

Assessing the Influence of the National Standards for Systems of Care for Children and Youth with Special Health Care Needs

SUMMARY OF AN EVALUATION

Prepared for the
Lucile Packard Foundation for Children's Health

Submitted September 22, 2020
Revised November 16, 2020

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Summary of an Evaluation

Children and youth with special health care needs ([CYSHCN](#)) have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and they require health and related services of a type or amount beyond that required by children and youth generally. The *National Standards for Systems of Care for Children and Youth with Special Health Care Needs* aim to improve health care quality and outcomes for CYSHCN, who make up nearly one of five children and youth in the United States. The National Standards were [developed](#) by staff of the National Academy of State Health Policy ([NASHP](#)) and the Association of Maternal and Child Health Programs ([AMCHP](#)), with input and guidance from a national work group and financial support from the Lucile Packard Foundation for Children's Health ([LPFCH](#)).

[Issues Research](#) conducted an impact evaluation for LPFCH to understand the uptake and influence of the National Standards as well as future opportunities to promote their use among key audiences. The evaluation synthesized the experiences and views of 50 stakeholders who are knowledgeable about the development, dissemination, and influence of the National Standards through their work in federal and state agencies, managed care organizations, health care provider organizations, professional associations, and family advocacy groups.

Key Findings from the Evaluation

Since their launch in 2012, the National Standards have been [used by states](#) to guide system improvements for CYSHCN and their families. These efforts include the design of managed care programs to promote access to and coordination of care; development of formal interagency agreements between state [Medicaid](#) and [Title V](#) Maternal and Child Health agencies to improve coordination of services; expansion of comprehensive care coordination through primary care medical homes; and stakeholder engagement in defining and identifying policy priorities to improve planning and collaboration in designing systems of care. In particular:

- The National Standards have become a foundational resource for the field by highlighting the core components of the structure and process of an effective system of care for CYSHCN
- The Standards offer a framework for conducting research as well as evidence-based guidance to engage stakeholders in planning and implementing changes in policy and practice
- Making CYSHCN a priority population for Medicaid creates a strong footing for operationalizing the National Standards
- Embedding the National Standards in interagency agreements and managed care contracts helps ensure attention, uptake, and accountability

- The primary care [medical home](#) and comprehensive care coordination activities offer a focal point for implementing the National Standards and furthering system integration
- Creating a system of care means widening the focus beyond clinical care: many CYSHCN have nonmedical needs that require coordinated community-based services and supports
- Engaging family advocates in giving input for setting priorities and implementing the National Standards creates an organic opportunity for education and empowerment
- Despite progress, stark [inequities in services](#) remain to be overcome for CYSHCN.

Inspiring the Work of Change Agents

State officials used the National Standards to inform state plans and strategies, foster collaboration between agencies, design and oversee [managed care programs](#), and implement evidence-based Medicaid Early and Periodic Screening Diagnostics and Treatment ([EPSDT](#)) programs for CYSHCN. Family advocates engaged in state efforts around the National Standards said that they offer both an aspiration to aim for and credibility in advocating for systems change and for better care of individuals.

The influence of the National Standards has expanded over time. Interviews with state Medicaid staff and managed care organizations ([MCO](#)) leaders revealed an emerging understanding of the basic consensus about requirements for systems of care, recognizing the basic framework even when presented with the National Standards document for the first time. State officials saw a need to translate the Standards into contractual language and financial incentives, while MCO executives viewed the Standards as an impetus to sharpen quality improvement activities and foster whole-person care. They noted opportunities for applying the Standards to medical home and comprehensive care coordination activities, especially the integration of behavioral health and social services, which requires coordinated community-based services and supports.

New Opportunities to Apply the Standards

The work to improve systems of care for CYSHCN continues across the country, with a new generation of leaders emerging in a variety of sectors. Sustaining progress with the National Standards depends on being able to depict what “successful implementation” and “successful systems” look like according to shared indicators. Capturing the data needed to establish impact in areas related to access to and quality of care, as well as quality of life, is important to those who are trying to build systems in managed care. State leaders who are contracting with Medicaid MCOs for CYSHCN stressed the need to connect existing [quality metrics](#) and data sets within each of the National Standards domains. Developing a consensus on standardized metrics is a key challenge for the field.

As an ambitious and complex effort to guide the improvement of systems of care for CYSHCN, the National Standards project has raised awareness and elicited engagement from an array of stakeholders across the country. Many noted the value of implementation tools developed by [AMCHP](#) and [NASHP](#) including case studies, fact sheets, contracting language, quality measures, recorded Webinars, and other resources that states can use to design and strengthen health care systems serving CYSHCN and their families.

