

Health Oversight and Coordination Plan Strategic Plan for Children in State Custody 2015 - 2019

- I. Introduction and Purpose:** Pursuant to H.R. 6893: Fostering Connections to Success and Increasing Adoptions Act of 2005, Section 205: Health Oversight and Coordination Plan, Section 422(b) (15) of the Social Security Act (42 U.S.C 622(b)(15)), the State of Missouri Children’s Division submits the following Health Oversight and Coordination Plan. The purpose of this Plan is to develop and implement a coordinated strategy and plan to ensure access to health care for all children in court care, including their mental health and dental health care needs.
- II. Agencies, participants and stakeholders:** The following agencies have agreed to collaborate to develop and implement this Plan: MO Department of Social Services including the Children’s Division, the MO HealthNet Division, the Department of Mental Health, as well as other pediatric and health care experts and stakeholders.

Agency or Participant	Contact	Role and Responsibility
Children’s Division	Tim Decker Melody Yancey Christy Collins Lori Masek	Submission of this Plan; Coordination and collaboration in development and implementation of this Plan.
Missouri HealthNet	Dr. Joe Parks Dr. Samar Muzaffar Dr. Paul Stuve Jenna Twehus	Coordination and collaboration in development and implementation of this Plan. Administration of the State Plan approved under Title XIX and Title XXI.
Division of Youth Services	Phyllis Becker Scott Odum Dr. Kathryn Dewein	Coordination and collaboration in development and implementation of this Plan.
Department of Health and Senior Services	Cindy Rackers	Coordination and collaboration in development and implementation of this Plan.
Office of State Courts Administrator	Kim Abbott	Coordination and collaboration in development and implementation of this Plan.
Private Foster Care Case Management Provider	Dr. Jerrie Jacobs-Kenner, Missouri Alliance for Children and Families	Coordination and collaboration in development and implementation of this Plan.
Pediatricians	Dr. Katie Plax Dr. Sarah Garwood Dr. Claudia Preuschoff Dr. Terra Frazier	Coordination and collaboration in development and implementation of this Plan.

	Dr. Stuart Sweet	
Recipients of Child Welfare Services	Anthony Morgan	Coordination and collaboration in development and implementation of this Plan.
Foster Parents	Nickie Steinhoff Regional/State Foster/Adoption Board Focus Groups	Coordination and collaboration in development and implementation of this Plan.
Mental Health Care Experts	Dr. Patsy Carter	Coordination and collaboration in development and implementation of this Plan.
School of Social Work/Research	Dr. Ramesh Raghaven	Coordination and collaboration in development and implementation of this Plan.
Child Advocacy Centers	Jerry Dunn	Coordination and collaboration in development and implementation of this Plan.
Residential Facilities for Children in Foster Care	Paula Fleming, Great Circle Denise Cross, Cornerstones of Care	Coordination and collaboration in development and implementation of this Plan.

III. Plan

A. Foster Children defined. The number of Missouri children in state custody as of December 31, 2014 was 12,998.

B. Strengths:

1. Use of EPSDT – Under Federal EPDST guidelines, states must provide for comprehensive health and developmental assessments and vision, dental, and hearing services to children and youth up to age 21. States must also provide all necessary treatment as identified through health screenings and assessments.

2. Medicaid Managed Care provides access to numerous potential primary practitioners and services. Missouri managed care contracts stipulate compliance with EPSDT.

3. CyberAccess System – Missouri’s MO HealthNet database system contains claims data for visits, diagnoses, prescriptions, and prescribers. Children’s Division staff now have clearance to obtain healthcare information from the CyberAccess System for children in CD legal custody.

4. Partnership between Children’s Division and Medicaid for Quality Improvements in Health Care – Children’s Division and Missouri’s Medicaid administrator, MO HealthNet, collaborate closely in effort to improve health care access and services for children and youth in foster care. Mo HealthNet has created a dental director position who will, among many duties, be available as a consultant to Children’s Division, as needed. Mo HealthNet is also developing a position for a pediatrician to provide consultation services to CD.

5. Trauma-Informed Care—Children’s Division continues its focus on addressing the trauma impact experienced by children in foster care. In March 2014, the Department of Mental Health’s Director of Children’s Clinical Services, Dr. Patsy Carter, began a shared employment position with Children’s Division to oversee the Division’s progression toward becoming a trauma-informed agency. A team of specialized staff completed train-the-trainer on the National Child Traumatic Stress Network *Child Welfare Trauma Training Toolkit*. This team, in turn, is responsible for training all staff in their respective regions with a targeted completion date at the end of CY15.

C. Identified Challenges and Opportunities. Missouri recognizes the following challenges and opportunities for change and improvement:

1. Fragmented Care—Foster children receive fragmented health care. Lack of a medical home, inadequate medical record management and poor communication between multiple health care providers contribute to this challenge.

2. Information Management—There is a lack of health care information about children as they enter care, and once a child has entered care there are significant difficulties retaining accrued information in a form readily accessible to staff. No central database or communication system exists for children in foster care. Children in foster care typically have numerous individuals involved in their health care, yet an effective means of communication and record management does not exist.

3. Transitions between placements—Foster care providers and others assisting the child or family do not always have updated health information to make decisions related to the child’s health care.

4. Medication management issues - Many foster care children are prescribed multiple psychotropic medications without clear evidence of benefit and with inadequate safety data. The use of multiple medications (psychotropic or otherwise) creates the potential for serious drug interactions.

5. Rural challenges and lack of qualified professionals - In rural regions of the state it is difficult for foster children to readily access health care due to limited availability of qualified professionals in various disciplines.

6. Training - There is a need for training related to the access and delivery of evidence-based health care for foster children including trauma-informed care and developmental screening.

