Report of Health Services and MATCH Oversight for Children in Out-of-Home Placement (Foster Care) in Baltimore City (2017 – 2019)

Jenine Woodward, R.N., M.P.H., CCHQM
Quality Data and Report Analyst
July 13, 2020

Prepared for:
Rhonda Lipkin
L.J. v. Massinga Independent Verification Agent (IVA)
Rhonda.lipkin@gmail.com
410-499-3752

Executive Summary

L.J. v. Massinga IVA commissioned this study to determine if: (1) children in BCDSS OHP were receiving certain required health care service on a timely basis; and (2) the primary medical health care portion of those services met the Early, Periodic Screening and Diagnostic Testing (EPSDT) clinical standards set by the Maryland Department of Health. The time period under review are the three years from January 1, 2017 through December 31, 2019.

The methodology of the study involved a random selection of active children in each categorical grouping within the MATCH program. The number of children (94) in the study was equivalent to the proportion of children in each study grouping represented in each categorical MATCH grouping.

The quality analyst reviewed documentation from the CHESSIE database, ECW data, and the hard copy chart documentation for each participant to assess compliance with service timeliness. The areas assessed for timeliness include the following indicators. Compliance timelines were consistent with the timeliness in the established in the consent decree and can be found in the report.

DOE to Initial Exam	DOE to Comp Exam	DOE to MH Exam	Timely EPSDT Visits	Untimely EPSDT Visits	Immunizations UTD	Infant &Toddler	DOE to Initial Dental Visit	Dental Periodicity

Clinical care was assessed for compliance relative to the Maryland Early Periodic Screening and Developmental Testing (EPSDT) Guidelines. The specific EPSDT components assessed in the study are history and developmental assessment, physical exam, age-appropriate risk assessments, age-appropriate immunizations, and health education, anticipatory guidance and/or specific health counseling.

The report contains a detailed analysis of each categorical grouping and the overall compliance for each grouping. The reader will find charts in the appendices that provide detailed information which are intended to assist in understanding compliance findings. The report narrative also assists the reader to understand when and why inter-categorical groupings are not appropriate for comparison.

The study findings indicate that:

1. Although there was variation by age and health status, upon entry into OHP, children in BCDSS OHP received the required "new entrant" health services - those required during their first sixty days in OHP - on a reasonably timely basis.

2. For ongoing EPSDT exams, meeting the timeliness requirements proved more challenging. Varying significantly by age and health categories, timeliness ranged from 50% for transitioning youth to 85% for healthy 6 to 17 year olds. Across all categories, immunizations

were timely in 74% of cases. Meeting the semi-annual dental exam requirement was particularly challenging; in no age or health status category was that requirement met more than 33% of the time. A variety of reasons are attributed to challenges meeting timeliness requirements, some directly within the control of MATCH while others require cooperation and collaboration of bureaucratic partners to achieve improved compliance. Suggestions for improvement are included in the report.

3. For children ages 0-5, the primary medical health care services generally met the Early, Periodic Screening and Diagnostic Testing (EPSDT) clinical standards set by the Maryland Department of Health, although there were some lapses in completeness of some physical exams and some timely immunizations. Except for those 0-5 year olds and transitioning youth (18-20 year olds), the report does not address overall rates of compliance with EPSDT standards for the other MATCH program categories due to age diversity and, therefore, differences in EPSDT requirements, within categories.

At the end of the report, identified opportunities to enhance compliance are discussed. The greatest opportunity identified was more collaboration and timely information sharing between the Baltimore City Department of Social Services (BCDSS) case worker staff and the MATCH care coordination staff. Other strategies are also offered which target improved programmatic advocacy as a mechanism to assist foster children maintain their optimal state of health while in OHP.

Introduction

The State of Maryland Department of Human Services, through regulations, provides requirements to each local jurisdiction in the state regarding the care provided to children in foster care/Out-of-Home Placement (OHP) within the state. The L.J. v. Massinga federal class action, through a Modified Consent Decree (MCD) ordered in 2009, provides additional requirements for the children in OHP in Baltimore City. It also provides for an Independent Verification Agent (IVA) who has the responsibility to determine if the information provided by the Baltimore City Department of Social Services (BCDSS) as to the care of the children in OHP is reliable, verifiable and accurate.

The L.J. v. Massinga IVA commissioned this study to determine if: (1) children in BCDSS OHP were receiving certain required health care service on a timely basis; and (2) the primary medical health care portion of those services met the Early, Periodic Screening and Diagnostic Testing (EPSDT) clinical standards set by the Maryland Department of Health. The time period under review are the three years from January 1, 2017 through December 31, 2019. During that period of time, the number of children in BCDSS OHP was between 1,800 and 1,900 children at any one time.

To accomplish the duties required to ensure that children in BCDSS OHP receive the health and support services needed to maintain health, BCDSS contracts with Health Care Access Maryland (HCAM). HCAM created the Making All The Children Healthy (MATCH) Program in 2009 to fulfill the requirements of that contract. MATCH provides those services through licensed nursing and social work staff and care coordinators. MATCH coordinates medical, dental and behavioral health exams for all children in OHP; enrolls them in the state's medical assistance program; case-manages children's complex behavioral and physical health needs; and assists young people in assuming responsibility of managing their own health care when transitioning from foster care into independent adult lives. (https://www.healthcareaccessmaryland.org/programs-services/match/)

The basic requirements of the current contract are to ensure, through regular contact with caseworkers, caregivers and/or older youth, and health care providers, that care and services are provided within established timeliness standards. The specific requirements are that:

(1) Each child entering foster care ("new entrant") has an initial health assessment within 5 days of the child's date of entry into OHP (DOE). This is currently accomplished through referral to the Baltimore City Child Abuse Center (BCAC) program

(2) Each new entrant has comprehensive mental health, medical and dental assessments within 60 days of the child's DOE.

(3) After the first 60 days, each child receives timely, age-appropriate care examinations and services consistent with the EPSDT guidelines as well as timely semi-annual dental examinations, therapeutically-indicated behavioral health services, and appropriate follow-up and specialty care in each of these areas.

(4) After the comprehensive examinations are completed, MATCH staff create an initial health plan to be provided to the child's caseworker, caregiver, and primary health care providers.

(5) At least annually, and more frequently for children ages 0-5 and children and youth with moderate and high level physical and behavioral health needs, MATCH staff create a new health plan to (1) reflect the child's current health status, (2) provide health care guidance to the caregiver, (3) list upcoming appointments or dates to schedule appointments, health care providers, and medication and (4) provide age-appropriate developmental guidance.

During the first sixty days after children enter OHP, all children are assigned to a special "New Entrant" team of nurses. At the end of the new entrant period, each child is assigned to a program category based upon the child's age and physical and mental health needs. The cohorts are staffed by different types of MATCH staff – nurse, social work staff and care coordinators – dependent on need. Over time, children may move between categories as they age and/or their physical and mental health needs changed. Children's cases are reviewed by MATCH staff at different intervals dependent upon category.

The categories, assigned MATCH staff and review intervals (as of 2019) are as follows:

1. Healthy Children ages 0-5 - nurse and care coordinators – every six months
2. Healthy Children ages 6-17 – care coordinators – once a year
3. Healthy Transitioning Youth ages 18-20 – care coordinators – once a year
4. Children and Youth with Moderate Behavioral Risk – social work staff – every six months
5. Children and Youth with High Behavioral Risk – social work staff – every six months
6. Pregnant and Parenting Youth – care coordinator – every three months
7. Medically Fragile Children and Youth – nurses – every three months

The report is divided into the following sections:

1. Methodology
2. Timeliness of Health Care Services

Figure 1. Health Services Timeliness by Metric and MATCH Program Category

a. Clients Entering Foster Care Placement During or After 2017

b. Clients Entering Foster Care Placement Before 2017

Figure 2. Overall Timeliness for All Health Services by MATCH Program Category

3. Clinical Care Metrics

Figure 3. Clinical Care Metrics Compliance Summary for Ages 0-5 and Ages 18-20

Figure 4. Clinical Exam Analysis Detail for Ages 0-5

Figure 5. Clinical Exam Analysis Detail for Ages 18-20

4. MATCH Program Advocacy

Figure 6. Examples of Opportunities for MATCH Program Advocacy for Children Ages 0-5, 6-17, and 18-20, Medically Fragile Children and Children with Moderate Behavioral Health Risk

Figure 7. Examples of Opportunities for MATCH Program Advocacy for Children with High Behavioral Health Risk

Other Observations and Suggestions to Ameliorate Service and Clinical Program Gaps

5. Final Thoughts

Appendix I: Service and Clinical Worksheets by MATCH Program Categorical Groupings

Appendix II: Jenine Woodward CV

METHODOLOGY

A randomized list of 200 hundred of the 1,834 children active in the MATCH program as of October 2019 was provided to the report analyst. Cases were chosen without regard to when the child had entered OHP. The two hundred children were proportionally represented in alignment with their proportional representation in each of the assigned program categories.

The report analyst reviewed the cases of children which were randomly selected every 10th child from the list of 200 children with the sequence repeated until the appropriate number of clients from the sample corresponded with the MATCH category grouping proportion.[1] Best attempts were made to keep the proportion of the children reviewed by category within five percentage points of the proportion of children in the total caseload by category.[2]

MATCH Category	Approximate % of total caseload	# of Cases Reviewed	% of total # cases reviewed	Cases opened 2017-2019	Cases opened Pre-2017
Healthy Ages 0-5	30%	25	27%	24	1

[1] A few adjustments to assignment to categories were made due to the small name of children in two categories – New Entrant and Pregnant and Parenting. (Children can qualify for two or more different categories based on time in OHP, age, and physical and mental health.) The six children in question were moved to the other categories as follows: New Entrant – one each to Medically Fragile, Moderate Behavioral Risk, and Healthy Ages 6-17. Pregnant and Parenting – two to Moderate Behavioral Risk and one to Healthy Ages 18-20 (Transitioning Youth).

[2] Four cases had to be removed from the review due to insufficient file information which caused two of the categories (Ages 6-17 and Medically Fragile) to be 6% rather than 5% off from the desired proportion.