Looking toward the future, the National Standards can help expand the national conversation beyond a narrow focus on cost containment to assure that CYSHCN receive the care they need to achieve their developmental potential. To facilitate ongoing work with the National Standards, stakeholders suggested developing a consensus-based conceptual framework that builds on past successes, guides future action, and cultivates engagement from new stakeholders, who would benefit from understanding a step-by-step process for harnessing the potential of the Standards.

Systems Change in Five States

The evaluation highlights systems change from five states selected to represent a diversity of approaches in terms of leadership, engagement, collaboration, strategies, and practices.

Colorado: enhancing comprehensive care coordination for CYSHCN through an Accountable Care model made up of Regional Accountable Entities

Florida: using the National Standards to guide the redesign of a Children's Medical Services Health Plan for CYSHCN and contract with a statewide MCO to operate it

Kansas: developing a State Plan for CYSHCN through statewide collaboration involving families and partners who engaged with the National Standards as a guide

Texas: implementing specialized managed care programs for CYSHCN through the design of the statewide STAR Health and regional STAR Kids Programs

West Virginia: developing an interagency agreement to coordinate service delivery for CYSHCN in managed care, as outlined in the National Standards.

Profiles of individual change agents who have used the National Standards include:

- ***Gina Robinson***, Colorado Department of Health Care Policy and Financing
- ***Jeffrey Brosco***, M.D., Ph.D., Florida Department of Health
- ***Tami Allen***, Families Together, Kansas
- ***Donna Pauley Wilson***, R.N., West Virginia Bureau for Public Health

STATE PROFILE: COLORADO

Summary Points

- Colorado used the Standards to inform policy planning and implementation as well as the EPSDT early intervention and medical necessity determination process.
- Medicaid managed care includes risk-stratified comprehensive care coordination for CYSHCN and expectations for quality improvement.

History/Background

Stakeholders report that since 2012 the National Standards have been used to promote a systems perspective and to refine the state's [longstanding leadership](#) in implementing the primary care medical home model. The Standards were recently used to inform the development of a state [policy agenda](#) that outlines priorities for improving systems of care for CYSHCN related to access, behavioral health, and coordination of services. A group of stakeholders convened by the state's Title V Maternal and Child Health Program met throughout 2018 to craft the plan, which is framed in terms of the National Standards. Colorado has active and informed family advocates involved in state policy efforts. They express familiarity with the National Standards and report they have used the Standards in their work with Title V and through participation on the State's [Medicaid Medical Services Board](#) and [Children's Disability Advisory Committee](#).

Strengthening Medical Homes, Care Coordination, and EPSDT

The National Standards were a resource in cross-agency coordination between the Colorado Department of Health Care Policy and Financing and the state's Title V Program to develop contractual requirements for Regional Accountable Entities (RAEs) that make up the state's Medicaid [Accountable Care Collaborative](#) (ACC) program. Although the ACC does not designate CYSHCN as a target population in contracts with RAEs, many contractual requirements are congruent with the National Standards. For example, contracts call for risk stratification of the attributed Medicaid population to identify high-risk beneficiaries — including youth transitioning from pediatric to adult care — for comprehensive care coordination with health and social service providers including county child welfare agencies. The contracts also include expectations for quality improvement plans that outline how the RAE will monitor the needs of children and adults with special health care needs.

"What better place to focus in a stratified program than children and families at risk, and children with special health care needs... The fact that there isn't a special deliverable for CYSHCN shouldn't matter: if you have a strong primary care strategy, if you have a strong behavioral health strategy, you are going to account for kids and families." —MCO leader

The regional model does not ensure statewide standardization of services but does allow for local innovation. For example, one RAE contractor — [Rocky Mountain Health Plans](#) — developed a comprehensive risk model for early identification of CYSHCN based on clinical, functional, and social needs. Care coordinators employed by the RAE participate on integrated community care teams with child welfare agencies and health departments that coordinate care for CYSHCN through the state’s Title V Program. An enhanced payment model and a practice transformation program offer financial incentives and peer coaching to help pediatric practices build medical home capacity, implement screening for depression, and integrate behavioral health care in the practice. The RAE’s leaders expressed view that this stratified population management approach is well suited to identify and address the needs of many CYSHCN.

