

HEALTH MANAGEMENT ASSOCIATES

**BALTIMORE CITY DEPARTMENT OF
SOCIAL SERVICES**

**MATCH AND HEALTH CARE
PROGRAM EVALUATION**

PREPARED FOR

INDEPENDENT VERIFICATION AGENT,
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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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We are grateful for the opportunity to participate in the review of the Making all the Children Healthy (MATCH) program and to Rhonda Lipkin and Lisa Mathias, the Office of the L.J. v. Massinga Independent Verification Agent (IVA) for their candor and insights into the program. Mr. Mitch Mirviss was also generous in sharing his thoughts and his hopes for a successful MATCH program. Director Walters of the BCDSS has been supportive and responsive to our request for access to staff, and Jennifer Rosen was also helpful in connecting us to staff within the Department. We want to express our gratitude to the staff at BCDSS who were so generous with their time in meeting with us – Sean Bloodsworth, Janet Bridges, Terri Alston, unit staff for the Ready by 21 program and unit staff for the medically fragile unit. Their inputs were invaluable in helping us determine current status and in mapping future recommendations.

Key informants outside of BCDSS included MATCH leadership and providers connected to the MATCH program. Traci Kodeck, the Executive Director of HealthCare Access Maryland has been involved with the MATCH program since its inception and was candid with us about the opportunities and challenges with the MATCH contract. She was supportive of her team opening their doors to our review. Ms. Kimberly Floyd and Dr. Jenene Washington (Director and Medical Director of the MATCH program, respectively) spent almost two hours sharing their perspectives and many documents important to our review. Dr. Shannon Barnett, consulting psychiatrist to the MATCH program was helpful in sharing her perspectives about the needs of children and youth with mental health conditions. Dr. Wendy Lane described the partnership of MATCH with the Baltimore Child Abuse Center and the workflow across both of those programs. We had a helpful discussion with Dr. Becky Seltzer, pediatrician of the Johns Hopkins Harriet Lane clinic associated with Priority Partners, MCO. Dr. Seltzer's commitment to children in foster care was indicative of the commitment of stakeholders to the health and wellbeing of children and youth in foster care. Dr. Seltzer's insights into how MATCH works and processes she would like tweaked were very helpful to our inquiry. We also had a helpful discussion with staff from the Catholic Charities, Behavioral Health team led by Laurie Vozella-Bell and including Beth Benson and Ginna Wagner. They provided useful insights into the behavioral health screening and assessment protocols for foster children upon entry into care and the current status related to follow up care. Lastly, we are very grateful to Jenine Woodward, who supported our medical case record review and provided further content and texture to our report.

EXECUTIVE SUMMARY

Since 1988, the Secretary of the Department of Human Services has been under a consent order to take substantial positive actions to improve the quality of care and services provided by the Baltimore City Department of Social Services for children and youth in foster care in its custody. In 2009, a Modified Consent Decree (MCD) went into effect which required the development and implementation of a health care management system based upon the American Association of Pediatrics (AAP)/Child Welfare League of America (CWLA) Standards. In 2010, health care access and coordination services specified in the MCD were awarded contractually to Health Care Access Maryland's (HCAM) Making all the Children Healthy (MATCH) program. Since 2010, these services have been provided uninterrupted by HCAM. In advance of re-procurement of the MATCH program, in 2020, the IVA engaged Health Management Associates to assess the MATCH program processes and outcomes to identify opportunities to continue to take substantial positive action to improve the quality of care and health and behavioral health services for foster children in the custody of Baltimore City BCDSS. The HMA team assessed the MATCH program between September and late November of 2019. Assessment methods included document reviews, process reviews, key informant interviews and case reviews. Key findings reflect the following six takeaways:

- The MATCH program works very well for new entrants and for medically complex cases but is less seamless for continuing care needs, and for behavioral health case management,
- MATCH program leadership is accessible, responsive and directly engaged in coordinating the management and processes among BCDSS, community providers and other partners. For various reasons from high caseloads, turnover and lack of role clarity, MATCH nurses and social workers are not well known to continuing permanency workers and hence collaboration is weak,
- Disconnected, uncoordinated and antiquated information technology systems result in significant lost productivity among MATCH and BCDSS staff. This impacts negatively on the sharing of information across both teams, which is critical to ensuring appropriate and responsive care,
- Communication about kids who exit care or who experience a change of placement is inadequate and their care is compromised due to poor communication. These children need to continue to stay with their primary care provider after they exit foster care and need to have a pre-scheduled follow up appointment if possible. Continuity of care is critical. This is often interrupted due to change in providers resulting from placement changes. Medication continuity is also interrupted.
- Staff turnover, particularly among MATCH nurses and among BCDSS case workers challenges coordination of care,
- Given high turnover in BCDSS leadership and concomitant verbal, unwritten changes in MATCH program operational standards and procedures, there is a critical need for the

responsibilities of MATCH staff and BCDSS staff to be clearly mapped so there is no role confusion.

