Building Cross-Sector Partnerships from the Ground Up:
Lessons on Aligning Medicaid and Early Childhood Initiatives

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Nemours® Children's Health System

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Introduction

This policy brief highlights lessons learned from Florida, Georgia, and Washington, D.C. where small groups of leaders from the health care and early childhood sectors committed to working together to address a shared need. This work was supported by grants from the Alliance for Early Success to the Georgia Early Education Alliance for Ready Students (GEEARS), the Florida Association of Healthy Start Coalitions (FAHSC), and DC Action for Children. Financial support from these organizations enabled Nemours Children's Health System to provide technical assistance to the early childhood cross-sector endeavors. This work builds on previous Nemours' efforts to test approaches to financing upstream prevention and addressing the social determinants of health, described in a series of **policy briefs**.

Nemours worked closely with a key group of stakeholders in each state to: (1) identify and convene a core group of participants from the health care and early care and education (ECE) sectors; (2) determine an area of focus for a joint initiative; and (3) develop a specific small-scale pilot project. The goals were to foster alignment across Medicaid and ECE, uncover barriers to collaboration and identify solutions, and lift up learnings to enable other states to pursue cross-sector upstream prevention initiatives.

It is important to acknowledge the significant impact of the coronavirus on the partners in the three states. The global pandemic has had far-reaching effects as many workers inside and outside of government pivoted to address the immediate safety and well-being of state residents, including children. The projects in the three states were at varying stages of development in the Spring of 2020 but all halted as priorities shifted. Despite ending earlier than anticipated, a number of key lessons emerged from the work in these three states.

Background

The following are summaries of each state project.

In **Florida**, the team was focused on improving access to early childhood mental health services. Representatives from FAHSC and Florida State University's Center for Prevention and Early Intervention Policy, as well as providers of early childhood mental health services, were interested in exploring Medicaid coverage of early childhood mental health consultation services. This is a preventive service that pairs a mental health professional with families and adults who work with young children in the settings where they learn and grow, such as preschool and home. Consultation aims to build adults' capacity to prevent, identify, treat and reduce the impact of mental health problems among children. Initial plans included developing a roadmap for Medicaid coverage of early childhood mental health consultation services. The roadmap was intended to clarify the operational and administrative elements needed to meet federal, state, and managed care requirements. However, in light of pandemic-related needs, work was pivoted to develop an overview document for managed care plans and state leadership on the potential benefits of Medicaid coverage for consultation services.

The **Georgia** team's goal was to increase collaboration between Medicaid managed care organizations and Healthy Beginnings, a program that embeds nurse navigators at Head Start centers. The nurse navigator helps families and Head Start staff navigate the health care system, with the goal of addressing unmet health needs and social needs. Because Healthy Beginnings is embedded within the ECE setting, it provides opportunities for diagnosis and early intervention that might otherwise be missed. Increased collaboration among Medicaid managed care organizations and Healthy Beginnings could help clarify communication pathways and policies for referrals and handoffs between systems when working with families. The Georgia coalition included representatives from GEEARS, Children's Healthcare of Atlanta, United Way of Greater Atlanta, managed care organizations, the Georgia Department of Early Care and Learning, the Georgia Department of Public Health, and Emory University.

In **Washington, DC**, the core team – comprised of officials from Medicaid, the Office of State Superintendent of Education (OSSE) and Children's National Hospital – chose to focus on strengthening communication across the Medicaid and ECE sectors about completion and results of developmental screens. An additional element that developed over the course of the pilot was equipping and empowering parents to initiate conversations with the pediatricians about their child's development. This core team, augmented by United Planning Organization (a grantee of OSSE that provides technical assistance to ECE centers to help them meet the Head Start standards) developed a pilot to implement in three ECE centers and two health centers. DC requires every child to submit a Universal Health Certificate (UHC) to their school or child care facility every year. During the pilot, physicians in the two participating health centers agreed to staple the Ages & Stages Questionnaire® developmental screening tool (ASQ) that is completed and reviewed during well-child visits to the UHC. Parents returned the stapled UHC/ASQ to their ECE center. This built on the existing workflow of parents bringing the UHC signed by the physician to the ECE center or school. ECE centers that participated in the pilot completed a short "ASQ summary form," which included information on ASQ screenings completed by the ECE center, for each child who was scheduled for a 9-, 18- or 30-month well-child visit, points at which Medicaid requires a developmental screen. Parents were given the "ASQ summary form" completed by their ECE provider to bring to their child's physician to discuss during the visit. These ASQ summary forms also were hand-delivered to the health clinics in advance of the child's visit.

