that 60-day marker, where we're just under 90 percent, and, in fact, we had 12 of our 15 CCOs actually meet the 90 percent goal, and since 2018, ten of them actually have improved, and so we're now looking at what are the mechanisms and processes for us to get us to that 90, the actual 90-percent mark and over. But definitely have seen in our data sharing partnership and relationship, and then, subsequently, with changing from manual to having it be automated, has really improved our ability to make sure that children are getting what they need when they're entering into foster care. Next slide.

As I mentioned, timeliness and accuracy of the data is actually critical, and so we are working really hard on making sure the information is getting in correctly and accurately and, again, moving into an automated process where it isn't having to be done manually to Medicaid. That is helping in us being able to have a data that's matching and aligning. The incentive metrics have demonstrated effectiveness in

increasing our target goals. We have specific positions that include parallel positions across agencies that are handling both the case-specific and policy-driven issues with regular communication.

Lori and I have a monthly meeting with our teams together, and our teams are meeting on a regular basis, really, to make sure that we're continually keeping our eye on the metrics and how we're doing, but also identifying those areas systemically that we want to improve and trying to come up with some collaborative strategies and problem solving to work across. And then, really just highlighting the need for developing these mechanisms for collaboration, but it isn't person-specific. We want to make sure that, whether Lori and I are in our seats, that this is a partnership and data sharing process that is really just embedded into how we do our work day to day and can withstand any sort of personnel changes.

So, lessons learned, this is my theme: I continue to reiterate the fact that accuracy of information is critical, and the timeliness and accuracy of the information is going to be key. Meeting our assessment metrics for the timeframe doesn't always lead to timely access to care. That's one of the areas that we're really working on, and wanting to make sure that if a child is already enrolled in a CCO and has a provider, say a therapist or a counselor, that there is some mechanism for them to be able to have some continuity of care, if that is feasible, and wanting to make sure that we don't have systemic barriers for that to actually happen.

Children and youth in child welfare custody still experience some of those significant access to services, especially specialized behavioral health services that are attributed to workforce and system capacity. Our assessments in short timeframes are great but require capacity to fill the recommendations of the report, and so just, again, not sitting back and being satisfied with the progress that we've made but really continuing to look for areas that we need to improve.

And then our processes vary between CCOs, and some of the lack of standardization in things like utilization management increase some of the difficulty for child welfare in accessing services that our children may need, depending on what region or CCO that they're connected to. Next slide, and I'm going to turn it back over to Lori.

Lori Coyner:

Great. Thank you, Rebecca. And can you move forward one more slide, please. So, I'm just going to summarize, I guess, at the end, in term of where we're going. And the first is this continued work on cross-agency collaboration and really looking at how we can just optimize our systems to improve both service capacity and availability of resources. The second is looking at current funding streams and regulatory authorities to ensure that we're receiving maximum impact. And what do I mean by that? That means maximizing our federal match through Medicaid dollars.

So, we know that we aren't leveraging certain assets of behavioral rehabilitation services that are home-based and so we have the Medicaid team working on that, and also personal care services for youth with ADL and IADL, and really looking to see how we can work together to leverage Medicaid funding and that we're maximizing that impact.

And then, finally, we're continuing to collaborate on preventive services that are related to Family First Act and family preservation. So, one of the areas that we'd like to focus on – I know Rebecca and I both feel strongly about this – Is how do we provide preventive services to families through Medicaid before a child has to leave the home and enter child welfare services. It's important that child welfare and Medicaid do this. One example is to really find the ways to provide SUD, substance use disorder, services

for parents that are struggling so that they don't lose their children and kind of kick into the child welfare or criminal justice System. Next slide.

I want to thank everyone for having us and listening to us this morning, and I'm going to turn the conversation now over to the state of Washington. Thank you.

Barbara Putnam:

Sorry. I was muted. Good afternoon to everyone. I am Barb Putnam. I am at headquarters in child welfare, Department of Children, Youth, and Families for the state of Washington. I am the administrator over the continuum of behavioral health and intensive services for kids in foster care. I have two other presenters with us today, and they can introduce themselves. We also have a couple of other folks that are here and available as a part of our team, depending on where the questions are. So I'm going to pitch it to Kathleen.

Kathleen Donlin:

This is Kathleen Donlin from Health Care Authority. I'm an Occupational Nurse Consultant and in the Medicaid Compliance Review and Analytics section of Health Care Authority, and I'll turn this over to Barb Lucenko.