Healthy Ages 6-17	20%	13	14%	8	5
Moderate Behavioral Risk	24%	18	20%	13	5
High Behavioral Risk	9%	13	14%	7	6
Medically Complex	10%	15	16%	10	5
Healthy Ages 18-20 (Transitioning)	7%	7	8%	6	1

After the sample of clients was selected, the report analyst reviewed information and documents for each child in CHESSIE (child welfare database) and eClinicalWorks (eCW) (MATCH database), and the MATCH hard copy client files for each child. These data sources were used to assess compliance with routine, recommended health services according to the EPSDT periodicity schedule as well as the additional L.J. v. Massinga requirements (5 day and 60 day exams and semi-annual dental exams). A worksheet was created for each of the MATCH Program Categorical Groupings, and the information gleaned from the records was recorded for each child on the applicable. (See Appendix I).

TIMELINESS OF HEALTH CARE SERVICES

The following rules and procedures were used in preparing the analyses of timeliness of services presented in Figures 1 and 2 below:

a. Two tables for service timeliness are presented: Clients entering foster care placement 2017 - 2019, and Clients entering foster care placement prior to 2017. Compliance rates for the new entrant (5 and 60-day) exams and Infants and Toddlers referrals are presented only for children entering OHP 2017 - 2019.

b. Compliance with services timeliness was calculated using business days.

c. Cases were considered "Not Applicable," or "NA" as follows:

1. Initial Exam (5 days from DOE) – Children entering OHP at birth.

2. Comprehensive Dental Exam (60 days from DOE) – Children under the age of 1 at the time of entry into OHP.

3. Infants & Toddlers Referral (30 days from DOE)- Children whose mental health testing does not show a need for an Infants & Toddlers Referral.

4. Dental Periodicity (semi-annual exams) – Children under the age of 18 months. (Although recommendation is for dental visits to begin at age 1, due to difficulty in scheduling, an additional 6 months was allowed.

5. Any medical or dental visit due after the first 60 days if there is documentation that the child was told to return on the wrong date.

d. Children who had a service during an inpatient stay shortly before entering OHP formally were deemed compliant for that service if the documentation was reliable.

e. Services that were noted as performed but for which no documentation was found were deemed as non-compliant.

f. The EPSDT well-child exam compliance rate was calculated as follows: the sum of actual visits documented for the children in the particular MATCH category was divided by the total expected visits for those children based upon their age and the EPSDT exam schedule. For example, if five children's cases were reviewed, and, during 2017-2019, those children were due a total of 15 EPSDT visits while they were in OHP, and 10 of those visits occurred timely, the compliance rate would be 10/15 or 66.67%. The comprehensive exam was and is therefore counted as one of each child's EPSDT well-child exams.

g. For each child, semi-annual dental visit compliance was rated as either "yes" or "no." The rating was "yes" only if the child had timely semi-annual dental visits each time they were due during whatever part of 2017-2019 the child was in OHP. If the child missed any visits due while they were in OHP during that period of time, the child's case was considered non-compliant for that metric. For the total compliance rate for a particular MATCH category, the number of children with a "yes" rating was divided by the total number of children in that MATCH category (minus any who were deemed "N/A" per (c)(4), above).

h. For each child, Immunizations being Up-to-Date (UTD) was rated as either "yes" or "no." The rating was "yes" only if the child had timely immunizations for any immunizations that were due during whatever part of 2017-2019 the child was in OHP. (Exceptions were made for children who entered OHP behind on their immunizations so that they had to "catch up" over a pediatrician-mandated period of time or children for whom their pediatrician determined that giving the children the immunization on the date in question was not in the child's best interest. In those cases, so long as the child was brought to the doctor's office when instructed by the pediatrician for any make-up immunizations, those "late" immunizations did not cause the case to be rated "no" for this metric.) For the total compliance rate for a particular MATCH category, the number of children with a "yes" rating was divided by the total number of children in that MATCH category.

i. For expected EPSDT and dental visits after the new entrant period, services provided 30 days plus/minus the periodicity timeframe date were deemed compliant.

Figure 1: Health Services Timeliness by Metric and MATCH Program Category

a. New Entrant Services (Clients Entering OHP During or After 2017 only)

Timeliness Metric	Timeliness Target Goal	Ages 0-5 n=24	Ages 6-17 n=8	Moderate Behav. Risk n= 13	High Behav. Risk n= 7	Medically Fragile n=10	Transitioning Youth n=1	Total All-MATCH Categories
Date of Entry (DOE) to Initial Exam	≤ 5 days	80%	75%	77%	71%	83%	100%	78%
DOE to Comprehensive Exam	≤ 60 days	96%	100%	100%	86%	100%	100%	97%
DOE to Mental Health Exam	≤ 60 days	96%	100%	100%	100%	89%	100%	97%
Infant and Toddler Referral to Coordination by MATCH	≤ 30 days from Mental Health Exam	100%	NA	NA	NA	100%	NA	100%
DOE to Initial Dental Exam	≤ 60 days	100%	62.5%	100%	100%	100%	100%	92%
Average All New Entrant Exams		94%	84%	94%	89%	94%	100%	92.5%

b. Ongoing Health Services (All Clients)

Timeliness Metric	Timeliness Goal	Ages 0-5 n=25	Ages 6-17 n= 15	Moderate Behav. Risk n=18	High Behav. Risk n=13	Medically Fragile n=15	Transitioning Youth n= 7	Total All MATCH Categories
EPSDT Exams by Age	EPSDT Schedule	68%	85%	77%	62.5%	74.5%	50%	70%
Immunizations UTD	Md. DOH Immun. Schedule	80%	62%	89%	38.5%	87%	71%	74%
Timeliness of Dental Periodicity (semi-annual dental exams)	Every 6 months after 1 year old	25%	27%	12.5%	17%	33%	0%	21%
Average All Ongoing Services		58%	58%	59.5%	39%	65%	40%	53%

Discussion

When looking at the 0-5 grouping, most of the missed well care visits occur at the 9-month, 15 months, and 30-month visits. The study "Gaps in Well-Child Care Attendance Among Primary Care Clinics Serving Low-Income Families" published in the professional journal Pediatrics, found that the 15- and 18-month well child visit as well as the 4-year well child visit are the least frequently attended. The study highlights the importance of these visits as the opportunities to identify developmental delays at 15 and 18 months, and the opportunity to identify assess school readiness at the 4-year visit. The reader is urged to review the 0-5 age grouping worksheet to better understand barriers to well-child visits and care at the client level.

Transitional age children have much less compliance with well-child visits due to numerous reasons, including but not limited to: youth choice of not attending visits, runaway status during the later teen years, and behavioral health issues that interfere with decision making and the ability of older children to cooperate with their care practitioners. The individual worksheet for this cohort of children can be reviewed to understand barriers to well care visits at the individual client level.

Compliance also was calculated across client categorical groupings for each timeliness metric. This information is represented in tables following the worksheets found in the appendix portion of the report. Compliance calculated across categorical groupings with narrow age bands are more representative of true compliance. This is due to the varying requirements across large variance age

groupings. Attempts to summarize data for categories with large variations were found to distort compliance. For example, medically fragile clients generally demonstrate high compliance rates. However due to the fact that many of these clients are infants, a number of categories are not applicable (n/a) thus creating a small (n) eligible number of clients. Summaries for the 0-5 grouping and transitional youth grouping represent the more accurate compliance that can likely be applied to the program grouping for those categories.

Figure 2: Overall Timeliness for All Health Services by MATCH Program Category

Ages 0 - 5	Ages 6 - 17	Moderate Behavioral Risk	High Behavioral Risk	Medically Fragile	Ages 18 - 20 (Transitioning Youth)
76%	71%	77%	64.0%	69%	70%
	Overall Health Services Compliance Rate				71.2%

Discussion

The medically fragile age grouping achieved the highest timeliness compliance rate closely followed by the 0-5 age group. The finding that the medically fragile group had the highest compliance is evidence that children with complex needs are receiving most well-child services with timeliness on par with their peers. Of particular interest is that the medically fragile cohort does not appear to enter the "specialist care cycle" without attention to well-child care. During review of medical documentation, the analyst noted that many of the specialists documented in their notes, "return to PCP for well-child care".

Another factor that likely impacts this finding is that the cohort grouping spans a wide diversity of ages with varying timeliness requirements for visits and immunizations. Compared to the 0-5 group, the medically fragile group had 5 clients within the ages of 0-3 years. The significance of this is that the number of well child visits required of this age group can be as many as 10 depending upon the age of entry into care. There are many more opportunities to miss appointments in this age grouping. The 0-5 group had 10 children in the 0-3-year ages. Thus, although the 0-5 group scored .1% less than the medically fragile group, the 0-5 group may be viewed as the most diligent group to achieve timeliness goals.

As can be expected in all other groupings, as the clients age, their periodicity and timeliness lessened due to their ability to choose to attend well care visits. Behavioral health clients had lower timeliness compliance for reasons of choice as well as other factors such as runaway absences.

CLINICAL CARE METRICS

This clinical care metrics section is a detailed clinical review of all of the EPSDT examinations for all of the reviewed cases during 2017, 2018 and 2019. The exam components analyzed include the following:

- ❖ Risk assessment performance
- ❖ Developmental surveillance screening performance
- ❖ Appropriate screening performance
- ❖ Diagnostic performance according to EPSDT periodicity schedule
- ❖ Follow-up of abnormal findings by the primary provider

The categorical groupings for this portion of the analysis remain unchanged from the timeliness section. This grouping schema can be misleading if used to determine compliance. This is because the client grouping is not controlled for age-appropriate exam components, clients' duration in foster care, and the diversity of age within each grouping. For example, the Ages 6-17 cohort can leave the reader with an inaccurate perception of compliance if the sample grouping contains many clients who are at the older ages of the grouping and entered care during 2018 or 2019. Older children have less visit requirements and therefore would be expected demonstrate greater compliance.

In planning this effort, the analyst did not foresee the potential impact of intra-categorical age variation and duration in foster care performing the random selection sample for review. Therefore, to avoid a misinterpretation of the data, summaries of findings for clinical care metrics compliance are presented only for two program categories for which there is relative homogeneity of the clinical exam components and age within each group – the Ages 0-5 and Ages 18-20 (Transitioning Youth) program categories. A comparison between these two groups provide greater confidence regarding the intergroup compliance. For the Ages 6-17, medically fragile, moderate behavioral health risk, and high behavioral health risk categories, the data is presented for each individual child in the Appendix 1 worksheets. Detailed information impacting each sample client is presented to allow the reader to draw conclusions about the compliance at the individual client level.