Change Agent Profile: Gina Robinson

Program Administrator, EPSDT

Colorado Department of Health Care Policy and Financing

Gina Robinson first heard about the National Standards when she was invited to participate in their development. The invitation came from the [Catalyst Center](#), where she has served for many years as part of a strategic advisory group. She found the development of the Standards to be a useful process. “They’re a tool that states can use to imagine systems of care and work toward improvement,” she says. She feels that the National Standards project has been successful in reaching those who can influence policy.

In her role administering [EPSDT](#) for Colorado, Robinson has used the National Standards to guide the expansion of early intervention services and the development of an evidence-based process for making medical necessity determinations for specialty care carve-out services. She reported that other states have been interested in adopting this process. She also uses the Standards as an educational tool to train care coordinators and case managers across the state. Stakeholders report that the state’s oversight of EPSDT offers a critical point of engagement with Medicaid Regional Accountable Entities to help sharpen their implementation of standards and ensure that the comprehensive needs of CYSHCN are being met.

Robinson emphasized that “the people who can really change the system do so by using payment mechanisms and contracting.” She noted that the National Standards have influenced national managed care contracting provisions in several important respects and expressed hope that, in the future, public and private contracts will hold payment systems accountable for meeting the Standards through specific deliverables or performance metrics for CYSHCN.

STATE PROFILE: FLORIDA

Summary Points

- Florida’s Children’s Medical Services (CMS) Health Plan, administered in partnership with WellCare of Florida, Inc., is an example of a Medicaid MCO for CYSHCN directly informed by the National Standards, based on definition of CYSHCN as a specialized population.
- Florida’s Department of Health used the National Standards as a guiding document to develop the RFP and related performance metrics for the managed care contract. The National Standards gave the state an authoritative resource to support policy innovations and program changes.

History/Background

In 2011, the State of Florida moved Medicaid clients to mandated managed care. Through a partnership with Florida’s Agency for Health Care Administration, the state Department of Health administered a non-capitated managed care program for CYSHCN known as the CMS Health Plan. In 2017, following extensive consultation with stakeholders, the state used the National Standards to redefine systems of care for CYSHCN under a capitated insurance model. The state granted a contract to WellCare to operate the redesigned [CMS Health Plan](#) starting in February 2019. The program currently enrolls approximately 81,400 CYSHCN.

A Medicaid MCO for CYSHCN

According to key stakeholders, the National Standards were extremely influential in the design of the capitated CMS Health Plan model. The Standards provided the state with an evidence-based and nationally recognized consensus on best practices to support policy change. The request for proposals, and the subsequent contract with WellCare, aligns with the National Standards’ domains and expectations.

“Title V is dwarfed by the size of the Medicaid program in Florida, which has a budget of \$29 Billion — the Title V budget is about \$9 million — but we can influence the conversation for CYSHCN. We have a close advisory relationship, and an outsized influence, when we leverage the National Standards to promote systems change.” –*Title V CYSHCN official*

WellCare’s model is based around local dedicated pediatric care managers who conduct comprehensive needs assessments and coordinate with families, primary care providers, schools, early intervention programs, and community organizations to provide a continuum of medical, behavioral, and social services. The state is also redesigning its pediatric behavioral health

network so that academic medical centers serve as hubs for referrals of complex cases as well as for training primary care practices in integrated care for routine conditions.

The state is focused on documenting quality and outcomes of the CMS Health Plan to support improvements over time. The Florida Title V program convened a [technical advisory panel](#) (TAP), which included providers, insurers, family, youth, and Medicaid officials, to discuss what measures should be used to track performance in managed care for CYSHCN. The TAP proposed measuring families' assessment of improvement in activities of daily living and other quality of life indicators. Overall, the state identified approximately 40 metrics linked to the National Standards for use in the managed care contract. These are supplemented by financial sanctions around operational standards such as timely response to member service calls.

Change Agent Profile: Jeffrey Brosco, M.D., Ph.D.

Title V CYSHCN Director and former Deputy Secretary for Children's Medical Services at the Florida Department of Health and Professor of Clinical Pediatrics at the University of Miami

In 2016, Dr. Jeff Brosco was invited to participate in the national working group to update the National Standards 2.0. In his role at the Florida Department of Health, he was also involved in local efforts to improve systems of care in accordance with the Standards. "The National Standards have been extraordinarily useful — the single most important document we've had," he says. "The Standards have transformed the Title V program in Florida and provide the foundation for all the work we do."