Barbara Lucenko:

Hi. This is Barb Lucenko, and I am the Chief of the Office of Program Research and Evaluation Services in RDA, which is the Research and Data Analysis Division of the Department of Social and Health Services in Washington State. Happy to be here today. Thank you.

Barbara Putnam:

So let's move to the next slide, please. We're going to briefly talk about the timeline and health and child welfare, our systems. Next slide.

So, this is an overarching map of the Washington State system. We have been in transition and in movement for multiple years, with different initiatives, initiated by the legislature. So, if you look at the blue umbrella on top, the Department of Social and Health Services (DSHS) was really our overarching Health and Human Service agency of which child welfare programs, mental health programs, juvenile rehab programs, and Research and Data Analysis, we were all housed in that agency with one Secretary, so it was here to data share and keep things unified and work across the table for many, many years amongst the team that you're going to be talking to today.

In 2016, there was a piece of legislation that augmented Health Care Authority, which are our Medicaid partners, and Medicaid's always been in our structure outside of DSHS. It authorized Health Care Authority to run an RFP and move all of the foster care kids into a specialized MCO (managed care organization) for foster kids. And that happened in 2016, and that is with Coordinated Care of Washington, is our agency. They have a program called Apple Health Core Connections, and it serves all of our foster kids, all of our adoption support kids, and all of our alumni of care up to age 26 are in that pool. It averages around 25,000 kids a year, and families in that subset of services.

I'm going to move over to the purple umbrellas. Another piece of legislation then carved out two things. They took our behavioral health services, all of our mental health services and carved it out and moved it into Health Care Authority, and that happened in 2018. In 2018, they also stood up a different agency to

serve kids and families, and so child welfare moved into a broader agency under the umbrella or DCYF, the Department of Children, Youth, and Families, and child welfare and early learning merged. And in 2019, juvenile rehab came and joined that agency, so the agency that we're in now, child welfare, now has those three prongs to it. The legislature, again, in 2019, gave us some legislation to fully integrate behavioral health, through the Health Care Authority, into all the MCO plans. And there are five plans across the state, but only one doing specific foster care business. Next slide.

So, this is just a data slide to show you kind of our conjointly served population. So, you know, this is something that our Research and Data Analysis [team] can do and provide for us. Barb Lucenko is going to be addressing that more as we move along, about how those systems are set up. We have a range of data-share agreements, so as we split out a DSHS, we had to have a range of service-level agreements and data-share agreements to cross over and keep going, the business that we had already started together, which is quite intricate, and in several different places across all three agencies. Next slide.

So, for child welfare, we got a one-state agency. You know, child welfare is administered different in every state. But we have one state agency with six regionally administered regions, so the state is divided into six. Each region has their own regional administrator, and when you look at the states, there are about 50 field offices that we manage across the state. The regional administrators report to field operations in headquarters. They're the social worker staff side of every typical child welfare program that you can think of, you know, Child Protective Services, Child Welfare Services, front-end services, and Adoption Services for kids that come into our care.

Headquarters also has my division, which is child welfare programs, and so we do all of the policy and legislative work in our division, but we also have contracting for the state and licensing is all housed up at headquarters.

When we look at our population of kids in state care, at any point in time, at this point in time, there's about 8,000 kids in care who are dependent, and they are in an array of foster homes, in-home dependencies and extended foster care options. Washington State does have a high percentage of kids where we're very good at finding relative homes for kids and doing dependency in a relative home rather than putting a kid in stranger care or foster care, and that runs about 48 to 49 percent at this point in time.

To speak to a little bit of the kind of structure between Child Welfare and Health Care Authority, Health Care Authority has the Foster Care Med Team. It is a unit that manage Medicaid eligibility. We do have a data-share agreement, and that group has access to our SACWIS system, our family system, and there are ticklers. It's automated to a certain extent. That team is notified when a kid is placed in our care, when a kid moves, and when a kid goes home. So that team at Health Care Authority moves eligibility around and takes care of that piece on our behalf, and they also communicate with the MCOs and our MCO with coordinated care around the needs of our kids. Next slide.

So, Kathleen, this bumps to you then.

Kathleen Donlin:

Great. Thanks, Barb. So, in Washington State, Health Care Authority is a single-state Medicaid agency and as we've talked about a little bit before, we call ours Managed Care Organizations or MCOs, and we do have five in the state of Washington. However, for our foster youth, it is one MCO, Coordinated Care of Washington has the foster care plan, and it provides integrated managed care physical health and behavioral health together. IFC (Integrated Foster Care) covers all children in foster care, within foster

care, alumni, foster care and adoption support; however, the alumni to foster care and adoption support clients may opt out of Apple Health Core Connections and into Fee for Service if they so choose.