Our recommendations address the following domain areas:

- MATCH contract scope
- Foster care staff and partner roles and responsibilities
- MATCH staff training, capacity and retention
- MATCH caseloads and supervision
- Child and adolescent behavioral health system
- Data sharing and system interoperability across the many child welfare information system databases

INTRODUCTION

The Baltimore City Department of Social Services (BCDSS) and the Secretary of the Department of Human Services are under the L.J. v. Massinga MCD. Rhonda Lipkin, the MCD Independent Verification Agent (IVA), engaged HMA to conduct a thorough evaluation of the MATCH program. This program has been in existence since 2010 and provides health care access and coordination services for Baltimore City children in foster care. This service is provided by Health Care Access Maryland (HCAM) through a 5-year contract with a \$15 million allocation over five years (\$3 million a year). A new contract period is expected to start on July 1, 2020. The IVA and the BCDSS are both interested in determining what works within the MATCH program so that they can make adjustments to the scope of work for the next contract period to better meet the needs of children in foster care. This comprehensive report identifies what works well and opportunities for improvement in the delivery of healthcare services to children in foster care.

Setting the Context

Children and adolescents involved with the child welfare system, especially those who are removed from their family of origin and placed in out-of-home care, often present with complex and serious physical, developmental, behavioral health and psychosocial problems rooted in childhood adversity and trauma. These complex needs require a well-coordinated and well-resourced system of care. There are many barriers to providing high-quality comprehensive health care services for children and adolescents whose lives are characterized by transience and uncertainty. High-quality pediatric health services are critical to diagnosing and treating physical, developmental and emotional health problems early, and pediatricians are important advocates and coordinators of specialty care.¹ Coordinating specialty services and behavioral health through the medical home is also critical to seamless care. Since 1988, the Secretary of the Department of Human Services has been under a consent order to take substantial positive actions to improve the quality of care and services provided by the Baltimore City Department of Social Services for children and youth in foster care. The 2009 MCD specifically provides that:

- *Defendants shall develop and maintain a medical care system reasonably calculated to provide comprehensive health care services to foster care children in a continual and coordinating manner in accordance with their needs.*
- *All foster children shall have an initial health care screening if possible before placement in an out-of-home care setting, but in any event, no later than five days following placement.*
- *All foster children shall have comprehensive medical, dental and mental health examinations and a comprehensive health assessment completed within 60 days of entering placement. This assessment shall address the child's medical, emotional and developmental needs. The results of this assessment will be made available to the child's health care provider(s).*
- *All foster children shall have periodic medical, dental and developmental examinations in accordance with the schedules or protocols of the EPSDT. All foster children shall be provided on a timely basis with all health services that they need.*

¹ Szilagyi, M.A., Rosen, D.S., Rubin, D., and Zlotnik, S. (2015). Health Care Issues for Children and Adolescents in Foster Care and Kinship Care. *The Journal of the American Academy of Pediatrics*, 136 (4) e1131-e1140. <https://doi.org/10.1542/peds.2015-2655>

- *For each child in foster care the defendants shall provide a medical assistance card and shall develop and use an abbreviated health care record (e.g., medical passport), which shall accompany the child through the out-of-home care system. An abbreviated health care record shall require the following information: the medical facilities where the child usually receives care, the child's condition at placement as documented by his or her physician, and the child's immunization record, allergies/adverse reactions, chronic health problems and present medications. The foster parents of the child shall be provided with the health passport completed to the extent possible at the time of a child's placement, but in any event no later than ten days after placement.*

Since 2010, health care access and coordination services specified in the consent decree have been provided contractually by Health Care Access Maryland's Making all the Children Healthy (MATCH) program. The most recent five-year MATCH budget totals \$15,000,000 for medical case management services. In addition, BCDSS contracts with Behavioral Health Systems Baltimore (BHSB) to subcontract to Catholic Charities for:

1. Initial mental health screens and part-time psychiatric consultation services (\$750,000); and
2. Wrap around services and crisis intervention for children in foster care and in the care of their families (\$523,000).