Figure 3: Clinical Care Metrics Compliance Summary for Ages 0-5 and Ages 18-20 (Transitioning Youth)

	Ages 0-5	Ages 18-20 (Transitioning Youth)
History/ Developmental	100%	70.6
Physical Exam	78%	73.9%
Risk Assessment	100%	35.3%
Immunizations	75%	75%
Health Education	100%	18.2%

Discussion

As discussed in the timeliness section, above, when looking at the 0-5 grouping, most of the missed well care visits occur at the 9-month, 15 months, and 30-month visits. The study "Gaps in Well-Child Care Attendance Among Primary Care Clinics Serving Low-Income Families" published in the professional journal Pediatrics, found that the 15- and 18-month well child visit as well as the 4-year well child visit are the least frequently attended. The study highlights the importance of these visits as the opportunities to identify developmental delays at 15 and 18 months, and the opportunity to identify assess school readiness at the 4-year visit. The reader is urged to review the 0-5 age grouping individual case worksheet to better understand barriers to well-child visits and care at the client level.

Although, as explained in the timeliness section, above, transitional age children have much less compliance with well-child visits due to numerous reasons, among the positive findings, perhaps the strongest is that if the visit did occur, all physical components of the exam were consistently done and documented. Only one clinician was found not to document physical findings but rather documented ordered labs and return visit timeframe.

Generally children in the moderate and high behavioral health risk groupings received formal mental health screening (e.g. depression screening tool; alcohol screening tool) more frequently than healthy Ages 6-17 or medically fragile categorical groupings although depression and alcohol screening is recommended at well child visits for all children starting at age 11 years of age. Anticipatory guidance is universally completed as part of the well child visit in the 0-5 age grouping while it occurs less frequently among the youth transition group. This finding may be a documentation issue verses a resource issue as the transition group exam is generally more time-consuming than the 0-5 group exam. When analyzing the history and development assessment, the driver of the compliance in the 0-5 grouping is the developmental surveillance which is consistently done at each well child visit. Many times, the history for the 0-5 grouping is not available to the practitioner the time of the mental health and well child visit. This is especially true of clients entering foster care as infants. Older children are able to offer information on their own health histories while biological family history is often limited. Most referrals for this grouping were made to Infant and Toddlers for evaluation and habilitation care (PT/OT/ST/and delayed development).

Figure 4. Clinical Exam Analysis Detail for Ages 0-5

0-5 Grouping Total Cohort Members: 25	2017	2018	2019	Program Compliance
Well-child clinical component				
Health History and Development				
* Medical and family history update	see narrative	see narrative	see narrative	
*Psycho-social/environmental update	3	31	30	100%
*Developmental surveillance	3	31	30	100%

0-5 Grouping Total Cohort Members: 25	2017	2018	2019	Program Compliance
* Mental health/behavioral assessment	3	31	30	100%
Physical Exam (A) Actual (E) Expected	(A) 10 (E) 13	(A)31 (E) 43	(A) 30 (E) 45	78.0%
*Systems physical exam-				
*Vision/hearing assessments	See narrative			
*Nutrition assessment				100%
*Blood pressure- >3 years				100%
Risk Assessments by questionnaire				
Lead assessment by questionnaire				100%
Tuberculosis				100%
Heart disease/cholesterol > 2 years				100%
Sexually Transmitted infection				N/A

Laboratory Tests				
Anemia				100%
Lead				100%
Dyslipidemia				
HIV				N/A
Other: vitamin D				N/A
Hepatitis C				100% when at risk
Immunizations				
History				See Timeliness worksheet
Health Education				

Age appropriate education/guidance				100%
Counsel/referral for identified problems	See narrative	See narrative	See narrative	
Dental education/referral			1 referral	See Narrative
Scheduled return visit				100%

Risk Assessments by questionnaire				
Lead assessment by questionnaire	NA	NA	NA	
Tuberculosis	3	2	0	29.4%
Heart disease/cholesterol	3	4	0	41.2%
Sexually Transmitted infection	3	4	1	47.0%
Anemia	2	2		23.5%
Laboratory Tests				
Dyslipidemia	2	3	0	29.4%
HIV	1	3	0	23.5%
Other: vitamin D	2	3	0	29.4%
Hepatitis C	1			
Immunizations				
History	1	2	1	23.5%
Health Education				
Age appropriate education/guidance	1	2	2	5.6%
Counsel/referral for identified problems				

Dental education/referral		1		5.9%
Scheduled return visit		1		5.9%

Figure 5. Clinical Exam Analysis Detail for Ages 18-20

Clinical 18+ Transitioning Group	2017	2018	2019	Program Compli-ance
Total cohort members= 7				
Well-child clinical components				
Health History and Development				
* Medical and family history update	5	3	3	64.7%
*Psycho-social/environmental update	5	6	3	82.4%
*Developmental surveillance	5	6	3	82.4%
* Mental health/behavioral assessment	5	3	3	64.7%
*Substance use assessment	5	3	3	64.7%
*Depression Screening	5	3	3	64.7%
Physical Exam				
*Systems exam- E=expected; A=actual	E-7 A-6	E-8 A-7	E-8 A-4	73.9%

*Vision/hearing assessments				see discussion
*Nutrition assessment		1		5.9%
*Blood pressure	6	7	3	94.1%

Risk Assessments by questionnaire				
Lead assessment by questionnaire	NA	NA	NA	
Tuberculosis	3	2	0	29.4%
Heart disease/cholesterol	3	4	0	41.2%
Sexually Transmitted infection	3	4	1	47.0%
Anemia	2	2		23.5%
Laboratory Tests				
Dyslipidemia	2	3	0	29.4%
HIV	1	3	0	23.5%
Other: vitamin D	2	3	0	29.4%
Hepatitis C	1			
Immunizations				
History	1	2	1	23.5%
Health Education				
Age appropriate education/guidance	1	2	2	5.6%
Counsel/referral for identified problems				
Dental education/referral		1		5.9%
Scheduled return visit		1		5.9%

Discussion

Dental referrals are only counted above if the child was referred by a primary care practitioner for non-preventive dental care. Due to the every six-month requirement for dental preventive care, these visits were not included in dental referrals. The reader can refer to the categorical worksheets to review dental periodicity at the individual client level. Other care referrals for transitioning youth include obstetrics (1), general surgery (1), and urology (1). Vision screening was done for all clients (100%) while hearing screening achieved a 42.9 percent compliance. In review of the scheduled return visit, six of the seven clients were in their transition year which may explain why only one client in this grouping was given a return appointment. Only one client, however, received information regarding transition to adult care. This is an opportunity to reinforce the importance of preventive health care as adults and to help clients achieve an orderly transition to adult care.

MATCH PROGRAM ADVOCACY

As briefly discussed in the introduction, the MATCH Program is focused upon providing health advocacy for the foster care client. MATCH care coordinators and case managers perform this role through the following activities:

- Attention to follow-up of specialty care or other referrals
- Follow-up relative to concern of physical findings at the time of physical examination
- Follow-up for non-ESPDT visits requested by a practitioner
- Anticipatory Guidance/Developmental Guidance offered to caregivers by the MATCH case manager or coordinator.

The following section of the paper reviews MATCH Program opportunities in performing these advocate functions. The analyst highlights opportunities assessed for categorical groupings in the tables below.

Figure 6. Examples of Opportunities for MATCH Program Advocacy for Children Ages 0-5, 6-17, and 18-20, Medically Fragile Children and Children with Moderate Behavioral Health Risk

	0-5 year grouping	6-17 grouping	18+ Transitioning	Medically fragile	Mod. Risk Beh. Health
Follow-up Specialty Care	• referral for mental health 11/17; appt not scheduled until 6/18. No assistance with obtaining WIC services • No assistance with obtaining KKI appointment Recommendation for child psych appt. 12/18; no assistance with obtaining appt. did not get appt. until 08/19. • Lack of f/u with neurology appt. • Generally no f/u documentation of I&T or Child Find Referrals	• Lack of follow-up of depression` • Lack of follow-up of speech therapy • Lack of mental health/behavioral health therapy to assess impact upon client's ability	• No assistance with follow-up of missed psych visit • follow-up of discontinued thyroid medication without lab follow-up • Review of medications during pregnancy • Follow-up of missed appts at KKI; client dismissed from therapy due to missed appts.	• Follow-up of missed appts. at KKI; client dismissed from therapy due to missed appts.	• No follow-up of KKI appts. • No f/u of gyn appt.

	0-5 year grouping	**6-17 grouping**	**18+ Transitioning**	Medically **fragile**	**Mod. Risk Beh. Health**
Follow-up of Care Giver Concerns	• No assistance with obtaining WIC services x2 caregivers • No assistance with obtaining immunization history • No assistance with obtaining clothing • Insurance coverage lapse • No assistance with information for obtaining financial resources for foster clients	N/A	N/A	N/A	• Concern for Mental health medication • Assistance with transportation requested by 3 caregivers • No assistance with insurance coverage lapse
Follow-up Anticipatory Guidance	• Offered by MATCH staff: Consistently-7 Inconsistently-1 Seldom-1 • Never-7	Offered by MATCH staff: Consistently-5 Inconsistently-9 Never-1	Offered by MATCH staff: Consistently-0 Inconsistently-1 Never-7	Offered by MATCH staff: Consistently: 4 Inconsistently: 8 Never-3	Offered by MATCH staff: Consistently-5 Inconsistently-9 Never-1
Follow-up visit with Non-EPSDT Visits	No f/u of scheduled visit for sickle cell No follow-up of microcephaly (written by staff as macrocephaly)	N/A	• No f/u of client with 2 yo-is client's child in care; any issues with care for toddler • No follow-up of untreated STI No follow-up of client needing		• No follow-up on unfilled prescriptions • No follow-up on flu shot and delayed immunizations • No follow-up on postpartum exam and infant care of ~ 2-month infant • Follow-up of new diagnosis of diabetes without counseling/guidance for self care

	0-5 year grouping	6-17 grouping	18+ Transitioning	Medically fragile	Mod. Risk Beh. Health
			postpar-tum exam or other services post delivery		• No input or knowledge regarding health status for reunification

Figure 6: Figure 6. Examples of Opportunities for MATCH Program Advocacy for Children with High Behavioral Health Risk

Follow-up of Specialty Care	Follow-up concerns of caregivers	Anticipatory Guidance	Follow-up of non-EPSDT related visits
• Follow-up of missed therapy visit not done	Multiple concerns with obtaining appoint-ments for both primary care and mental health	• Consistently-3 • Inconsistently-4 • Never-2 (dentition) 2 (AWOL) 2 No client reason noted	• Untreated STI-1 • Follow-up ensuring infant has health care provider and appointment for care

Discussion:

The tables above represent potential missed opportunities during MATCH encounters with caregivers or the foster client (18+ transitioning youth). The identified opportunities were abstracted from review of the documentation during physical or behavioral health visits. The analyst then reviewed the health care plan update correspondence sent to foster caregivers every six months for clients 0 to 3 years and annually for all ages thereafter. Included documentation for review occurred during 2017, 2018, and 2019. The analyst sought to find documentation in the health care update that denoted follow-up of an identified issue by the MATCH staff person. When the analyst did not find follow-up documentation in the health update, the telephone logs in eClinicalWorks were reviewed. The table documentation represents issues for which the analyst did not find follow-up by MATCH staff. More information about the missed opportunity can be found in the service worksheet comments section for each categorical grouping.