Cross-Cutting Themes for Collaboration Between Medicaid and ECE

Building the Cross-Sector Team

Nemours worked closely with key stakeholders in each state to identify and convene a core group of participants from the early childhood and Medicaid sectors to collaborate on addressing a shared need and identifying solutions. The makeup of the group was guided by the area of focus. The nature of projects and the pace of progress was unique to each state. Still, several themes that were applicable across states point to lessons for other efforts to bridge the Medicaid and early childhood sectors. There were commonalities in approaches to building successful cross-sector teams.

Seek representation from the Medicaid agency and/or Medicaid MCOs

A previous Nemours brief described the importance of identifying a high-level champion within the State Medicaid/CHIP agency who believes in improving child outcomes with the early childhood sector. This recent work underscores the need to have representation from the state Medicaid agency as part of the team. Alternatively, given the essential role of managed care in delivering Medicaid services, representation from a Medicaid managed care organization (MCO) engaged in the state can also be effective. MCOs have a high degree of flexibility, and some initiatives can be run directly by MCOs without any change in state Medicaid policy.

State Medicaid programs cover an array of populations with different needs, including adults with disabilities, nursing home residents, and children with special health care needs. Team members representing the Medicaid agency or a Medicaid MCO can provide context on how a project fits with Medicaid's existing initiatives and priorities, can help elevate a project among the many competing demands within a Medicaid program, and can convene colleagues from sister agencies or outside organizations. In DC, the team member from Medicaid provided introductions to staff at an MCO and invited key staff from the Department of Health to attend meetings when needed.

This principle was also illustrated in Florida. The team was committed to promoting collaboration between Medicaid and early childhood sectors in the interest of improving early childhood mental health. The experts, providers, and advocates engaged in this effort had already made significant strides in promoting early childhood mental health within Medicaid. However, the lack of direct representation from the Medicaid agency or an MCO meant the team needed a longer timeframe to consider how potential project focus areas might align with current Medicaid priorities, as there does not appear to be a clear alignment at this time. Direct input from a Medicaid perspective would have been valuable.

Rely on a coalition approach to engage multiple organizations

Ideally, leadership from the Medicaid agency and/or MCOs should be present alongside leadership from multiple other organizations. Georgia's effort to build a cross-sector team relied on a coalition approach with strong leadership across multiple organizations. The coalition approach involved a collaborative of partners advocating for the expansion of an effective service delivery model. The team felt it was important to include providers from both the health care and early childhood sectors, to understand current workflows and requirements from the provider perspective. The coalition approach was viewed as more effective than a single contracted provider approaching the Medicaid MCOs or Medicaid agency.

Achieve sustainability with buy-in from multiple levels of an organization

The work also emphasized the importance of achieving buy-in from multiple levels within an organization to ensure that support is widespread and sustainable. This is essential when attempting to introduce new organizational workflows and shift program operations. Obtaining buy-in and identifying a champion from leadership with priority-setting authority helps to elevate an initiative among many existing demands. Staff with competing priorities are more likely to adopt changes that are either mandated by the institution or viewed as a top priority of its leadership. In addition, engaging individuals who understand the nuances and execution of workflows will help ensure the success of the initiative. In DC, for example, the pilot

grew organically from within the participating health clinics. This meant that the initiative benefitted from having the perspective of staff involved with a deep understanding of clinic workflows; it may have been even more successful if it also had been prioritized by clinic leadership.

Having commitment from participants at multiple levels of an organization also supports sustainability. Involving multiple staff from within an organization in the initiative helps ensure continuity in the event of personnel turnover. In DC, for example, two of the three core team members accepted new positions during the course of the two-year project (one year of planning, one year of pilot implementation). This required time to engage the new team members.
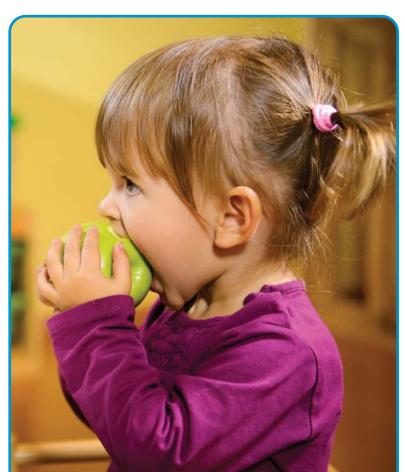
Leverage existing relationships to extend capacity

The goal of Nemours technical assistance is to supplement state team staff. In this project, momentum was stronger when this external technical assistance staff had established relationships with state team members. The project director from Nemours had a long-standing relationship with the core team member from the DC Medicaid agency and had previously worked collaboratively with the other two core team members in DC. This made it more feasible for the Nemours technical assistance provider working with the DC team to convene meetings and engage pilot partners. The combination of trusted relationships and an understanding of local dynamics enabled technical assistance staff to become more integrally embedded in the project work. Given the competing priorities and limited resources of health care and early childhood programs, the ability of supplemental technical assistance staff to ease the workload of program staff helps advance project progress.