HCAM shared that the MATCH program has been challenged by multiple changes in BCDSS leadership over the years. Stability of leadership is important to monitoring the contract with fidelity and a unified, consistent and collaborative agenda to achieve improved outcomes for children in foster care. A shared agenda across BCDSS and HCAM around MATCH related outcomes for children and youth in foster care would be helpful to coordinate the program and improve responsiveness.

METHODS

The HMA team assessed the MATCH program from September through the middle of November 2019. Our process involved review of documents, key informant interviews and records review.

We set out to evaluate the core components of the MATCH program to determine whether:

1. It meets the requirements set forth in the LJ consent decree
2. It provides mandatory and clinically appropriate and timely services for children in foster care – including medical, dental and behavioral –
3. Staffing levels and workforce capacity within MATCH meet prescribed consent order standards
4. BCDSS and MATCH staff care coordination processes and standards are adequate, especially for high and complex need children
5. Outcomes improve with health care coordination, a critical requirement when children's health and behavioral health are negatively impacted by placement changes, disruptions, need for higher levels of care, etc.
6. Whether the interpretation of the LJ Modified Consent Order around health care delivery is appropriate

In September, the HMA team reviewed background documents provided by the IVA (Appendix Section A) prior to an in-person meeting where the IVA also provided a list of MATCH program key informants. After discussing background documents and IVA goals, we developed tailored interview guides for each group of key informants: BCDSS, MATCH, and community partners. We scheduled interviews with MATCH program staff and stakeholders from HealthCare Access Maryland, the Baltimore Child Abuse Center (BCAC), Catholic Charities Behavioral Health Services, the Harriet Lane Clinic, the plaintiffs' attorney, and staff within the BCDSS.

Feedback from medical chart review and pediatrician reviews:

At the recommendation of the IVA Rhonda Lipkin, we reached out to Jenine Woodward, a Registered Nurse, healthcare quality expert, and former MATCH employee to discuss her concurrent records review. Jenine's preliminary findings identified an opportunity for MATCH nurses to play a stronger advocacy role on behalf of foster care children with their health care providers. The findings needed further verification and were not ready to be included in this report.

In a related review Dr. Jenene Washington, the MATCH Medical Director, identified several needs expressed by pediatricians serving the foster care population that also pointed to the need for a closer collaboration between the permanency worker, foster parents, the MATCH staff person and the pediatrician. Pediatricians serving foster children are asking for:

1. A completed health passport
2. More comprehensive medical records including a detailed medical history and medical history summary (especially from initial exams)
3. Developmental exam histories or completed developmental questionnaires (ASQ) where possible
4. Documentation outlining consents to treat, vaccination status, medication lists, and court orders

This level of detail will help the pediatrician to understand the child's history at each visit and identify if current developmental challenges are due to out of home placement adjustments or other reasons. This will also help to facilitate transition communications and help to identify reasons for missed appointments. It is helpful for pediatricians to know when their patients have entered out of home placement or have changed their insurance so that they can assist with record transfers, medication reconciliation, and other administrative matters.

FINDINGS

Our in-depth interviews with over two dozen staff and stakeholders resulted in largely cross-cutting themes and conclusions, although we also uncovered areas of diverging and unclear perceptions and understanding. This was most pronounced in our discussions of MATCH and BCDSS roles and responsibilities for foster care children and youth past the new entry phase, which includes the first 60 days after a child's entry into foster care

We evaluated six core questions about the MATCH program.

1. **Does MATCH meet the requirements set forth in the LJ consent decree?**

Partial Compliance: Our study found that the MATCH program only partially meets the requirements set forth in the LJ consent decree. Ongoing delivery of health care services are not well coordinated and there are significant gaps in the behavioral health delivery system and children's needs are not being met, and evidence-based behavioral health practices are not being implemented.

Role definition: There is a critical need to clearly define roles, responsibilities, handoffs and effective communication approaches for MATCH and BCDSS staff in jointly providing for the health needs of foster care children and youth after the new entry period. There is significant role confusion and lack of clarity about expectations of MATCH workers and BCDSS workers for each foster care child and adolescent. This leads to duplication of effort and missed opportunities to better meet the needs of children in care. Frequent changes in BCDSS leadership and direction, and high staff turnover rates magnify the importance of this need. Workflows from intake to case closure involving all aspects of service coordination from assessment to delivery of health, behavioral health and dental services are not clear. HMA has mapped the processes involved in the MATCH program and this process map is attached in Appendix Section C.