Brosco led a group of stakeholders to apply the National Standards to the design of the CMS managed care contract (described above). Each of the Standards was translated into practical terms, which was useful not only for contracting purposes but also in educating stakeholders about the Department's vision for the program. "The Standards were a launching pad — a point of departure for our work," he says. The state's decision to award the contract to WellCare was based in large part on the MCO's specific proposals for accountability to the Standards. The Standards also proved useful in demonstrating the state's rationale for selecting WellCare to administer the CMS Health Plan in a subsequent legal proceeding when the vendor selection process was challenged by an administrative plaintiff.

As in many states, Brosco and his colleagues have contended with diverse responses to the changes brought about by introducing capitated managed care for CYSHCN. He and his colleagues at the Florida Department of Health remain committed to the design improvements of this model of care and encourage patience until solid data is available to assess the overall impact on children's care and health.

STATE PROFILE: KANSAS

Summary Points

- Kansas received an Integrated Community Systems Grant from the federal Health Resources and Services Administration to create a State Plan for CYSHCN, which can serve as a model for other states.
- Through an inclusive community engagement process, each domain from the Standards was addressed and a variety of stakeholders provided input specific to Kansas. Family advocates who were involved in this process used the National Standards to increase awareness of a systems perspective for CYSHCN.

History/Background

Stakeholders in Kansas see themselves as early adopters of the National Standards, which they used in the development of a state-wide Strategic Plan for CYSHCN and Title V. Before the planning process began in 2013, informants felt there had not been strong community or family engagement, and that state leaders were not talking with families about their needs. When the state began using the National Standards as a guide for developing a state plan, families were drawn into the process in a way that made their participation feel valued and important. Ultimately, the Standards validated findings from local voices, which emphasized comprehensive care coordination.

“The Standards helped state leaders to design a process to include families as well as providing them with a tool to use to for engaging them. Now, when we’re training new staff and parents, we go through each one of the domains of the Standards — it’s part of the Family to Family training.”
—Family Advocate

An Inclusive Process for Developing a State Plan for CYSHCN

The [Kansas State Plan for CYSHCN](#) focuses on medical homes, which goes beyond the scope of the Title V work plan. State policy leaders used a series of consumer surveys, as well as focus groups held across the state, to elicit input. Each of the National Standards domains was addressed during a two-year process designed to help families and stakeholders define CYSHCN services for the state. Ultimately, their definition was in line with the definition outlined in the Standards. The 2018 State Plan for CYSHCN does not address insurance and financing, quality assurance, or health information technology. Many saw these issues as beyond the scope of the current plan, but they expressed determination to address them in the future.

Medicaid partners participated throughout the development of the Kansas State Plan for CYSHCN — viewing their role as advising a stakeholder-led process. Title V agency staff work with a Medicaid liaison in an ongoing collaboration. A recent change in Medicaid agency leadership offered an opportunity for Title V staff to introduce and orient their new Medicaid partners to the National Standards, which proved to be a useful educational tool for conveying the special needs of this population.

“For Title V, the Standards are our Bible, we carry it around with us — we have access to it at all times. We have it integrated into everything we do — but not all the Standards can be met in public health. We need direct service providers to be involved in several of these domains... familiarity with the Standards needs to be more widespread.”
—Title V program official

Change Agent Profile: Tami Allen

*Co-Executive Director
Families Together, Kansas*

With 30 years of experience working as an advocate for CYSHCN, Tami Allen also cares for family members with special health care needs. Allen has found the National Standards to be a helpful resource for advocacy work, training new staff, and helping families understand the policy process. The National Standards help families understand how to frame their personal experiences with health care within a larger systems perspective, she says. In addition, Allen reports that the document is aspirational — giving advocates something to aim for and providing stakeholders in Kansas with a guide for the future.

Allen believes her perspective may differ from those who work with the National Standards in other contexts. “At the national level these standards make sense, but each state is different. In Kansas we don’t always have the ability to reach these goals” due to limited funding and resources, she says. As an example, she notes that there is a lot of interest in primary care medical homes but implementing them “is just not realistic at this time.”

Based on her experience working with families, Allen has some suggestions for making the National Standards even more useful. She would like to see a simplified version of the Standards geared to families’ educational level as a resource for day-to-day advocacy work. Allen also recommends that the National Standards be translated into Spanish, with cultural information about how to present them to a Spanish-speaking audience.

STATE PROFILE: TEXAS

Summary Points

- Texas operates two Medicaid managed care programs, STAR Health and STAR Kids, that provide care coordination for CYSHCN.
- The influence of the National Standards is evident in the design of the STAR Kids program, which sets contractual expectations for assessing needs and coordinating care for CYSHCN.