Our American Indian and our Alaska Natives also have the option of Fee for Service coverage, and they may opt into Coordinated Care of Washington and Apple Core Connections. Coordinated of Care Washington also offers enhanced care for our foster youth. And I will turn this over to Barb Lucenko.

Barbara Lucenko:

Thank you. Next slide, please. So, again, I'm Barb Lucenko, and I am with the Research and Data Analysis (RDA) Division of the Department of Social and Health Services in Washington State. As you might guess, RDA does a lot of program evaluation, research, and performance measurement, and we do this using, primarily, administrative data. Next slide, please.

So, the integrated client databases housed within RDA, this is a very over-simplified representation of those data structures, but what we lovingly call the ICDB (Integrated Client Database) contains integrated service information at the individual level across systems and times. The Health and Human Services systems in Washington State, as you saw earlier in the Venn diagram, is not just one agency delivering services but a number of agencies now. In addition, kids in foster care, and their families, are likely to touch many systems in any given month or year, and the integrated client data allows us to look across systems and times for indications of risk and outcomes for our kids in care. So that's primarily what I am going to be talking to you about today.

This integrated client data structure that you see here has been built over, literally, decades of work, with each bullet representing a link that was initiated with a single project or, potentially, multiple projects with reporting needs or questions that were asked by our program partners that required that link. And as you might imagine, each bullet here represents a data sharing effort involving agreements, which could be MOUs, data sharing agreements or, potentially, confidentiality agreements that are generated by Washington State. Next slide, please.

So, the bottom line here – and I could spend a lot of time talking about each of those bullets and the sources and the agencies they represent. We don't really have time for that today. The bottom line is that all of this has been built based on agency needs, questions, and demands, and as you've heard from Oregon, the key to success there is collaboration, and especially communication with our program partners who have learned to come to RDA when they realize not just that there's a question about kids in care or about kids' behavioral health needs, but a question that involves information across different data sources or systems, and we really have built our capacity gradually over time, specifically to fulfill those needs of our customers, who are actually also data owners.

The other key to success here is really developing expertise in health. One of the things I'm thankful for almost every day is the staff that I get to work with, and I work with a lot of very smart people. But it wasn't just hiring smart people. It's also developing that expertise in-house that is specific to our child welfare system and our health care delivery system, because without that, we can't really provide the answers to the questions that are needed from our program partners. Obviously, a lot of technical staff and infrastructure is also required, but that subject-matter expertise just is so essential to the work that we do. Next slide, please.

So, I want to show you three different products that has come out of data sharing efforts in Washington State. This is just a sampling of many projects that have come from these data sharing efforts. So I'm going to talk about the children's behavioral health dashboard, a predictive model, looking at family risk

factors and health outcomes, and a child welfare and health service trend tracker that we developed during the COVID pandemic. Next slide, please.

So this is a page drawn from children's behavioral health dashboard that was originally developed to look at characteristics, risk factors, and outcomes for children on Medicaid who have behavioral health needs or who receive behavioral health services. And a few years ago, through a collaborative project with our child welfare program, which is now a separate agency, and a grant from ACF called "Creating Connections," we worked with our partners to develop a subset of measures for children in care. And as you can see here on the left, we have all children on Medicaid and their behavioral health needs represented in blue, and on the right, the same measures are presented for children in foster care, and it really jumped out immediately how important this work is, given the prevalence of mental health and substance use disorder treatment needs among our kids in care. Next slide, please.

This particular product presents, over 45 pages now, of detail around behavioral health for kids in the general Medicaid population, as well as those in care. This includes things like diagnoses, services, prescriptions filled. Next slide, please.

And what has become, really, our most popular set of measures is the treatment penetration for kids with behavioral health needs sets of measures. This helps our data audiences get a sense of, among those who have either mental health or substance use disorders treatment needs, what proportion of them are getting actual treatment services. And these measures are, for the most part, presented by age, by gender, by region, and they help us answer questions not just through our program partners at the Health Care Authority and Department of Children, Youth, and Families, but also questions that come to us from a managed care organization, from legislators, the Governor's Office, and interest groups about how are we doing in Washington State with respect to serving these kids in care. Next slide, please.