Inadequacy of health and behavioral supports sometimes results in lack of adequate supports to placement resources for foster children within the City of Baltimore: These significant placement challenges within city limits result in children being placed outside the city in more intensive placement types and workers having to drive long distances in order to comply with regulatory and consent order requirements.

2. Does MATCH coordinate mandatory, clinically appropriate and timely medical, dental and behavioral services for children in foster care?

Well-coordinated Care for the First 60 Days from Entry into Foster Care: Our study found that the mandatory, timely and clinically appropriate services for children entering foster care through their first 60 days are being met.

Challenges with Continuing Care: The ongoing delivery of required MATCH services was inconsistent and not supported by standardized business workflows. Communication about children who exit care or who experience a change of placement is inadequate and their care is compromised due to poor communication. These children need to continue to stay with their primary care provider after they exit foster care and need to have a pre-scheduled follow up appointment if possible. Continuity of care is critical, and this is often interrupted due to change in providers resulting from placement changes. Medication continuity is also interrupted.

Dental Services: No gaps in Dental Services were identified.

Gaps in Behavioral Health Services: The Behavioral Health Systems Baltimore (BHSB) paid to train psychologists in trauma-focused cognitive behavioral therapy (TFCBT) but after these therapists were trained, they left for private sector employment. There is no viable hook to

retain qualified and trained staff. There is a lack of ongoing treatment, monitoring and re-assessment of child's mental health needs and re-adjustment of the care plan. Problems often escalate and a crisis occurs, and placement changes happen.

There are usually long waitlists averaging two months for outpatient behavioral health and subsequent long delays in treatment. This leads to placement disruptions and risks for decompensation. The lack of behavioral health treatment staff to fill the gap between assessment and the start of treatment with a long-term therapist was a recurring theme in our interviews.

Lack of Interoperability and Data Sharing Practices: There is a lack of Interoperability and data sharing to support coordinated care. The lack of interoperability between MATCH and BCDSS data systems and lack of access to CRISP alerts and notifications poses a significant barrier to MATCH care coordination quality. The need for MATCH staff to enter, check and retrieve information from eClinicalWorks, CHESSIE and MMIS (cumbersome very old data systems) results in incomplete and untimely assessment of health needs. Every month staff need to get exit reports and assess transitions. MATCH staff and BCDSS staff are very challenged getting required documentation. The continuity of primary care could be better supported through an integrated data management system. There is no electronic communication system to share health information between MATCH, medical and behavioral health providers. Information sharing between clinical providers and MATCH varies tremendously between clinical delivery sites. Some sites do not provide critical information. Currently, MATCH does not document all of its work in CHESSIE and therefore that information is not available to BCDSS case workers. BCDSS will need to determine what is the best system to house the child welfare data including the MATCH data and what opportunities MDTHINK will present.

Inadequate Communication Across Providers: MATCH does not always provide timely feedback within 60 days or periods beyond new entry to providers to ensure coordinated care delivery for the foster child. There is a MATCH social worker who acts as liaison for behavioral health follow-ups, but this role still does not enable any real-time data sharing.

CAP in the REM Medicaid Waiver: It is hard for children without Medicaid or some medically fragile children to get comprehensive care. Maryland has a Rare and Expensive Medical Care (REM) Medicaid waiver cap for medically fragile children. The cap is now at 200 kids statewide, which is insufficient to meet the needs of medically fragile children in Baltimore City.

Caregiver Engagement: Timely and adequate education, training and care coordination with foster parents and birth parents is inadequate. When a child enters placement or when there is a placement change including return home, it is critical that the new provider has a Medicaid card, Health Passport, and information about the child's immediate healthcare needs. Engaging caregivers to meet the needs of medically fragile children is a big need and failure to train often results in discharge delays of children from hospital into less restrictive placement settings. Foster care workers are also asking for training in managing the needs of medically fragile children.