History/Background

Texas operates two Medicaid managed care programs that serve CYSHCN enrolled in Medicaid. The [STAR Health](#) program, launched in 2005, serves children in or formerly in foster care, some of whom have special health care needs. The [STAR Kids](#) program, launched in 2016, serves children with disabilities under a federal 1115 waiver. The state created a [STAR Kids Managed Care Advisory Committee](#) of stakeholders to help prepare for the launch of STAR Kids, which also has been helpful in the implementation phase of the program. The Texas [Health and Human Services Commission](#) (HHSC) contracts with a single managed care organization (MCO) to serve enrollees in STAR Health statewide, and with several MCOs to serve enrollees in STAR Kids on a regional basis.

Care Coordination for CYSHCN

All STAR Kids members receive service coordination, which is a specialized care management service performed or arranged by the MCO to facilitate the development of a service plan and the coordination of services among a member's providers. STAR Health members with special health care needs receive service management, which is a clinical service performed by the MCO to facilitate the development of a health care service plan and coordination of clinical services among the member's providers. Under a federal 1915(c) waiver, both the STAR Kids and STAR Health programs include Medically Dependent Children Program services, which are home and community-based services for children and youth age 20 and younger who meet the level of care criteria for medical necessity for nursing facility care.

[Superior HealthPlan](#), a subsidiary of the Centene Corporation, is one of several MCOs serving the STAR Kids program regionally and is the sole contractor for the STAR Health program. The plan is testing a trauma-informed mobile outreach program that offers crisis stabilization and wraparound services to help avoid inpatient stays for children with acute behavioral needs.

Use of National Standards in MCO Contracting

The state's contracts with MCOs serving the STAR Kids program include provisions based on the National Standards for assessing needs and providing comprehensive care coordination to children with complex needs. This language is included in the AMCHP/NASHP resource, [Serving Children and Youth with Special Health Care Needs in Medicaid Managed Care: Contract Language and the Contracting Process](#).

"Many of the ideas from the Standards are reflected in the Star Kids program – I'm not sure whether the Standards have driven change in Texas – but they do reflect the basic assumptions of the Star Kids program."

-Medicaid official

"Certainly there are parts of the STAR Kids program that reflect the Standards' expectations; I'm not sure whether this is because the Standards have driven change or because the Standards now just sort of reflect expertise in the field." *-Former CSHCN official*

The influence of the National Standards on Medicaid contracting reflects past collaboration between the state's Medicaid and Title V agencies. Following recent changes in Medicaid leadership, Title V program staff in the Department of State Health Services are working to establish relationships with new HHSC staff responsible for Medicaid contracting. (Turnover in staff at state agencies and MCOs, which is not unique to Texas, highlights the need for ongoing national and state efforts to build and sustain awareness of the National Standards.)

Texas is one of ten states that has established a working group to address children with medical complexity, with federal funding to create a model that could be replicated by other states. The goal of the working group is to create a clinical center of excellence specifically focused on children with medical complexity. Through participation in this effort, Title V is hoping to cultivate a focus on the National Standards, as well as cross-agency relationships with Medicaid that they hope will become more fruitful over time.

Definitions of Care Coordination in Texas MCO Contracts

In the [STAR Kids Managed Care Contract](#), Service Coordination means the service performed or arranged by the MCO to facilitate development of a service plan, or individualized service plan as appropriate, and coordination of services among a member's primary care provider, specialty providers and non-medical providers to ensure appropriate access to covered services, non-capitated services, and community services.

In the [STAR Health Managed Care Contract](#), Service Management is a clinical service performed by the MCO for members with special health care needs and other members when appropriate to facilitate development of a healthcare service plan and coordination of clinical services among a member's primary care provider and specialty providers to ensure members have access to, and appropriately utilize, medically necessary covered services.

STATE PROFILE: WEST VIRGINIA

Summary Points

- West Virginia has developed a productive collaboration and cross-sectoral approach to systems change for CYSHCN.
- A Memorandum of Understanding between the state Title V agency and contracted Medicaid MCOs was directly informed by the National Standards.