Each example noted is viewed as a situation in which follow-up was needed to avoid potential disruption to the client's health or foster care stability. For example, there were many missed visits however the visits noted here represent particularly important situations at a time when the client is vulnerable for adverse consequences. The analyst perceived follow-up important to ensure that an intervention prevented continued the vulnerability of the clients' health or circumstance.

An explanation regarding why MATCH follow-up was not done could be due to the timing of receipt of documentation from visits. When documentation is not received timely to align with the health plan update, the MATCH staff remains unaware of the situation leading to an opportunity for intervention. However, if these opportunities were assessed as potentially adverse upon the clients' wellbeing, the analyst expected documentation of follow-up in subsequent health plan updates, but none was found. This type of follow-up is an integral component of client advocacy. Further exploration of situations requiring MATCH staff follow-up may assist in ensuring that a declination in client health or foster care circumstance does not occur.

Another unsettling finding is that no caregiver concerns were articulated related to 6-17 age grouping, the transitioning youth group, nor the medically fragile group. The reviewer found the medically fragile group relatively stable in their health care and services. Only one situation was identified among this group where missed care was of concern. However, the client frequently transitioned between Baltimore and Washington D.C. for care thus making follow-up of this client's care very difficult. External to this case, it is plausible that care giver concerns exist. However, for the 6-17 age group and the 18+transitioning group, the analyst found multiple situations that were assessed worthy of concern by care givers. The fact that there were no documented instances related to caregiver concerns among these groups, importance of MATCH advocacy for these clients becomes paramount. The possibility does exist that caregivers have concerns but do not articulate them. However documentation indicating that caregiver concerns were assessed with an outcome indicating that there are no concerns or the concern(s) will be addressed by MATCH or collaboratively with BCDSS demonstrates that MATCH staff perform at a level align with the importance and scope of their advocacy role.

The act of health education, represented as offering anticipatory guidance, also demonstrates inconsistency in performance. The transitional youth, 18+ had the worst performance in this area. This finding is of concern as most of the group was in the transition period of care from pediatric to adult. One would anticipate that this grouping would benefit from understanding the anticipated health care to be expected during transition to adulthood.

The importance of MATCH advocacy responsibilities of follow-up of missed EPSDT opportunities, assessing and addressing caregiver/client concerns, and follow-up with progress related to treatment regimens are activities that need to be done on behalf of foster care clients. While barriers such as health plan update frequency, timeliness of documentation receipt from health care practitioners, and other client-issues such as refusal of care, MATCH case managers benefit from awareness of these issues. While the scope of obtaining information includes telephonic communication, this means is often unavailable due to the caregiver work outside of the home. The implementation of new mechanisms such as secure digital health updates may allow more and effective contacts with care givers. The analyst did note during documentation review many of the care givers did not follow the health update recommendations documented. MATCH staff knowledge of appointment dates would provide them the ability to know when appointments are missed. Additionally, the ability to have information for appointments that are not preventive care focused would also allow follow-up of non-preventive visits. Non-preventive care needs and follow-up require attention because if left unattended these conditions could attribute to further debility among currently vulnerable clients. Perhaps one of the largest efforts posed for the MATCH Program is to re-engineer its health status update process to enhance staff knowledge of current client information. Also, promotion of greater collaboration with BCDSS client social workers may be a helpful adjunct in addressing advocacy gaps.

Other Observations and Suggestions to Ameliorate Service and Clinical Program Gaps

Throughout the tenure of this project, the analyst captured notes regarding situations perceived as barriers to optimal service and/or care for foster clients. One of the avoidable causes of gaps in care was lapse in insurance coverage. The reader is referred to the comments section of the categorical service worksheets for review of individual cases. While lapse of insurance is highly disruptive, resolution of this issue does not appear complicated. A suggestion is a report that provides the termination date of each client. In addition, any client who transitions from foster care to kinship care is also listed on a monthly report that is distributed to MATCH case manager and care coordination staff. Any transitioning child's insurance account could be researched to ensure that insurance coverage is active. If insurance is not active due to a transition, the MATCH worker can provide outreach to ensure that the foster caregiver has contacted the appropriate agency such as HealthChoice in order to initiate insurance coverage by HealthChoice. This proactive approach is suggested as many foster caregivers are often unaware of a change in the clients' insurance coverage.

Another opportunity that is amenable to collaborative resolution between the health care provider and MATCH is the lack of alignment between health care updates and the receipt of documentation from health care and/or behavioral health providers. The development of a report indicating the month and time of the next appointment for MATCH worker caseloads could be processed one month in advance prior to the month of the visit. MATCH workers could proactively outreach to the caregiver to ensure that the caregiver is aware of the appointment and has no barriers to attendance. Another alternative is to reach out after the appointment date to the provider location to confirm that the appointment was attended. If the appointment was not attended, this type of follow-up affords the MATCH worker proximal outreach opportunity to assist the caregiver to obtain an appointment relatively close to the missed appointment. This activity can also support timely immunizations and screenings.

The MATCH staff could work with BCDSS staff to help ensure that client information such as immunization records or hospitalization discharge information, when applicable, is present at the time of the Mental Health evaluation, Infant and Toddlers evaluation, and/or the comprehensive visit. Practitioners reviewing and examining foster clients for the first time are often disadvantaged due to a lack of health information about the foster client. This lack of information often hampers treatment needs as practitioners often reschedule the client for potentially needed clinical care external to the physical exam. Collaboration and communication between BCDSS and MATCH regarding scheduling for the comprehensive exam, mental health exam, or any specialty care exam allows MATCH to facilitate needed client information exchange to enhance the thoroughness and efficiency of initial visits of the foster care journey. Enhanced advocacy for foster care clients is viewed as an adjunct to the advocacy functions of MATCH as previously discussed.

There are other opportunities discussed in previous sections of the paper. One opportunity that has not been mentioned previously is the capture of more opportunities through review of the cases. Opportunities identified by the analyst do not appear to have been perceived as requiring follow-up by the MATCH staff. For example, one of the transitioning teens had a two year old. From the analyst's perspective, there should have been a brief assessment regarding the child's health. Questions such as how has your child's health been, where is he seen, appropriate developmental questions, and when is the next appointment, can be alerts for a well child verses a child in need of intervention. However, from review of the documentation the analyst did not find any reference to the child's health. Another example is a transitioning youth who had an infant. The analyst did not find documentation regarding the infant's health or health care nor questions about the services such as WIC or infant care needs including the client's support system. The analyst also did not find evidence of questioning about the

postpartum appointment or counseling regarding the importance of attending the appointment. Other examples can be found on the categorical service worksheets.

A periodic case review forum may be helpful to identify potential missed opportunities. MATCH staff caseload volume may make implementation of this process difficult. Therefore, one strategy to address this is to start with care coordination cases and proceed to a review process for licensed staff. Another strategy for consideration is the development of a prioritized systematic follow-up process. Collaboration with BCDSS on follow-up issues may assist MATCH with addressing opportunities that have a potential impact on health such as lack of transportation to health appointments.

Final Thoughts

This report reviews the care and services provided to foster clients through the collaboration of Health Care Access Maryland and BCDSS. HCAM, through its MATCH Program, provides coordination and advocacy for the health of foster clients. The ability to work with a team of health practitioners, health providers, BCDSS staff, and other public health resources as needed highlights the skills needed by the MATCH staff to achieve the responsibilities of health coordination and health advocacy. MATCH performs these responsibilities in a manner that fulfills the required duties. However, there are factors that are external to the MATCH which impact their ability to perform consistently at the highest level of service. Changes in the timeliness of information sharing and identification of opportunities that potentially impact the level of service or care coordination provided by MATCH can enhance the current performance. Due to variances in the diversity of ages, required preventive services within a category of care, and client factors, the reader should be careful to interpret the outcome percentages with these factors in mind. Throughout the report, analyst has attempted to highlight the multitude of factors that impact MATCH performance. Re-engineering some processes as well as enhanced collaboration with BCDSS may enhance MATCH's ability to perform at a consistently high level. The findings in this report are intended to be viewed as a catalyst for thought of alternative mechanisms to coordinate health services and care that are targeted to identify opportunities that prevent potential adverse impacts to client health and associated services.

Further discussion of questions related to the report findings or consideration initiatives for improvement may be directed to the Independent Verification Agent who sponsored the study.