3. Do staffing levels and workforce capacity within MATCH meet prescribed consent order standards?

Inadequate Staffing: MATCH staffing and workforce capacity does not meet consent order standards. The Baltimore foster care population has decreased in size, but the medical and behavioral health needs of the children and youth have increased in complexity. Staffing is inadequate to provide high quality care coordination. Acute health conditions include neonatal drug exposure, asthma, epilepsy, bowel transplant, heart transplant, and other complex medical conditions, which require coordination of care across many providers.

The MATCH contract requires provision of enough staff to handle all health care management for new entrants into foster care and subsequent health care management for all children except healthy children older than age 3. BCDSS was required to provide staff members to handle care coordination services for healthy children. A few years back MATCH absorbed the BCDSS care coordination when BCDSS and MATCH orally agreed that the staff would be reassigned back to BCDSS for child welfare work. However, MATCH staff found more health, dental and behavioral health needs when they had more time to work on these “healthy” cases.

Caseload Challenges: MATCH caseloads are an area of concern in this review. For MATCH staff serving medically complex children, caseloads should be limited to 30 cases per staff person, but staff are handling 50 cases now which leads to adequate levels of care management and not the highest quality of service MATCH expects to provide. MATCH leadership believes that the program needs two more staff to get caseloads where they should be to serve medically fragile children. It is unclear if any of these 50 cases on a case manager’s calendar are placed in treatment foster care or therapeutic group care, which would affect this calculation of staffing gaps. For healthy 0-5-year old’s, four staff handle 600 cases.

Supervisory Span of Control: MATCH is also very lean administratively. It is critical for MATCH to examine its supervisor to staff ratios. The span of control per the attached organization chart (Appendix Section C.) is excessively high and does not meet CWLA recommended standards for work with foster care populations. The supervisory span of control recommended is 1 supervisor to 5 clinicians and 1 administrative staff person. While the medical ratios are likely to be different from case carrying permanency staffing units, these ratios are excessively high.

Other Workforce Observations within the MATCH program include:

- Staff turnover rates are high, particularly among RNs, where pay is not competitive with local hospitals.
- There is no cross training between MATCH and BCDSS staff to build a sense of team and collaboration.
- Staff retention challenges on the BCDSS side make it challenging to ensure continuity of care for children in their case collaboration efforts with MATCH. Inadequate training including around trauma informed care, compensation challenges, relaxed education and licensure requirements and inadequate skilled clinical supervision capacity were all identified as factors for BCDSS staff.
- MATCH and BCDSS caseloads were much higher than the recommended standards and the supervisory span of control was not conducive to high quality supervision.

- Co-location of BCDSS and MATCH staff will lead to better collaboration and teaming and participation in FIMs by MATCH staff.

4. Is BCDSS and MATCH care coordination adequate, especially for high and complex need children?

Specific findings related to care coordination for high and complex need children include:

- a. There are inadequate, ad hoc communication channels to support MATCH and BCDSS care coordination. There is a communication gap between permanency workers and MATCH staff. MATCH should function as a support system to BCDSS. BCDSS drives the coordination and supervision of that child's care as the child welfare agency with custody of the child when placed in foster care. However, there are no regular mechanisms for BCDSS and MATCH staff to discuss cases, share information and collaborate to meet the needs of the children and youth.
- b. The role of MATCH when children are placed into treatment foster care and with therapeutic group homes needs to be clarified.
- c. The MATCH program is working well for new entrants into foster care, for medically fragile children and youth, and for 18 – 20-year old's in the Ready by 21 Program. Health and behavioral health screening and assessment services from shelter care until the first 60 days are provided according to established timelines. This was conveyed to us by both an administrator within BCDSS and in our conversations with staff at BCDSS and at MATCH. Interviewees communicated the consistent understanding of roles and responsibilities of MATCH and BCDSS during this period. Interviewees also reported that children who are medically fragile receive comprehensive assessments and care coordination. A child placed in treatment foster care or a treatment group home must have his or her health and behavioral health needs met by the placement provider under contract. Regular family foster care placement or kinship care are often the placements where children remain most vulnerable as a result of a failure to coordinate access to and delivery of medical and behavioral health services. In our interviews, we did not identify any concerns with transition planning for adolescents in the Ready by 21 Program.
- d. MATCH participation in Family Involvement Meetings (FIMs) is not routine. MATCH staff are invited to attend FIMs and join by telephone when possible. FIMs are held with some regularity for children entering care and for children exiting through the Ready by 21 program and MATCH staff. When MATCH staff participate, the value and positive outcome of collaboration is universally recognized. However, lack of co-location and high caseloads of MATCH staff make regular in-person participation difficult. BCDSS currently does not regularly schedule FIMs around placement changes and other permanency needs and inclusion of MATCH staff is irregular.
- e. Permanency workers asked about MATCH's role after initial evaluations are coordinated. Often the MATCH worker calls the foster care worker for supporting medical and behavioral health documents to fulfill their 6 month and annual health care check-in requirements to

