CROSS-SYSTEM APPROACHES THAT PROMOTE CHILD WELL-BEING

By Susan Foosness, William Shutt, and Richard Whipple, Public Consulting Group, Inc.

September 2014

INTRODUCTION

In this paper, PCG highlights important findings from research on the prevalence and costs of behavioral and physical health concerns that arise from child abuse and neglect. From our extensive experience working with child welfare agencies and stakeholders to address the needs of vulnerable children and positively impact long-term outcomes, we have helped child welfare agencies to successfully partner with Medicaid and managed care organizations to address the complex health and behavioral needs of children who experience maltreatment. If prevention and intervention efforts are applied early and effectively, these high-risk children and youth may avoid costly health conditions and experience improved health and psychological outcomes.

PCG | Human Services
Public Focus. Proven Results.™

148 State Street, Tenth Floor
Boston, Massachusetts 02109
tel: (800) 210-6113

www.pcghumanservices.com

THE REAL COST OF CHILD ABUSE AND NEGLECT

Child abuse and neglect negatively affects the physical and psychological well-being of a population that is already vulnerable. Increased preventive services to children in high-risk households can help states minimize the cost of health/medical services to deep-end youth, reduce the number of children with chronic medical conditions, and improve general well-being outcomes. Providing targeted prevention programs and interventions to these children of at-risk families has been shown to reduce the cost of providing intensive services to children with poor health outcomes later on.

Children who are investigated for maltreatment or enter the child welfare system have greater health needs. Children investigated by the welfare system have been found to have 1.5 times more chronic health conditions than the general population.[1] After controlling for other risk factors, children with maltreatment reports have a 74-100 percent higher risk of hospital treatment.[2] Over 28 percent of children involved with maltreatment investigations are diagnosed with chronic health conditions during the three years following the investigation.[3]

These increased health conditions and the occurrence of child abuse or neglect have long-term economic and health effects. The estimated lifetime cost per victim of nonfatal child maltreatment is over $200,000, which includes $32,648 in childhood health care costs.[4] Children who experience maltreatment have higher rates of adverse health conditions and chronic illnesses as adults, including greater rates of heart disease, cancer, lung and liver disease, obesity, high blood pressure, and elevated cholesterol.[5]

PARTNERSHIP OPPORTUNITIES

There are several opportunities for states and their stakeholders (child welfare agency, Medicaid agency, managed care organizations, and other state departments) to partner and address the health care needs of children from at-risk households and youth in the child welfare system. These opportunities include Section 1115 waivers, health home initiatives, care coordination, and well-being passport or data sharing.

Opportunity #1: Section 1115 Waivers

States have the option to design and apply for Section 1115 research and demonstration projects, which allow states to test new/existing approaches to financing and delivering Medicaid and the Children's Health Insurance Program (CHIP). Section 1115 waivers give states additional flexibility to redesign and improve their programs to

- Expand eligibility to individuals who are not otherwise Medicaid or CHIP-eligible.
- Provide services not typically covered by Medicaid.

Section 1115 waiver projects may expand coverage, change delivery of services, alter benefits or cost sharing, or modify provider payment structures. States can apply for and implement a Section 1115 Demonstration Waiver that integrates Medicaid physical and behavioral health services and child welfare services. For example, a waiver could propose to use Medicaid dollars for non-billable social services that prevent foster care placement or promote reunification. Functional Family Therapy is one program that includes both Medicaid-billable therapeutic services and non-billable integrated case management services.

Example: In Hennepin County, Minnesota, Hennepin Health[6] implemented an 1115 Demonstration Waiver to use Medicaid funds to support social service programs such as employment assistance. Through this waiver, the county has been able to provide employment services in an integrated health and social service setting to childless adults.

Example: Austin Travis County Integral Care[7] of Austin, Texas has multiple projects under the Texas 1115 Demonstration Waiver that provide innovative adults services. Texas recently applied to the Centers for Medicare & Medicaid Services (CMS) for a three-year project to increase access and capacity for integrated primary care and behavioral health services in public schools for children with serious emotional disturbance (SED) and co-morbid medical conditions. The state also applied to increase specialty care for young children with developmental delays who do not qualify for other state services.

Opportunity #2: Health Homes

PCG has helped states develop a health homes program in accordance with the Affordable Care Act, including assisting with patient population identification, provider readiness assessment, stakeholder outreach, financial modeling, and drafting a State Plan Amendment. Health home services can be used by states to address the physical condition of youth in at-risk households and also engage at-risk families by providing linkages to long-term community supports, social services, and other family services. Through health home models, states can potentially reduce per capita costs of health care, lower rates of emergency room use, reduce hospital admissions, and lower the intake of residential/facility placements (particularly therapeutic foster care).