APPENDIX I

SERVICE AND CLINICAL WORKSHEETS BY MATCH PROGRAM CATEGORICAL GROUPING

Ages 0-5 Grouping

0-5 Grouping	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Toddler Referral	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual) (yes or no)	Comment
A	4	4	14	yes	n/a; under 1 year at DOE	4	2	yes	no	DOE: 5/18/18 WCC exam 4 mo and 12 mo not found. DOB: 5/9/18
B	3	14	18	yes	yes	3	0	yes	no; missing 9/2018 dental exam	DOE: 12/14/2017 DOB: 6/9/15
C	9	64	19	n/a	yes	2	1	yes	no; missing dental 10/18; 4/19 dental late and done 6/6/19	DOE: 02/23/2018 DOB: 5/14/2015
D	11	26	11	n/a	yes	1	2	yes	no; dental for 2019 not found	DOE: 10/27/17 no other WCC documented DOB: 4/4/2014
E	3	12	22	yes	yes	2	1	yes	no; 2/2019 dental exam not found	DOE: 7/6/2018 missing 30 mo visit DOB: 8/9/2016
F	10	30	20	yes	n/a; under 1 year at DOE	4	4	yes	no; dental exam due 2/2019 not done until 9/11/2019	DOE: 04/14/2017 missed 6, 12, 15, 18 mo

Ages 0-5 Grouping

0-5 Grouping	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Toddler Referral	DOE to Comp Dental (<= 60 days) (yes or no)		Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual) (yes or no)	Comment
											DOB: 3/23/2017
G	2	26	22	n/a	yes		3	0	yes	no; dental exam due 2/2018 not found	DOE: 7/26/2017 DOB: 10/05/2013
H	na-entered into care from birth	15	no MH eval found	n/a	n/a under 1 year at DOE		4	3	yes	no dental exams found	DOE:05/29/18 missed 4, 6, 18 mo DOB: 5/29/2018
I	10	4	0	yes	Yes		2	1	yes	no; dental due for 4/20 was late; done 6/13/2019	DOE: 10/2/2018; missed 36 mo DOB: 10/6/2016
J	5	32	16	n/a	Yes		2	3	no	no dental exams found Aug/Sept 2017; Feb/Mar 2018; nor any time in 2019.	DOE: 1/12/2017; no 30 mo, 36 mo, 4 yo DOB: 6/11/2015
K	n/a entered care	15	25	n/a	n/a under 1		3	2	no	n/a-not due until~ 6/2020	DOE: 12/13/2018 Missing 6 mo, 1 year

Ages 0-5 Grouping

0-5 Grouping	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Toddler Referral	DOE to Comp Dental (<= 60 days) (yes or no)		Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual) (yes or no)	Comment
	from birth				year at DOE						DOB: 12/5/2018
L	2	18	22	n/a	yes		1	1	no	no; dental 10/19 not found	DOE: 10/03/2018; no evidence of 11/19 WCC DOB: 4/17/2015
M	2	6	18	yes	yes		2	0	yes	no dental found for 2019	DOE: 01/29/2019 DOB: 4/27/2015
N	4	30	16	yes	yes		4	1	yes	yes	DOE: 07/11/2018; no evidence of 24 mo. exam DOB: 12/7/2017
O	n/a entered care from birth	5	17	n/a	n/a; under 1 year at DOE		5	2	yes	n/a; age	DOE:08/01/18 9 and 15 mo missing DOB: 7/30/2018
P	3	24	18	n/a	n/a; under 1		2	3	no	n/a, age	DOE: 01/28/2019

Ages 0-5 Grouping

0-5 Grouping	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Toddler Referral	DOE to Comp Dental (<= 60 days) (yes or no)		Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual) (yes or no)	Comment
					year at DOE						9 mo, 1 yr, 15 mo missing DOB: 8/21/18
Q	n/a entered care from birth	3	24	n/a	n/a; under 1 year at DOE		5	0	yes	n/a; age	DOE: 11/05/2018 DOB: 10/14/2018; left FC 8/27/19
R	1	27	14	n/a	n/a; under 1 year at DOE		6	0	yes	n/a; age	DOE: 01/24/2019 DOB:10/11/2018
S	n/a entered care from birth	n/a entered before 2017	n/a entered before 2017	entered before 2017	n/a entered before 2017		6	2	yes	yes	DOE: 07/22/2016 9 month and 30 month visit not found DOB: 7/22/16
T	3	25	16	n/a	yes		2	1	No, did not return for catch-up immun. nurse visit	yes	DOE: 09/29/2017; No WCC visits found for 2019 DOB: 2/18/2015
U	3	14	22	n/a	yes		2	1	yes	yes	DOE: 08/25/17 Missing 36 mo DOB: 1/5/2015

Ages 0-5 Grouping

0-5 Group ing	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Tod-dler Referral	DOE to Comp Dental (<= 60 days) (yes or no)		Timely EPSDT Vi-sits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immuniza-tions Up-to-Date	Dental Perio-dicity (semi-annual) (yes or no)	Comment
V	2	13	10	n/a	yes		1	0	yes	no; Nov 2019 dental not found	DOE: 05/24/2019 DOB: 07/29/2015
W	4	13	18	n/a	yes		2	1	yes	yes	DOE: 09/22/2018 Missing 30 month vist DOB: 9/03/2016
X	5	22	17	n/a	yes		2	0	yes	no; Feb 2019 dental exam not found	DOE: 7/20/2018 DOB: 08/5/2014
Z*	3	11	21	yes	n/a; un-der 1 year at DOE		5	4	yes	No; missing dental for 7/2019	DOE: 11/3/17 DOB:10/31/17

* Child Y was removed from the cases reviewed due to insufficient file information.

Ages 0-5 Grouping

Ages 0-5 Total Cases: 25	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Toddler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Visits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual)
Entry 2017-2019 Total = 24							Total Expected EPSDT Visits: 102			
Compliant	16	23	23	8	15		69	0	19	4
Non-Compliant	4	1	1	0	0		0	33	5	15
N/A	**4**	**0**	**0**	**16**	**9**		**0**	**0**	**0**	**5**
Compliance Rate	80%	96%	96%	100%	100%		68% Timely	32% Untimely or Missing	79%	21%
Entry pre-2017 Total = 1							Total Expected EPSDT Visits: 8			
Compliant	NA	NA	NA	NA	NA		6	0	1	1
Non-Compliant	NA	NA	NA	NA	NA		0	2	0	0
N/A	NA	NA	NA	NA	NA		0	0	0	0
Compliance Rate	NA	NA	NA	NA	NA		75% Timely	25% Untimely or Missing	100%	100%
Total Ages 0-5 =25							**Total Expected EPSDT Visits =110**			
Total Compliance Rates	**80%**	**96%**	**96%**	100%	100%		**68% Timely**	**32% Untimely or Missing**	**80%**	**25%**

Ages 6-17 Grouping

6 - 17 GROUPING ID	**DOE to Initial Exam** (days)	**DOE to Comp Med Exam** (days)	**DOE to MH Exam** (days)	**DOE to Comp Dental (<= 60 days) (yes or no)**	**Timely EPSDT Visits** (# visits)	**Untimely or missing EPSDT Visits** (# visits)	**Immunizations** Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
A	42	48	47	no	1	1	no	No dental after 10/18	DOE: 07/18/2018; no evidence of 2019 WCC reunified 12/2/19
B	9	18	11	yes	1	0	no	N/A- time in program only allowed for initial compliance	DOE: 06/28/2019
C	3	9	16	yes	2	0	Yes	yes	DOE: 11/12/2018
D	n/a	n/a	n/a	n/a	3	0	yes	no	DOE 2013 therefore started with 2017 information
F*	n/a	n/a	n/a	n/a	3	0	no	no; missed dental October 2018 and April 2019	DOE: 12/20/2012
G	1	18	18	no	1	0	no- no confirmation of immunizations	no; missed dental for April 2019; dental visit done 6/17/19; no dental visit found for 12/19.	DOE: 5/23/2019
H	n/a	n/a	n/a	n/a	2	1	yes	no; dental visit due 3/2018 not found.	DOE: 12/15/2016; other client's info

Ages 6-17 Grouping

6 - 17 GROUPING ID	**DOE to Initial Exam** (days)	**DOE to Comp Med Exam** (days)	**DOE to MH Exam** (days)	**DOE to Comp Dental (<= 60 days) (yes or no)**	**Timely EPSDT Visits** (# visits)	**Untimely or missing EPSDT Visits** (# visits)	**Immunizations** Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
									in chart; no WCC 2019; reunif 6/19
I	n/a	n/a	n/a	n/a	3	0	yes	No; visits due 9/17, 3/18 not found	DOE: 07/26/2016
J	2	16	14	no	1	1	yes	No; missing dental for 2/19	DOE: 08/21/2018; wrong client info in chart; WCC visit for 2019 not found
K	3	32	11	yes	2	0	yes	Yes	DOE: 11/24/2017 No evidence of f/u for speech evaluation
L	1	10	15	yes	1	0	yes	Yes	DOE: 10/3/2018; child reunified before WCC due in October 2019
M	0	15	9	yes	1	0	yes	N/A; next dental exam April 2020;	DOE: 09/17/2019
O*	n/a	n/a	n/a	n/a	2	1	no	No	DOE: 07/26/2016; no 2019 WCC

* Children E and N were removed from the cases reviewed due to insufficient file information.

Ages 6-17 Grouping

Ages 6-17 Total Cases: 13	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Toddler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Visits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual)
Entry 2017-2019 Total = 8							Total Expected EPSDT Visits: 12			
Compliant	6	8	8	NA	5		10	0	5	3
Non-Compliant	2	0	0	NA	3		0	2	3	3
N/A	**0**	**0**	**0**	NA	**0**		**0**	**0**	**0**	**2**
Compliance Rate	75%	100 %	100%	NA	62.5%		83% Timely	17% Untimely or Missing	62.5%	50%
Entry pre-2017 Total =5							Total Expected EPSDT Visits: 15			
Compliant	NA	NA	NA	NA	NA		13	0	3	0
Non-Compliant	NA	NA	NA	NA	NA		0	2	2	5
N/A	NA	NA	NA	NA	NA		0	0	0	0
Compliance Rate	NA	NA	NA	NA	NA		87% Timely	13% Untimely	60%	0%
Total Ages 0-5 =13							**Total Expected EPSDT Visits =27**			
Total Compliance Rates	**75%**	**100%**	**100%**	NA	62.5%		**85% Timely**	**15% Untimely or Missing**	**62%**	**27%**

Ages 6-17 Grouping

MODERATE RISK BEHAVIORAL HEALTH ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
A	4	37	65	yes	1	1	yes	no; no dental exams found after 5/25/2018	DOE: 04/25/2018 No WCC visit for 2019
B	36	36	19	yes	1	0	yes	no exam due 12/2019; not found	DOE: 05/7/2019
C	3	14	4	yes	2	0	yes	no; missed 7/2018 dental exam	DOE: 3/6/2018
D	4	17	9	yes	1	0	no	yes	DOE: 12/21/2018
E	4	46	17	yes	2	0	yes	No; client missed appt. for dental and vision due to no insurance	DOE: 05/14/2018
F	2	23	12	Yes	2	1	yes	no; missed dental visit for 4/19; had appt 6/27/19	DOE: 08/29/17
G	9	42	10	yes	1	0	yes	n/a: next dental due Feb 2020 which is	DOE: 06/27/2019 next dental due 2/2020; next WCC; 7/2020

Moderate Behavioral Risk Grouping

MODERATE RISK BEHAVIORAL HEALTH ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
								not in scope for study.	
H	2	25	20	yes	2	1	yes	no; dental visit due 12/17 and no dental visits for 2018 found	DOE: 05/3/2017 became pregnant 2/19. no WCC in 2018. did not have PP appt after delivery. Delivered July 2019.
I	n/a	n/a	n/a	n/a	3	0	yes	yes	DOE: 10/26/2011
J	n/a	n/a	n/a	n/a	2	1	Yes	no; dental visit 12/17 not found	DOE: 06/16/16 WCC 2017 missing;
L*	n/a	n/a	n/a	n/a	2	1	yes	No; missing dental exam for 11/20/2018	DOE: 08/11/2014 missing WCC exam for 2019.
M	n/a	n/a	n/a	n/a	0	3	no	no; missing dental exam 12/2017	DOE: 04/23/2003 client aged out in 2019 but no WCC noted since 2016.