complete the annual health report and health plan. MATCH staff conveyed that they are challenged by their reliance on data systems with inaccurate and incomplete data and often do not know where the child is currently placed. BCDSS confirmed that BCDSS staff make the appointments and collect required documents and then supply these to MATCH staff.

- f. When there was a connection through an FIM or due to prior contact and relationship between the permanency worker and the MATCH worker, especially for medically fragile or pregnant and parenting teens the teaming works well.

5. Do outcomes improve with health care coordination, a critical requirement when children's health and behavioral health are negatively impacted by placement changes, disruptions, need for higher levels of care, etc.

Our interviews revealed that the problem of multiple placements are a significant challenge for children in foster care in Baltimore City. The lack of FIMs to prevent multiple placement changes and the shortage of responsive behavioral health services to reduce placement changes are the two biggest findings that are relevant to this question. Though we were not able to definitively say that it was the lack of health care coordination that was leading to placement disruptions or exacerbation of presenting issues for the child in foster care as we identified multiple factors including a shortage of placement resources, lack of behavioral health services, staffing turnover, etc.

6. Is the interpretation of the LJ Modified Consent Order around health care delivery appropriate and does it clarify needs related to court reports, comprehensive health reports, health passports and health plans?

As detailed throughout this report, the interpretation of the LJ Modified Consent Order is not optimizing the health and safety of children in the Baltimore City foster care system. The interpretation question to be answered was as follows:

- a). What does the MCD require: a health passport or a health plan? This question should be revisited, to determine whether the contract should require a health passport or a health plan.

We have captured our interview notes in the Appendix Section D of the Report. In addition, we have catalogued all the documents we reviewed to formulate our findings and our recommendations in Appendices. We have also developed a process map and flow charts to outline what we understand to be current practice across MATCH and BCDSS.

RECOMMENDATIONS

We identified several recommendations to address the key findings in this report. We hope that they can be used to inform the next iteration of the MATCH contract.

1. Restructure the Scope of Work and Clarify the Roles.

1a. Retain the new entry scope of work in the current contract, which is working well from the perspective of all our sources.

Our assessment clearly reveals that the new entry scope of work within the first 60 days is working effectively as are services for the medically fragile children. Staff and stakeholders expressed their need for increased support for certain clinical service responses for children in care. We would therefore recommend that BCDSS consider the following:

- a. MATCH provides the new entry scope of work and be responsible for completing the Comprehensive Health Assessment
- b. MATCH provides the higher intensity support for medically fragile children who are not placed in a treatment foster care or therapeutic group home setting placement. MATCH should not duplicate medical and behavioral health coordination services where there is an existing requirement for a treatment foster care provider or a therapeutic group home provider to provide those services. This expectation needs to be clarified.
- c. Determine MATCH capacity to provide behavioral health coordination and services as outlined in Recommendation 2. Determine whether the delivery of temporary/interim community behavioral health services pending assignment of permanent clinician, should be awarded to a specialty behavioral health provider, or be brought in-house depending where there might be capacity and expertise.
- d. Build a trigger system for consultation with a medical or behavioral health provider at MATCH or the new Behavioral Health provider/consultant (depending on the model applied by BCDSS), when the following conditions are identified:
 - i. A change in physical or mental health status that results in a placement disruption. This change should also trigger a FIM, and MATCH consultation should be required to support the stabilization and treatment of child.
 - ii. Instances where there are delays in discharge from a higher intensity placement to a less restrictive placement because clinical needs cannot be met without additional support
 - iii. Pregnancy or parenting youth to facilitate connections to prenatal care and to home visiting services and 0-5 services, as appropriate (currently happening through MATCH).
 - iv. Youth become transition age (currently happening in the Ready by 21 Unit)

1b. Clearly lay out contract goals, requirements, processes, standards and accountability in writing.