States have been encouraged by CMS to explore health home models. The Affordable Care Act (ACA) places the Federal Medical Assistance Percentage (FMAP) for health home services at 90 percent for the first eight fiscal quarters that a State Plan Amendment is in effect.

---

[1] *Stein, Ruth EK, et al. "Chronic conditions among children investigated by child welfare: A national sample." Pediatrics 131.3 (2013): 455-462.*

[2] *Lanier, Paul, et al. "Child maltreatment and pediatric health outcomes: A longitudinal study of low-income children." Journal of pediatric psychology (2009).*

[3] *ACF. "Special health care needs among children in child welfare." NSCAW Research Brief No. 7 (2007).*

[4] *Fang, Xiangming, et al. "The economic burden of child maltreatment in the United States and implications for prevention." Child Abuse & Neglect 36.2 (2012): 156-165.*

[5] *Felitti, M. D., et al. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." American journal of preventive medicine 14.4 (1998): 245-258.*

[6] *http://www.hennepin.us/healthcare*

[7] *http://www.integralcare.org/sites/default/files/pictures/dsrip_project_summaries_including_3-year_projects.pdf*

Opportunity #3: Care Coordination

States can work with stakeholders to establish a structured system of care coordination for their child welfare populations. Care coordination can be used by states to help organize the services/activities provided to consumers and also to direct consumers to the appropriate resources. Specifically, states can target their care coordination services to children from at-risk families and youth involved with the child welfare system. Traditionally, these are the children/youth who struggle to access needed services and who transition into deep-end services and residential placements. States can create a Medicaid service definition for care coordination and work with Medicaid or managed care organizations to ensure that care coordination is a covered/reimbursed service.

Example: Massachusetts[8] has formed a partnership with health centers and managed care organizations to develop a network of Community Service Agencies that provide care coordination to children with SED who use multiple services or are involved with multiple agencies, including child welfare. These services are Medicaid-reimbursable through a State Plan Amendment.

Example: Connecticut[9] has developed a three-tiered model of care coordination for children with SED depending on a child and family's needs and level of involvement with child welfare and other agencies. Currently funded entirely by state dollars, CT is investigating expanding the program to be Medicaid-reimbursable through a State Plan Amendment or Health Homes through the ACA.

Opportunity #4: Data Sharing (Well-Being Passport)

States can work with the appropriate stakeholders to create policies, processes, and programs including technical solutions to share data amongst agencies that serve at-risk children, youth, and families. Data-sharing solutions may include both "big data" analysis and population management. States can use these solutions to inform policy recommendations and also to create a "child well-being passport."

States can issue each youth involved in the child welfare system a well-being passport which will serve as an identifier to track provided services. A well-being passport does not replace agency documentation systems nor function as an electronic health record, but increases communication among service providers, Child and Family Teams, and other stakeholders to improve care coordination, decrease costs and duplication of services, and improve family and client empowerment of their care. Additionally, a well-being passport can be used for scheduling and to track clinical and external outcomes.

Example: Texas[10] has successfully instituted a health passport for foster children which accomplishes these goals but still relies heavily on claims data and requires some manual data input.

Example: Our Kids, a child welfare lead agency in Florida,[11] has developed and launched an electronic medical passport program.

CONCLUSION

States can use the opportunities described above to identify and address the special health care needs of children who have experienced child abuse or neglect. Early interventions that impact the physical and psychological well-being for these high-risk children can reduce subsequent health concerns, lower costs to both Medicaid and child welfare systems, and improve long term outcomes. PCG has demonstrated experience working across human service and health programs and can be a valuable partner for states who chose to explore the opportunities such as 1115 waivers, health homes, care coordination, and data sharing.

CONTACT THE AUTHORS

Susan Foosness
sfoosness@pcgus.com
(919) 576-2215
Raleigh, NC

William Shutt
wshutt@pcgus.com
(717) 884-7701
Harrisburg, PA

Richard Whipple
rwhipple@pcgus.com
(850) 329-4915
Tallahassee, FL

[8] *http://www.masspartnership.com/provider/index.aspx?lnkid=CSARequestForResponse.ascx*
[9] *http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314350*
[10] *http://www.fostercaretx.com/health-passport/*
[11] *http://www.ourkids.us/newsandevents/SiteAssets/MedicalPassport.pdf*

PUBLIC CONSULTING GROUP

148 State Street, Tenth Floor
Boston, Massachusetts 02109
tel: (800) 210-6113

www.pcghumanservices.com