Moderate Behavioral Risk Grouping

MODERATE RISK BEHAVIORAL HEALTH ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
N	n/a	n/a	n/a	n/a	3	0	yes	no; no dental exams found for 2017 or 2018.	DOE: 11/03/2015
O	4	26	20	yes	2	0	yes	no; No evidence of July/Aug 2018 dental visit.	DOE: 01/03/2018
P	1	17	6	yes	1	0	yes	no; dental exam 11/19 not found in chart	DOE 5/16/2019
Q	no initial exam found	12	17	yes	2	0	yes	no; no dental exam found after 5/2/2018	DOE: 03/24/2018
R	1	26	6	yes	1	0	yes	n/a; none due until 2020	DOE: 09/12/2019
S	0	22	8	yes	2	1	yes	no missing dental exam 09/17	DOE: 03/21/2017 missing 2019 WCC

* Child K was removed from the case reviews due to insufficient file information.

Moderate Behavioral Risk Grouping

Moderate Behavioral Risk Total Cases: 18	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Toddler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Visits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immuniza-tions Up-to-Date	Dental Perio-dicity (semi-annual)
Entry 2017-2019 Total = 13							Total Expected EPSDT Vis-its: 24			
Compliant	10	13	13	NA	13		20	0	12	1
Non-Compli-ant	3	0	0	NA	0		0	4	1	10
N/A	**0**	**0**	**0**	NA	**0**		**0**	**0**	**0**	**2**
Compliance Rate	77%	100 %	100%	NA	100%		83% Timely	17% Untimely or Missing	92%	9%
Entry pre-2017 Total =5							Total Expected EPSDT Vis-its: 15			
Compliant	NA	NA	NA	NA	NA		10	0	4	1
Non-Compli-ant	NA	NA	NA	NA	NA		0	5	1	4
N/A	NA	NA	NA	NA	NA		0	0	0	0
Compliance Rate	NA	NA	NA	NA	NA		67% Timely	33% Untimely or Missing	80%	20%
Total Mod. Behavioral Risk=18							Total Expected EPSDT Visits =39			

Moderate Behavioral Risk Grouping

Moderate Behavioral Risk Total Cases: 18	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Toddler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Visits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual)
Total Compliance Rates	77%	100%	100%	NA	100%		77% Timely	23% Untimely or Missing	89%	12.5%

Hi Risk Behavioral Health ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Periodicity (semi-annual) (yes or no)	Comment
A	2	83	2	yes	0	2	no	no	DOE: 12/28/2017 Appt was delayed from 1/29/18 due to PCP availability. 5/29/19 visit was not found in medical documentation.
B	n/a	n/a	n/a	n/a	2	1	no	no; documentation of dental not found except 12/13/18	DOE: 06/10/2014; client was detained in juvenile corrections 2018
C	2	42	30	yes	1	1	no	no; dental visit for 2/19 not found	DOE :1/18/2018. WCC for 2/2019 was not found in medical docu-

High Behavioral Risk Grouping

HI RISK BEHAVIORAL HEALTH ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
									mentation; multiple runaway episodes
D	n/a	n/a	n/a	n/a	2	1	yes	no; No dental visit for 2017 found	DOE: 04/15/2014. Missing 2019 WCC
E	6	>5 month	18	1	1	2	no	no; dental visit of 3/2018 or 11/2018 was not found in medical documentation	DOE: 08/31/2017 missed comprehensive examX2 visit 1/8. No WCC 2019
F	n/a	n/a	n/a	n/a	2	1	yes	no; no dental visits found 2019;	DOE: 11/13/2014 missing WCC exam for 2018.
G	2	13	13	yes	1	0	yes	n/a	DOE: 06/18/2019
H	n/a	n/a	n/a	n/a	2	1	yes	no; dental visit of 6/19 was not found in documentation	DOE: 09/09/2015 late 2019 WCC
I	No not found in chart. Entered	13	11	yes	1	0	no	no: dental exams of 6/17 and 10/18 were not found in documentation	DOE: 03/13/2019

High Behavioral Risk Grouping

Hi Risk Behavioral Health ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
	care after mental health admission								
J	5	5	16	yes	2	0	yes	no; dental exam of 3/19 not found in documentation	DOE: 08/20/2018 Brief runaway periods
K	n/a	n/a	n/a	n/a	2	1	no	no; no dental visit found for 3/18	DOE: 12/10/12 No WCC found in 2018
L	n/a	n/a	n/a	n/a	2	1	no	no; client refused dental care after 2/3/17	DOE: 03/2/2015 Missing 2019 WCC
M	0	44	11	yes	2	1	no	no; dental exam for 11 or 12/2018 was not found in medical documentation.	DOE: 5/1/2017 had a delay in comp physical exam which was scheduled 5/1/17; had exam 6/30/2017. No 2019 WCC

High Behavioral Risk Grouping

High Behavioral Risk Grouping

High Behavioral Risk Total Cases: 13	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Toddler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Visits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual)
Entry 2017-2019 Total = 7							Total Expected EPSDT Visits: 18			
Compliant	5	6	7	NA	7		12	0	2	2
Non-Compliant	2	1	0	NA	0		0	6	5	4
N/A	0	0	0	NA	0		0	0	0	1
Compliance Rate	71%	86%	100%	NA	100%		67% Timely	33% Untimely or Missing	29%	33%
Entry pre-2017 Total =6							Total Expected EPSDT Visits: 14			
Compliant	NA	NA	NA	NA	NA		8	0	3	0
Non-Compliant	NA	NA	NA	NA	NA		0	6	3	6
N/A	NA	NA	NA	NA	NA		0	0	0	0
Compliance Rate	NA	NA	NA	NA	NA		57% Timely	43% Untimely or Missing	50%	0%
Total High Behavioral Risk=13				NA	100%		Total Expected EPSDT Visits =32			

High Behavioral Risk Grouping

Compliance Rate	71%	86%	100%	NA	100%		62.5%	38.5%	17%

TRANSITIONAL YOUTH 18+ GROUPING ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
A	n/a	n/a	n/a	n/a	2	1	yes	no; Dental visit UTD until 2019; no visits found for 2019.	DOE: 07/14/2013 No WCC visit for 2019 found.
B	2	18	20	yes	1	1	no	no; Dental exam for 2019 should have occurred between May/June 2019 but was done in Aug 2019.	DOE: 10/11/2018 No 2019 WCC
C	n/a	n/a	n/a	n/a	1	2	no	no; Dental exam for March 2018 and March 2019 not found.	DOE: 11/08/2013 WCC exams for 2017 and 2019 not found.
D	n/a	n/a	n/a	n/a	2	1	yes	no; missed dental for 6/2018 and Jan 2019;	DOE: 10/12/2015 WCC exam missing 2018. Early exam in 2019 due to pregnancy. Refused flu shot at this exam but did

Transitional Youth Grouping

TRANSITIONAL YOUTH 18+ GROUPING ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
									receive Tdap booster. Delivered in 7/2019 but no PP exam found or information re: infant's health or immunization status.
E	n/a	n/a	n/a	n/a	2	1	yes	no; No dental exams found for 2018; one for2017;	DOE: 02/27/2016 WCC no visit noted for 2019,
F	n/a	n/a	n/a	n/a	1	2	yes	No; missed dental f/u 8/18 but child was AWOL; only one dental visit recorded for 2019;	DOE: 06/29/2004 several runaway periods; 12/12/16-5/11/17; 5/11/17-9/14/18; multi-ple runaway pe-riod between 2014-2016; no WCC recorded for 2017 and 2019.
G	n/a	n/a	n/a	n/a	1	2	yes	no; dental for 7/17 and 1/18	DOE: 07/14/2014 missing EPSDT for 2018 and 2019.