The process of specifying the project focus and developing consensus on implementation steps requires significant investment of time by team members, amidst their already heavy workloads. Technical assistance staff add value by empowering state team members and helping them succeed in new ways, for example by providing background analysis, highlighting key decision points, and exploring implementation options. Technical assistance staff can also add value by filling a role that state team members cannot meet on their own.

Generating Support For The Initiative

The initial work of the state teams was determining an area of focus and scope for the initiative. Nemours helped scope initiatives in which increased coordination between Medicaid and the early childhood sector would advance participants' existing priorities. The next step for state teams was to develop a specific small-scale pilot approach, intended to test the feasibility of an approach to increase collaboration across early childhood and health care systems. An earlier Nemours brief identified some of the challenges of working across the Medicaid and early childhood sectors. The work to support initiatives in the three states identified several strategies for generating the support that is needed to engage pilot partners in each local initiative.

Demonstrate the case for support with data analytics

The conceptual basis for collaboration between Medicaid and early childhood is strong—the sectors share goals for the common populations they serve. To build concrete support among partners, however, it is important to move beyond the conceptual level. We found that without the availability of data demonstrating the shorter term potential benefits of collaboration, it can be difficult to move forward aggressively. For example, the Georgia ECE had not been aggregating and analyzing participants' managed care enrollment and health care utilization at the population level. It would have been useful to create a system to collect and analyze this information for six to twelve months prior to approaching MCOs. This type of information could have helped support the case for MCOs' direct financial investment in expanding care coordination and case management services provided in ECE settings. The capacity to capture and analyze data is important for gaining support, as well as for ongoing program improvement.

Revisit past initiatives

Another lesson from the work in the three states is to look to reinvigorate previously proposed but dormant initiatives. Given the complexity of collaboration across sectors, project implementation takes time. Disruptions can occur from leadership changes, budgetary constraints, or other external factors, even when support remains. If stakeholders are already familiar with an initiative, it can help streamline the process of engagement. In Georgia, the team focused on an initiative that had been initially proposed in 2014, but its momentum was upended by a change in Medicaid leadership. There had also been turnover among the managed care executives and project leadership since 2014, but new executive leadership expressed interest in revisiting the project. It can be valuable to look to previous efforts for guidance on future opportunities.

Balance project reach with implementation feasibility

Georgia's approach was also conducive to generating support of the initiative because it was focused on a well-formulated program. A project benefits from having a clear "ask" and specific definition, making it easier to engage supporters early on. Previous Nemours work has identified the value of improving program operations in incremental ways to surface policy barriers and solutions and build cross-sector relationships, without requiring significant financial investments beyond staff time. Alternatively, a broader initiative may have more significant impact but require larger budgetary investments or more ambitious policy changes. This can make it more difficult to engage supporters. Florida's focus on exploring Medicaid coverage for early childhood mental health consultation services falls under this latter category. A take-away from the work is the need to strike a balance between a project's initial implementation feasibility and the opportunity to advance more ambitious, long-term goals.

In DC, the team selected a project with achievable goals that would help prepare the state for scaling or expansion in future years. Selecting a small-scale project as a first step allows a state to identify and address barriers, thereby helping move the state closer to its ultimate goal.

Work in Washington, D.C. had been underway for a year longer than initiatives in Florida and Georgia, enabling DC to realize pilot implementation. In DC, the team initially sought to reduce duplication of developmental screening. As the planning evolved, the team recognized that, as a first step, both sectors would benefit from learning about completion and results of developmental screening that occurred across sectors. To this end, the DC team designed a pilot aimed at strengthening communication about screening between three ECE centers and two health clinics that served many of the same children.

In Florida, the team recognized that the state was not yet ready for the budget implications of expanding Medicaid to cover consultation services. An initial step is making the case to state leadership on the potential benefits of consultation services for children, families, and the community. In Georgia, the team saw the advantage on first taking steps to build collaboration between Healthy Beginnings and Medicaid MCOs, rather than pursuing financial support right away. These kinds of simpler changes can strengthen alignment between sectors, which is needed before pursuing more broader-reaching system-wide change.