History/Background

Medicaid and Title V agency staff in West Virginia were introduced to the National Standards at NASHP and AMCHP conferences. In part because of these meetings, they met and began a productive collaboration and cross-sectoral approach to systems change for CYSHCN. Over time, they established a close working relationship to cooperate in implementing managed care for this population. The formal relationship between Title V and Medicaid MCOs began in January of 2017, when the state transitioned the entire Supplemental Security Income (SSI) population to managed care; prior to that time, few CYSHCN were enrolled in managed care. With that transition, there was a need to clarify the collaboration between Medicaid MCOs and the Department of Health, recognizing the efficiencies to be gained through a formal relationship. A planned transition of the state's foster care population to managed care creates even greater need for close collaboration in this regard, officials say.

Title V and Medicaid Collaboration

Based on relationships established through their work with the National Standards, Title V staff cooperated with Medicaid staff and the state's contracted Medicaid MCOs to develop a memorandum of understanding (MOU) outlining roles and responsibilities of the state and the MCO for CYSHCN. The MOU clarifies mutual objectives, data sharing, working relationships, the provision of services, and quality reporting. Central to the success of the interagency work has been a mutual respect for the expertise each brings to the table. Medicaid staff defer to the content expertise of Title V staff, who then work closely with them on managed care contract language. "The National Standards defined the language within the MCO contracts and shaped the MOU," says a Medicaid official.

"The state has benefited from a clear influence of the Title V staff in how Medicaid can better serve these children. And in the end, we've done a decent job of incorporating the language from the National Standards into our MCO contracts. West Virginia is meeting expectations as outlined in the Standards, especially in certain areas: we feel very good about that."
—Medicaid official

As in all interagency work, both sides run into challenges, but the MOU provides them with a platform and structure for communicating more effectively. They report the MOU outlines a day-to-day operational process, avoiding duplication in care coordination and allowing staff to engage in an almost daily discussion of specific cases.

“Because of the MOU we have the backup we need to work together and build [systems of care]. We don’t seem to have a lot of difficult issues with Medicaid and the MCOs, in part because we have that latitude to reach out to them, and that connection because of the interagency agreement.” –*State Title V official*

Change Agent Profile: Donna Pauley-Wilson, R.N.

*Clinical Services Director, Office of Maternal Child and Family Health
West Virginia Bureau for Public Health*

As a clinician who has worked with CYSHCN, Donna Pauley-Wilson has first-hand perspective on the needs of children and families. In her current role with the state Title V program, she uses the National Standards as a guide for her daily work and to structure monthly teleconferences with MCOs. The group discusses specific children and their coverage, general issues related to access to care, and their common work on care coordination, both for specific cases and on a systems level. She says that the National Standards have fostered a preventive focus, which may not have otherwise been addressed in these conversations. The Standards also introduce new concepts for team members, who use specific language from the document in their work on particular domains such as care transitions and the transition to adulthood.

Pauley-Wilson conducts educational outreach and teaching about the National Standards with staff in managed care organizations and in clinical practices that are designated primary care medical homes. This need stems in part from the transition of the state foster care population to managed care. The Standards will be used to begin discussions related to building systems of care through electronic records, standardized care plans, and family-centered care. She also intends to use concepts from the Standards to inform educational sessions related to accessibility to the Medical Home model, general access to care, individualized planning, quality improvement, and a holistic approach to care coordination.

Through a partnership between Title V and Medicaid agencies, Pauley-Wilson works with key stakeholders to expand their familiarity with the National Standards and promote a better understanding of what is needed to improve care for CYSHCN. For example, she partners with EPSDT program specialists who work with primary care medical home practices. “We do a ‘meet and greet’ visit, explaining what our goals are, specifically in terms of the incoming foster population,” she says. “It helps them to see a name and a face — and they connect with us personally, as well as connecting with the concepts that are central to the National Standards.”

ACKNOWLEDGMENTS

The authors are grateful to the many interviewees who generously shared their experiences and insights to inform the evaluation. The authors thank Holly Henry, PhD, and Edward Schor, MD, at the Lucile Packard Foundation for Children’s Health for guidance on the project, as well as the National Standards project staff for sharing background on the initiative: Karen VanLandeghem, MPH, Senior Program Director, and Kate Honsberger, Senior Policy Associate, at the National Academy for State Health Policy; and Caroline Stampfel, MPH, Director of Programs, and Kate Taft, MPH, Associate Director for Child & Adolescent Health, at the Association of Maternal and Child Health Programs.

This evaluation was sponsored by the Lucile Packard Foundation for Children’s Health, which funded the National Standards Project. The views expressed are the authors’ and do not necessarily represent those of the Foundation or its officers, directors, or staff. No endorsement by study participants is implied or should be inferred.