Transitional Youth Grouping

Transitional Youth Total Cases: 7	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Tod-dler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Vi-sits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immuniza-tions Up-to-Date	Dental Pe-riodicity (semi-an-nual)
Entry 2017-2019 Total = 1							Total Expected EPSDT Visits: 2			
Compliant	1	1	1	NA	0		1	0	0	0
Non-Compli-ant	0	0	0	NA	1		0	1	1	1
N/A	**0**	**0**	**0**	NA	**0**		**0**	**0**	**0**	**0**
Compliance Rate	100%	100%	100%	NA	0%		50% Timely	50% Untimely or Missing	0%	0%
Entry pre-2017 Total =6							Total Expected EPSDT Visits: 18			
Compliant	NA	NA	NA	NA	NA		9	0	5	0
Non-Compli-ant	NA	NA	NA	NA	NA		0	9	1	6
N/A	NA	NA	NA	NA	NA		0	0	0	0
Compliance Rate	NA	NA	NA	NA	NA		50% Timely	50% Untimely or Missing	83%	0%
Total Transi-tional Youth=7							**Total Expected EPSDT Visits =20**			

Transitional Youth Grouping

Transitional Youth Total Cases: 7	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Toddler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Visits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual)
Total Compliance Rates	100%	100%	100%	NA	0%		50% Timely	50% Untimely or Missing	71%	0%

MEDICALLY FRAGILE GROUPING ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Toddler Referral	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Periodicity (semi-annual) (yes or no)	Comment
A	n/a	n/a	n/a	n/a (age)		1	2	No	no; Dental exam for 4/2018 late; occurred 06/23/18; Dental exam for 12/2018 not found in chart.	DOE: 04/12/2011 WCC for 2018 and 2019 not found in records. DOB: 9/23/04
B	n/a-entered care from birth;	8	No	n/a		2	1	Yes	n/a	DOE: 08/13/2019 MH assessment not found in chart; prolonged hospitalization from 08/13-30/2019 DOB 8/13/19. No

Medically Fragile Grouping

MEDICALLY FRAGILE GROUPING ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Toddler Referral	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Periodicity (semi-annual) (yes or no)	Comment
										timely 4 mo exam.
C	5	38	5	n/a (age)		2	0	yes	no; only dental exam found was 08/02/2018	DOE: 06/18/18 DOB 9/19/08
D	n/a	n/a	n/a	n/a (age)		2	0	**Yes**	**no: Did not get dental 04/20/19 due to incorrect paperwork. visit due 10/18 not found**	DOE: 09/05/2001 Due for WCC in 12/2019 DOB 8/9/2000
E	n/a, client entered from hospital	38	n/a hospitalized	Yes	n/a	4	2	**yes**	n/a	DOE: 10/4/2018 Ex 28 weeker with lots of specialty care. Admitted July 19, 2018- 11/29/18. Missing 18 and late 30 mo DOB: 1/24/18
F	not found in chart	10	18	n/a	n/a	4	1	Yes	no; Sept 2018 dental visit not found;	DOE:02/22/2018 WCC for 09/2018 not found. Not clear but client

Medically Fragile Grouping

MEDICALLY FRAGILE GROUPING ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Toddler Referral	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Periodicity (semi-annual) (yes or no)	Comment
										may have been hospitalized at during 09/2018. Multiple specialty care. Misssed 18 mo DOB 3/7/17
G	n/a- client entered care after prolonged hospital stay	4	19	Yes	yes	3	1	Yes	n/a-infant who will start dental care ~4/2020	DOE: 06/3/2019 prematurity@33 weeks and cardiac anoma-ly Incorrect WCC schedule on appointment log sheet sent to foster parent. 9 mo visit missing DOB 3/30/19
H	n/a, hospitalized at time of entry	15	19	Yes	n/a	4	3	Yes	No; August 2018 dental visit not found	DOE: 07/28/2017 Open heart surgery on entry DOB 2/25/17
I	12	19	13	n/a (age)	n/a, hospitalized	1	0	Yes	No; 10/19 dental exam not found in chart	DOE: 08/28/2018; DOB 3/4/03

Medically Fragile Grouping

MEDICALLY FRAGILE GROUPING ID	DOE to Initial Exam (days)	DOE to Comp Med Exam (days)	DOE to MH Exam (days)	Infant &Toddler Referral	DOE to Comp Dental (<= 60 days) (yes or no)	Timely EPSDT Visits (# visits)	Untimely or missing EPSDT Visits (# visits)	Immunizations Up-to-Date (yes or no)	Dental Perio-dicity (semi-annual) (yes or no)	Comment
J	n/a	n/a	n/a	n/a (age)	yes	3	0	Yes	no dental exams found for 2019	DOE: 08/20/2016 DOB 7/31/99
K	2	11	14	n/a (age)	n/a	1	0	No	yes	DOE: 03/20/2019 sickle cell DOB 3/27/15
L	1	12	20	n/a (age)	n/a	2	0	Yes	Yes	DOE: 11/29/2017 DOB 3/2/07
M	n/a	n/a	n/a	n/a (age)	Yes	2	1	Yes	Yes	DOE: 06/2/2016 DOB 9/30/07 No well child visit found for 2017.
N	2	23	20	n/a (age)	n/a	1	1	Yes	No; one dental exam found 11/12/2018.	DOE: 10/3/2018 DOB 1/30/09 WCC for 2019 not found in record.
O	n/a	n/a	n/a	n/a (age)	yes	3	0	yes	no; dental visit due 9/17 not found	DOE: 08/15/2016 DOB 2/14/11

Medically Fragile Grouping

Medically Fragile Grouping

Medically Fragile Total Cases: 15	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Toddler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Visits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immunizations Up-to-Date	Dental Periodicity (semi-annual)
Entry 2017-2019 Total = 10							Total Expected EPSDT Visits: 33			
Compliant	5	10	8	3	6		24	0	9	3
Non-Compliant	1	0	1	0	0		0	9	1	4
N/A	4	0	1	7	4		0	0	0	3
Compliance Rate	83%	100%	89%	100%	100%		73% Timely	27% Untimely or Missing	90%	43%
Entry pre-2017 Total = 5							Total Expected EPSDT Visits: 14			
Compliant	NA	NA	NA	NA	NA		11	0	4	1
Non-Compliant	NA	NA	NA	NA	NA		0	3	1	4
N/A	NA	NA	NA	NA	NA		0	0	0	0
Compliance Rate	NA	NA	NA	NA	NA		79% Timely	21% Untimely or Missing	80%	10%
Total Med. Fragile=15							**Total Expected EPSDT Visits = 47**			

Medically Fragile Grouping

Medically Fragile Total Cases: 15	DOE to Initial Exam (<= 5 days)	DOE to Comp Med Exam (<= 60 days)	DOE to MH Exam (<= 60 days)	Infant &Toddler Referral (<= 30 days)	DOE to Comp Dental (<= 60 days)		Timely EPSDT Visits (# visits)	Untimely or Missing EPSDT Visits (# visits)	Immuniza-tions Up-to-Date	Dental Perio-dicity (semi-annual)
Total Com-pliance Rates	83%	100%	89%	100%	100%		74.5% Timely	25.5% Un-timely or Missing	87%	33%

APPENDIX II

JENINE WOODWARD CV

Jéniné R. Woodward

Summary:

(6) An accomplished Medical Services Professional with over 30 years of experience professional in management areas of responsibility include compliance, risk and quality management, utilization management including risk assessment and case management, clinical claims resolution, health care planning, implementation and program evaluation, health data analyses, research and compilation of policy white papers, health policy analyses, information systems analyses for specific health programs and functions, and direct patient care in reproductive nursing and care of the normal and ill newborn.

j. She consulted with various managed care organizations and delivery systems in the areas of accreditation preparation, quality improvement initiatives targeted to improve clinical practice operations, customer and practitioner satisfaction, and HEDIS interventions.

(7) She held management positions within the acute hospital setting, health insurance and managed care industry, population and community health, accreditation and quality improvement organizations, and nonpartisan health research organizations.

(8) Her skills acquired in leadership, quality operations, measurement, and evaluation, risk assessment, budgeting, results-oriented management, training, teaching, and technical writing are easily transfer-able to any domain within health care.

Certifications:

❖ Member of Ambulatory Board of Quality and Utilization Review Physicians, Diplomat status, successfully completed the Health Care Quality Management Examination September 28, 2013.

❖ National Association of Health Care Quality, Certified Professional in Healthcare Quality, Jan. 2000. (now lapsed voluntarily due to quest to seek a more rigorous certification within quality)

Professional Presentations:

❖ Bridge Back to Quality, New York State Department of Social Services, 1994

❖ Healthcare to Indigent Populations, New York City Hospital for Reconstructive Surgery, 1995

❖ Providing Health care to Indigent Populations, American Public Health Association, 1995

❖ Providing Care to Medicaid Populations, American Association of Health Plans, 1999

Education:

❖ Courses toward Ph.D. in evaluation, research, measurement and Statistics University of Maryland, College Park, MD

❖ Master's in Public Administration in Health Care Administration, Policy and Finance, University of Baltimore, Balti-more, MD

❖ Certificate Program in Management, University of Baltimore, Baltimore, MD

❖ Master's in Public Health and Nurse Midwifery Certification, Bloomberg School of Public Health, Baltimore, MD

❖ Bachelors of Science in Nursing, University of Maryland, College Park, MD

Professional Experience:

Mindlance Professional Recruitment, New Jersey July 2019-Present

Federal Employee Program Analyst

- Perform quality improvement data analyses for the FEP health program
- Participate in and/or develop quality improvement initiatives
- Evidence-based research initiative
- Design data needs reports and work with various data applications to process reports
- Prepare presentations for assist others in the organization understand HEDIS and Federal Quality, Customer Service, and Resource/utilization metrics

- Other requests or initiatives identified

,MATCH Program, Health Care Access Maryland, Baltimore, MD — Mar 2019 – July 2019
RN Medical Case Manager
- Coordinate preventive services for foster care children ages 0-5 years.
- Develop health care plans to ensure foster children receive recommended care.
- Coordinate with health care practitioners to articulate identified health needs of foster care clients.
- Complete data screens for reporting purposes.
- Research medical conditions relevant to health care clientele in foster care.

AmeriHealth Caritas Delaware, Baltimore, MD — Dec 2017 – Oct 2018
Director for Care Coordination
- Develop operations workflow for the department.
- Trained staff relative to high quality care coordination operations.
- Policy and procedure development.
- Implemented integration of utilization management and care coordination rounds to enhance the transition of care process.
- Integrated NCQA and HEDIS standards and measures into the care coordination process.
- Prepared program documentation for external quality review organization (EQRO) review.
- Data analysis and research to demonstrate department efforts toward managing the population served and integration of evidence-based interventions to support subpopulations evidencing particular care needs.
- Revised the model of care to meet the identified needs of members more effectively.
- Participated in developing a statewide model intended to serve medically fragile children.
- Worked with acute physical and behavioral health hospitals to incorporate care coordination efforts targeted to promote more effective transition of care processes.