Implementing The Initiative

Based on the work with the three states to develop and implement joint cross-sector projects, states should consider the following strategies.

Demonstrate how other states have implemented similar changes

It is helpful to learn from other states that have implemented similar initiatives. Covering a new service under Medicaid can be operationally complex due to federal, state, and managed care requirements. Demonstrating the preparatory steps and specific actions taken by those who have gone before can help clarify the path forward for other states. The Florida team planned to pursue this strategy with development of a roadmap exploring the operational and administrative elements that would need to be in place for Medicaid to cover consultation services.

A number of public and private organizations have databases compiling existing initiatives. For example, the federal Centers for Medicare and Medicaid Services has searchable databases on Medicaid waivers and State Plan Amendments. The National Center for Children in Poverty has introduced PRiSM, a new searchable collection of profiles describing the most promising research-informed infant and early childhood mental health policies.

Recognize that workflows are challenging to change,
so make systemic changes or build on existing processes.

Both the physicians at the two health clinics and the staff at the three ECE centers in DC had extremely heavy workloads. While every attempt was made to minimize the amount of new work required, the pilot did ask participants in the two sectors to add new procedures to their existing workflows. The physicians and ECE center staff were quite supportive of the concept of the pilot but, in the majority of cases, they did not adopt the pilot workflow changes (for example, providing parents a copy of their child's ASQ to

share with the ECE center, or completing a form summarizing the ASQ performed in the ECE center and any action steps). To help ensure workflow changes gain traction, states should consider mechanizing them so they become a routine part of business.

States should look for ways to revamp the underlying systems — to make the change routine — rather than proposing workflow changes for only a segment of their patient/client population to achieve goals. Asking individuals to remember to execute a new procedure for the pilot population was not a successful strategy. One option would be for a state or locality to establish a secure online registry or hub for exchanging information. Providers in both sectors would be required to submit data on key measures and would have access to this information (e.g., results of developmental screens) for patients they serve.

If a systemic change is not feasible, the change could build on current practices. In DC, for example, parents must have their child's physician complete and sign a UHC in order to enroll their children in either public school or an ECE center. The existing form could be revised to allow the physician to include more nuanced information about developmental screening on the UHC form so no additional steps such as copying and stapling the ASQ are needed. Similarly, the ECE centers could ask parents to sign a consent form during enrollment and annually, when they are completing other paperwork, that allows the ECE center and the child's physician to communicate about the care of the child. This would eliminate the need to request that parents sign an additional consent when their children are due for developmental screening at their well-child visits.

Provide a clear rationale for the pilot and keep repeating it.

In DC, the ECE centers experienced significant changes in leadership and turnover of children enrolled during the one-year time period of the pilot. We recommend providing clear, consistent messaging about the rationale for the pilot prior to implementation and throughout its duration to help ensure continued commitment in the event of new participants. The messages should be conveyed verbally to all those involved in the pilot to allow for questions and answers as well as to solicit feedback. In addition, the rationale and pilot procedures should be provided in writing to ensure sustainability in a transition. Nemours, for example, prepared and shared a comparison chart of existing workflows versus pilot workflows for the physicians and staff at the health clinics and another one for the staff at the ECE centers. Varying the delivery mode of messaging is important as well. The parents at the three DC child care centers indicated that it would be helpful to have an array of reminders about the pilot procedures from e-mail to text to paper copies.

Review and revise forms and processes to ensure they facilitate communication across sectors.

Clearly-written forms and well-articulated processes can improve communication and coordination across sectors. In addition, establishing accountability up front about who is responsible for each element in the communication will aid the process. States should review forms to make sure they are clear and contain needed information, such as parental consent. States also should facilitate communication across sectors by ensuring that providers in both sectors taking care of a child have each other's contact information so they can communicate when parental consent is provided. This is especially critical for children with a developmental concern or delay that results in a referral for services. Finally, states should review their processes to ensure that early intervention services routinely provide follow-up information to both the ECE center and physician that care for the child about the evaluation and connection to services.

Conclusion

A final observation from our work with Florida, Georgia, and Washington, D.C is that building cross-sector partnerships takes time. We found that there is value in starting at a small scale and focusing on forging relationships. Initiatives also must be flexible enough to accommodate participants' needs to focus intermittently so they can balance their many responsibilities. Taking the time to work together to both identify a shared need and develop a joint solution is an essential part of building cross-sector partnerships. Working jointly on a project and understanding the factors affecting implementation in each sector will facilitate strong relationships and help ensure the success of the pilot.

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