This is a page from a study that was a predictive model conducted by Deleena Patton in RDA, looking at behavioral health youth among adolescents in the Medicaid population. And I'm showing this particular product because, again, it just highlights how important it is to bring these data sources together, because among all of the social determinants of health that we looked at, and other predictors, what comes out as most predictive of behavioral health youths along these adolescents is recent and other abuse or neglect experiences, as well as foster care placement experiences. So the risk factors that are getting our kids into care, obviously, are so related to the risk factors that bring these same kids to behavioral health services. Next slide, please.

And another way of looking at this is a predictive model of behavioral health costs in Washington State, and, again, those child welfare-related risk factors emerge as the most predictive of behavioral health costs in a particular year for adolescents with Medicaid. Next slide, please.

So, here is an example of something that is as close to real-time data exchange that we do in RDA. And this came up during the COVID pandemic, obviously, where the Department of Children, Youth, and Families was very concerned about the drop that they were seeing in CPS, Child Protective Services, intakes following the stay-at-home order in Washington last March, and they asked us to look at this a little bit more closely. As you can see, the drop there is driven by drops in reporting by mandated reporters, especially educators, because kids were not in school. So they asked us to look at medical services for kids in the state, and especially those services that are potentially related to child abuse and neglect.

So we put together a set of measures, such as injuries and abuse-related injuries, outpatient Emergency Department (ED) visits to see whether kids were showing up in those. As it turns out, there were also drastic drops in those medical services around the same time, some of which are starting to recover, although ED visits remain low compared to what we have seen in the past. This is an effort where we had to go a bit outside of our typical research comfort zone, and produce something that was really, really recent. This gets updated every single week, and we are going to our raw data sources, as opposed to our integrated data sources to avoid the lag involved there. Next slide.

Okay. So, I want to talk a little bit about something that we're working on in Washington State, although we are in the very early stages of this work. Next slide. So, the Department of Children, Youth, and Families is looking to expand out of home –

Joe Zickafoose:

Barbara, I apologize for cutting in. We just have five minutes until the top of the hour, so I wanted to give us a chance to address some of the questions that we've gotten in through the chat. I wanted to see if there was a final slide that you all wanted to share.

Barbara Lucenko:

Sure. We could just jump right to the next slide. This is contact information for those of us in Washington State. I just want to say, again, thanks for having us, and if there are questions specifically about the integrated data or any of the products that I showed you, please don't hesitate to contact me and the others from DCYF and Health Care Authority, also listed here, as points of contact. Thank you.

Joe Zickafoose:

Thanks so much. Very much appreciate all the sharing that you've done. We have just a couple minutes before we need to wrap up, and I apologize to folks who submitted a lot of great questions. I wanted to prioritize one big picture data sharing question that we've gotten in a couple different ways. I wanted to see if someone from each of the teams could reflect on the ways that you previously identified children in foster care and Medicaid before your current systems for states that may not have progressed to the degree of data sharing that you all have? I know this may be the way-back machine for some of you, but if you can reflect even on prior iterations of data sharing, that might help folks understand the progress. If we could start with the Oregon team.

Rebecca, I think you might be trying to speak, but we're having a hard time hearing you.

Rebecca Jones Gaston:

Okay. Is that better?

Joe Zickafoose:

Oh, much better. There you go.

Rebecca Jones Gaston:

Okay. Sorry. I was going to say, I must to defer to Lori, because, as she said, I've been in Oregon for just over a year, so I don't know necessarily all of the historical pieces. I do know that we have had medical

assistant specialists in the child welfare offices that have played the role of doing a lot of the manual work in exchange of information with Medicaid prior to the automatic data exchange. But hopefully Lori has some more details to that.

Joe Zickafoose:

We lost Lori. We can hand off to the Washington team, if they have anything they'd like to share.

Barbara Putnam:

So, this is Barb Putnam, and I think just because I have a historical context, you know, I can't answer that to you, because there was already a system in place with kind of the current model, the scaffolding that we have now, with Health Care authority. We had, initially, five staff over in the Eligibility Unit and had worked out the SACWIS system identifier of kids going on or coming into care. So, you know, that was in 2004, so we have been doing that part of the system for a very long time.

Joe Zickafoose:

Great. Thanks so much, Barb.

Well, we're at time, and we're going to put up here for folks that have ongoing questions, you can feel to submit them to the Medicaid and CHIP Quality Improvement mailbox, which we showed the e-mail address here, and we will do our best to respond. We wanted to thank our speakers again for attending and thank all the attendees for spending the time with us. We will be posting a recording of this session, along with the slides and a transcript in the coming weeks. Thank you all very much for attending today.