Evergreen Health Care, Baltimore, MD — Jul 2014 – Dec 2017
Senior Director for Utilization Management and Quality
- Planning, development, implementation, monitoring, evaluation, oversight of operations of utilization management programs.
- Planning, development, implementation, monitoring, evaluation, oversight of operations of quality management programs.
- Training of professional and support staff using formal orientation programs and informal "just in time" training to meet the demands imposed by regulators, accreditation bodies, and internal executive management in support of agile, effective, and efficient adaptation to change.
- Internal consulting to other departments for enhancement of process improvement activities, development of program goals and quantitative metrics to assess departmental performance and root cause analyses for identification of barriers to expected achievement.
- Data analyses and research in support of improved efficiency in operations and outcomes relative to accreditation activities, program operating procedures, policy and procedure development, evaluation of program effectiveness, quality improvement studies.
- Abstracted claims data and performed data analysis for NCQA QI 9, 10, and 11.
- Prepare analysis and documentation for NCQA accreditation.
- Attended quality subcommittees and drafted minutes for the same.
- Prepared utilization management documentation for NCQA.
- Conducted "gap analysis" of the clinical behavioral health programs and initiated efforts to address those gaps.
- Drafted business rules for utilization review in collaboration with the compliance department of Ever-green.
- Prepared a concept document related to delegation responsibilities of a health plan.
- Prepared a four week orientation program for utilization review nurses and support staff.

Hilltop Institute- UMBC, Baltimore, MD — Apr 2012 – Jul 2015
Senior Policy Analyst

k. Perform research either collaboratively or independently with the Health Research and Policy Team of Hilltop Institute.

l. Functions as the quality measures expert for the Institute and uses research skills to recommend valid, reliable, and industry standard quality measures to assess quality outcomes in various studies undertaken by the Institute.
m. Provide consultative expertise in clinical matters in research efforts by other members of the clinical research team.
n. Perform analysis of research findings and document findings in the formal product of the deliverable to the customer.
o. Participate in the feasibility evaluation of projects presented to the Health Policy and Research Team.
p. Functions as HIPAA coordinator which involves assessment of HIPAA compliance, HIPAA training, policy and procedure development for HIPAA compliance, and advising senior management of changes to HIPAA regulations at either federal or state levels.

QualityPlus Health Consulting, Baltimore, MD — 1995 – Present
Independent Health Consultant

q. Consulted with various managed care organizations and delivery systems in the areas of accreditation preparation, quality improvement initiatives targeted to improve clinical practice operations, customer and practitioner satisfaction, and HEDIS interventions.

MITRE Corporation — Aug 2011 – Apr 2012
Nurse Consultant

- Research for the Measures Subgroup for Hospital Value-Based Purchasing Program of the Affordable Care Act.
- Drafted several research documents relative to quality measures that were used to prepare rules briefings.
- Prepared crosswalks comparing quality measures among several national quality measures developers.
- Researched information and drafted recommendations for patient safety measures for inclusion as hospital value based purchasing measures for FY 2015.
- Developed, designed, and prepared several presentations including Clinical Process Measures for the non-clinical professional and National Health Safety Network (NHSN) hospital inquired infections.
- Prepared process flow diagrams depicting Sponsor processes that impact implementation of hospital value based purchasing to ensure processes are implemented in compliance with the intent of the Program rule.
- Prepared Sponsor/Hospital Value Based Purchasing Team minutes.
- Researched and maintained a database for programs that potentially impacts the Hospital Value-Based Purchasing Program.

United Healthcare, MD & DC Health Plans — Oct 2009 – Mar 2011
Associate Director Quality Improvement

- HEDIS Project Lead for developing, implementing and evaluating strategies to improve HEDIS preventive service results.
- Develop Quality Improvement Activities (QIAs) that assist in the improvement of barriers to quality in care and/or service.
- New program development for improving the receipt of preventive services by members.
- Redesign, implement, monitor and evaluate the Clinical Outreach Department for Early Periodic Screening and Diagnostic Treatment.
- Prepare for National Committee for Quality Assurance (NCQA) health plan accreditation.
- Prepare for External Quality Review Organization (EQRO) process by each regulatory jurisdiction.
- Review data and determine needs for improvement.
- Oversee quality management committee and subcommittee meetings.
- Perform evaluation of quality program and operations.
- Project management activities for member and practitioner satisfaction improvement.
- Policy and procedure needs assessment to enhance systemic processes.
- Quality of care investigation, tracking and trend analysis.
- Review UM data for opportunities for improvement.
- Prepare peer review cases.
- Perform UM and QI process monitoring audits to assess compliance.
- Perform staff education in matters of quality, risk and/or compliance.

- Develop position papers delineating the health plan position on various issues.
- Other managerial duties as necessary.

KePRO, Hunt Valley, MD Sep 2008 – Oct 2009
Project Director

- Maintained total responsibility for managing the performance of the operation in managing the State of Maryland Fee-for-Service Medicaid contract for hospital and long-term care services.
- Manage contract of 16 million in revenue and control expenses to ensure profitability
- Perform quality oversight of work performed in the contract.
- Assist DHMH of Maryland in opportunity identification to improve the effectiveness and intent of the contact.
- Perform utilization review and on-site visits as required to assure that potential patients meet criteria for medical necessity as Medicaid recipients.
- All managerial duties required to assure the appropriate a location of resources as well as effective processes to meet the intent of the contract implementation.

Chartered Health Plan, Washington D.C. Aug 2006 – Sep 2008
Sr. Director Clinical Quality Improvement

- HEDIS Project Lead for developing, implementing and evaluating strategies to improve HEDIS preventive service results.
- Develop Quality Improvement Activities (QIAs) that assist in the improvement of barriers to quality in care and/or service.
- New program development for improving the receipt of preventive services by members.
- Redesign, implement, monitor and evaluate the Clinical Outreach Department for Early Periodic Screening and Diagnostic Treatment.
- Internal consultant activities to clinical, behavioral health and service departments.
- Assist with the management of inpatient stays and transitional planning for discharge as needed.
- Monitor and evaluate vendor services (delegated credentialing).
- Oversee credentialing and re-credentialing processes.
- Managerial responsibilities of implementation, monitoring and evaluation of programs under the scope of responsibility.
- Managerial duties such as mentoring, leading and evaluating staff and assure tasks are completed proficiently.
- Collaborate with Medical Assistance Administration as necessary.
- Authorization of services for preventive care.
- Management and redesign of the high risk obstetrical program.
- Management and redesign of Children's Special Health Care Needs Program.
- Provide oversight and training for Health Education Department.
- Prepare population-relevant clinical practice guidelines.
- Prepare budgets and variance justification.

Delmarva Foundation for Medical Care, Hanover, MD Dec 2004 — Aug 2006
Director, External Quality Review

- Project Lead for California EQRO activities which includes review and evaluation of Quality Improvement Projects (QIPs), writing quarterly and plan-specific project reports to ascertain compliance with the state contract and Balanced Budget Amendment mandates; evaluation of the annual quality improvement strategy for Medi-Cal Managed Care.
- Implement research study, data collection and development of evaluation report for adolescent collaborative study.
- Evaluate HEDIS outcomes and make recommendations for improvement.
- Project Lead for re-engineering of the systems performance review process as well as participation in systems performance review for MCO's for which Delmarva functions as the EQRO.
- Prepare project budgets and justify variances.
- Managerial duties such as coaching, evaluations, and consultation to peers.
- Participation in special quality improvement projects as requested.
- State Baldridge examiner for Quality in 2005.

Amerigroup Corporation, Virginia Beach, VA Oct 2002 – Dec 2004

Assistant Vice President Medical Management
- Assumed responsibility for enhancing internal disease management program and developing case management indicators and outcome standards due to knowledge of subject area and effectiveness in achieving goals.
- Responsible for policy and procedure review and revision for corporate medical management policies.
- Internal consultant to intra-departmental functional units such as national call center, quality management, disease management and Amerigroup Cost Containment Team.
- Conducted corporate-wide inter-rater reliability.
- Developed audit tools for clinical quality and risk management assessment.
- Prepared medical management documents and information for AAAHC accreditation process (received no recommendations in the area of utilization management compliance).
- Acted as medical management leader for Amerigroup Florida health plan for 5 months while continuing to assume corporate duties.
- Lead process improvement efforts in national call center to enhance clinical transactions and risk management follow-up.
- Internal consultant to other Amerigroup health plans in areas of clinical process improvement.
- Designed disease management modules for specific diagnostic entities and developed criteria to assess effectiveness.

Quality Management, Whitman Walker Clinic, Washington D.C. — Jul 2002 – Oct 2002
Director
- Designed and implemented the first quality management program for the organization.
- Performed the first clinical performance data analysis.
- Help staff prepare for CARF and JCAHO accreditation.

Capital Community Health Plan, Washington, D.C. — Jan 2001 – Jun 2002
Vice President Health Services
- Manage utilization management, credentialing, and develop and execute the quality management program.
- Programmatic budgeting.
- Liaison and consultant to the organization for total quality management.
- Responsible for defining and reorganizing departmental infrastructure.
- Prepare health plan for Joint Commission Accreditation.
- Develop processes for systematic improvements in quality, utilization management and improved patient care.

Survey Management, National Committee for Quality Assurance, Washington, D.C. — Dec 1999 – Jan 2001
Director
- Responsible for production of the accreditation report.
- Responsible for building the infrastructure to allow for 100 day turnaround time of report.
- Responsible for operationalizing the processes related to accreditation visit for new products.
- Responsible for planning and prioritizing activities necessary to be completed by the department.
- Responsible for developing tools to demonstrate effectiveness of operations for Executive Management staff.
- Liaison with external customers to meet customer needs.
- Review of publications and tools need by external customers.
- Responsible for routine duties of management; assessment, planning , implementation, monitoring and evaluation of departmental activities

Clinical Experience:
Registered Nurse — 1975 – present
- Provide inpatient care to preterm and ill neonates. Practice as R.N. in almost all hospitals within Baltimore Currently practice on a P.R.N. frequency in the neonatal care unit at Medstar Harbor Hospital in Baltimore, Maryland.

Academic Experience:
Adjunct Professor
- University of Maryland, Baltimore County (Fall semester, 2011 – May 2013)
- Instruction to baccalaureate students majoring in health administration.

- Subject area is Health Regulation and Quality Improvement.

Morgan State University, Baltimore, Maryland (January 2010- June 2011)

- Instruction to graduate level nursing students in the subject areas of Health Care Law and Health Care Program Evaluation (temporary faculty position as needed)
- Clinical Faculty, Johns Hopkins University School of Nursing. Baltimore, Maryland. (Jan. 1981- May 1981) Taught intra-partum nursing to baccalaureate nursing students