- a. All modifications to contracts must be written as formal contract amendments and put in writing by BCDSS. MATCH should not agree to verbal contract amendments. Create a formal monitoring structure for the MATCH contract.
- b. Specify formal BCDSS-MATCH coordination and interface protocols. Establish clear roles and responsibilities for HCAM, BCDSS and partners. There are swim lane issues now between BCDSS and HCAM. Workflows need to be reviewed, tightened and implemented with fidelity.
- c. Establish quality assurance and improvement requirements including processes and staffing to allow clinical follow up reviews to ensure that children are receiving the medical and behavioral health care they need.

1c. Create formal mechanisms to improve MATCH-BCDSS seamless care coordination

- a. Consider co-locating MATCH staff with BCDSS staff if space can accommodate. Proximity of staff will support greater interpersonal interactions, which should support better coordination of care.
- b. Reinstate an overview of MATCH in BCDSS new employee orientation, ideally presented by MATCH staff. For many years MATCH was part of new employee orientation. This was discontinued more than 12 months ago. BCDSS staff orientation to the MATCH program and roles would be helpful. It would be ideal if there was a procedure to ensure that BCDSS workers check in with MATCH staff on any medical needs before home visits or a prompt for the MATCH worker to reach out to the BCDSS worker prior to home visits to flag potential issues or needs. This would lead to a more coordinated response and follow up on issues.
- c. Expand Family Involvement Meetings for placement changes and for permanency plan changes and include MATCH staff in those meetings even if by telephone conference to increase family engagement in care continuity
- d. Provide for joint home visits in cases where there is a barrier to care or in complex situations. For example, if a pregnant teen is refusing home visiting a joint visit may be helpful.
- e. BCDSS and MATCH should harmonize redundancies in workflows. We have attached a process map we believe captures current practice which might serve as a starting point for that discussion.
- f. Provide for outreach to community primary care providers to introduce MATCH and develop closed loop referrals for somatic care and specialty services.

- g. Create an expectation that participating clinics should send after care reports to MATCH. MATCH receives information and responds to providers but does not initiate communications with providers except as a reaction to anomalies. MATCH information is often unclear about follow-up needs and plans. The program needs a clear protocol to be able to communicate directly with providers so that this responsibility doesn't rest solely on Dr. Washington.

2. Expand the System of Care.

Maryland DHS and BCDSS need to coordinate to expand access to behavioral health clinical services.

Maryland's children's behavioral health system of care does not meet the needs of children in foster care. This gap is felt in Baltimore City acutely where needs are great. To address the lack of behavioral health service providers, we recommend providing an in-house behavioral health practice made up of a psychiatrist and licensed therapists to:

- a. Provide hands on follow-up to the Catholic Charities assessments and recommendations to ensure timely access to behavioral health care needs.
- b. Provide stop gap behavioral health treatment when there are long waiting lists for access to community providers and when it is not appropriate for the child to be served by crisis services.
- c. Provide specialty behavioral health consultation to foster care workers when there are critical issues arising in a child's case including placement instability or discharge challenges.

3. Address Workforce Challenges.

Ensure that there is necessary funding to support staffing of high-quality care through standards-based nurse and social work caseloads, and appropriate supervisor-staff ratios.

Organize BCDSS caseloads based on the needs of children and youth in foster care. For example, there are approximately 150 medically fragile children but only one unit to serve medically fragile children carrying about 60 cases. Other medically fragile children and youth would benefit from this focused staffing, as well.

It would be useful to the BCDSS to evaluate caseloads and right size them. We recommend using the 1998 HB1133 standards as a starting point for this caseload and span of control assessment as well as building some specialty staffing alignment capabilities. (See Appendix Section A for copy of legislation)

Similarly, MATCH caseloads are too high to be effective and to partner well with BCDSS staff. MATCH supervisory level staff also have two to three times the recommended direct-report ratios, impacting their ability to provide high quality coaching, staff development, and quality management. We recommend that BCDSS do the following with the next iteration of the MATCH contract:

- a. Ensure that the contract award and scope of work will support workforce retention and performance excellence. Analyze labor market environment (wages,

competition with hospitals and community-based organizations for a limited hiring pool, and competition with neighboring jurisdictions), and MATCH work environment (workload and caseload burdens and licensing capacities) to develop a staffing plan that will address root causes of current turnover and staff performance shortfalls.

- b. Establish management to staff ratios that support the staff supervision and development needs of the MATCH program. Per industry standards, clinical supervisory ratios should be around 1:6 including administrative support staff.

4. Provide the Infrastructure for Excellent Care through State-of-the-Art Technology and Data Analytics.

Strengthen the data infrastructure to support efficient, effective data sharing, reporting and information retrieval.

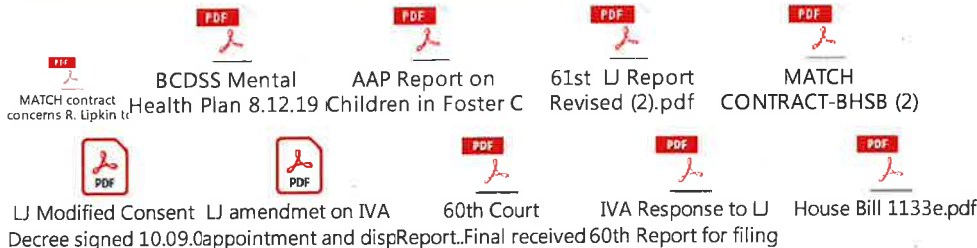
- a. BCDSS will need to determine what is the best system to house the child welfare data including the MATCH data and what opportunities MDTHINK will present. Data Infrastructure is weak and does not support meaningful program analytics.
- b. This problem is compounded by system accessibility issues. Access to the Maryland Health Information Exchange or Chesapeake Regional Information System for our Patients (CRISP which is the Maryland statewide health information exchange), alerts would facilitate more prompt interventions. More IT supports are needed. It takes a new hire 3 weeks to get into the state email system. There is a lack of cross-training on data systems and data sharing protocols. We are recommending that these IT infrastructure issues be problem solved by BCDSS and MATCH with support from DHS Central to help with the CRISP data portal discussions.

CONCLUSION

HMA found through our review of the MATCH program that the program performance is uneven. It is working well for new entrants into care, for medically fragile children as evidenced in the report sections above and supports coordination for transition age youth served by the Ready by 21 Program. For other populations of children in foster care, there needs to be greater coordination to improve outcomes. We have outlined our recommendations to support areas where processes, coordination and clinical practice can be improved.

APPENDICES

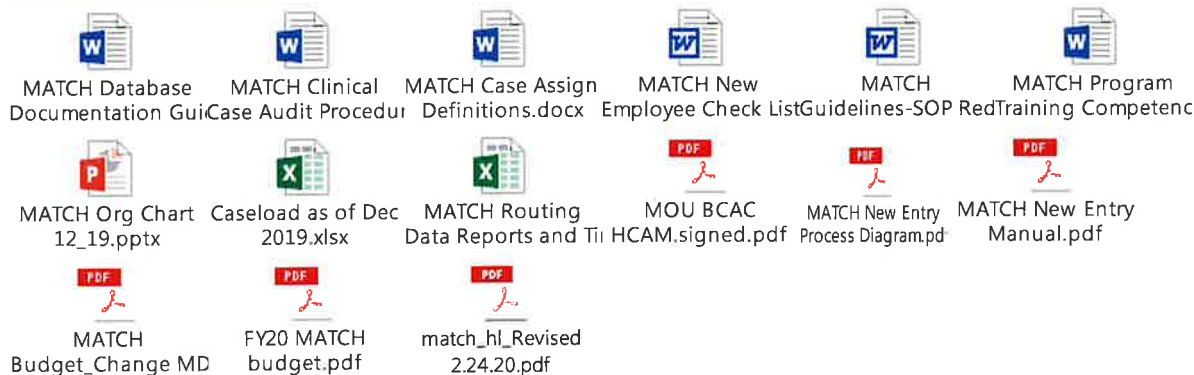
Appendix Section A. Background Documents



Appendix Section B. MATCH Forms



Appendix Section C. MATCH Protocols, Standard Operating Procedures and Related Materials



Appendix Section D. Interviews



MATCH Medically



MATCH Interview



MATCH Interview



MATCH Interview



MATCH Interview



MATCH Interview

Fragile Interview Now with Wendy Lane.d with Traci Kodeck.d with Terri Alston.d with Mitch Mirviss.d with Kim Floyd and .



MATCH Interview



MATCH Interview



MATCH Interview



MATCH Interview



MATCH BCDSS



Jenine Woodward

with Janet Bridges.c with Dr. Barnett.d with Catholic Charit with Becky Seltzer.d Interview with Sean Summary Report.d



MATCH Ready by 21
Focus Group Notes.