7. Dental—Dental providers are lacking and wait times to see a dentist, once found, can be considerable.

8. Behavioral Health Care - In some areas of the state behavioral health providers are sparse, particularly those who can meet the unique needs of children in foster care using trauma-focused, evidence-based practices.

D. Action Items to Address Identified Challenges and Opportunities:

1. Health Care Coordination Committee to hold regular meetings in response to Fostering Connections to Success Act.

The Health Care Coordination Committee (HCCC) meets quarterly to discuss and develop strategies for improving the accessibility and provision of healthcare services to foster children. This is an opportunity for the state agency to consult with medical professionals and stakeholders in assessing the health and well-being of children in foster care. The committee has focused on initial and ongoing health screenings, an electronic health record system, trauma-informed care, establishing a medical consultant, and exploring a health home model for foster children.

- Children's Division is in the preliminary stages of identifying a more efficient and effective system to track key health care requirements and outcomes for foster youth.
- There is high interest in establishing a medical home model for children and youth in foster care in partnership with Cardinal Glennon Children's Hospital for children ages 0 - 12 and Washington University through the Supporting Positive Opportunities with Teens (SPOT) clinic for adolescents. Funding appropriations for this initiative were restricted in the 2014 legislative session. Private funding was recently secured for a pilot to begin at Cardinal Glennon to provide health services and care coordination for younger children. Funding for the SPOT will likely come from state-appropriated funds allocated for services and care coordination to older youth. The pilot will begin by serving new children entering care. The hope is to eventually expand the pilot to all children in foster care in St. Louis. The providers will begin working with the children at the time of the 30 day comprehensive assessment. Efforts are being coordinated between the local office and the providers with implementation later in the calendar year.
- Evaluate recommended vaccines for preteens and teens, in addition to those required.
- MO HealthNet is finalizing plans to have a pediatrician on staff to provide, in part and among other duties to be determined, consultation services to Children's Division.

2. Information Management/Transitions between Placements:

At a minimum, every child in foster care should have a centralized medical record that is updated regularly. The record should contain historical information obtained from birth families, immunization records, notes and recommendations from primary care physicians, notes and recommendations of subspecialty providers that evaluated the child, pertinent test results, medication history, and school records.

- Develop an internet-based electronic health record system for children in foster care.
- Capitalize on expanded reporting requirements for Medicaid managed care.
- Expand immunization tracking capability.

- Capability for education/support of foster families and case managers.
- Create health passports from the existing data warehouse for case managers and health care practitioners.
- CyberAccess user clearance has expanded to allow frontline staff to readily access medical history.
- Policy and procedures were developed to address the specific needs of youth transitioning from foster care to legal guardianship, conservatorship, or supported living arrangements. This includes options for health insurance and education about a power of attorney and health care proxy.

3. Medication Management:

- A workgroup was established to examine oversight considerations for the appropriate use and oversight of psychotropic medications for foster children, including a second opinion review process.
- An initial review of ten cases meeting specified criteria was completed by a board-certified child psychiatrist. Obtaining complete records was a difficult task and the review did not render sufficient data.
- A new in-service training requirement has been added for foster parents on the subject of psychotropic medications. Foster parents will be required to complete training on psychotropic medications within their first year of licensure.
- MO HealthNet is exploring a monitoring method by which an edit will be programmed for antipsychotic medications prescribed for any child in Missouri, thus requiring a clinical review for approval.
- Missouri HealthNet Division (MHD) is considering raising the prior authorization requirement for antipsychotic prescriptions for children from under age six to any child under age ten.
- The MO HealthNet Division is contemplating removing Oppositional Defiant Disorder as a qualifying diagnosis for children of any age.
- Children's Division and MHD are examining prescribing practices in the state's residential treatment programs. The programs' Chief Executive Officers (CEOs) will be provided ongoing reports of their psychiatrists' prescribing practices for children in state custody. The CEO will be informed where their psychiatrists' practice falls within best practice guidelines and alerted to any identified practice concerns.
- Department of Mental Health board-certified psychiatrist, Dr. Laine Young-Walker, has conducted ad hoc second opinion reviews at the request of Children's Division on individual cases of concern.

4. Dental:

- MO HealthNet Division has acquired a dental director position to assist in the advocacy of dental health improvements and to provide consultation. The director, Dr. Ray Storm, will join as a member of the Healthcare Coordination Committee.

5. Behavioral Health:

- Review best practices for treatment of mental health disorders in the foster care population.
- Include substance use assessment as part of the mental health evaluation.
- Patsy Carter, PhD, Director of Children's Clinical Services with the Department of Mental Health has a shared position with Children's Division with the purpose of guiding Children's Division to becoming a trauma-informed agency.
- A team of specialized staff trained in the National Child Traumatic Stress Network (NCTSN) Child Welfare Trauma Training Toolkit has been established, partnering with Department of Mental Health and an expansive group of stakeholders to explore best practices for assessing and treating trauma of children in foster care.

6. Training:

- "Foster Care 101" and "Trauma-Informed Care" trainings for pediatricians. This can be accomplished through visits to practitioners' offices.
- Health Care Coordination Committee member and pediatrician, Dr. Katie Plax, will work with the MO Chapter, American Academy of Pediatrics to include in a Best Practices Bulletin the special health care needs and advanced screening schedule of children in foster care.
- Explore partnerships with psychiatry training programs regarding trauma.
- Training on the National Child Traumatic Stress Network Child Welfare Trauma Training Toolkit provided to staff statewide started February 2015.

7. Quality Assurance

- Increase the currency of immunizations and ensure recommended vaccines are explored.
- Increase the percent of children with comprehensive assessment completed in 30 days.
- Increase the percent of follow-up recommended from comprehensive assessment completed within 90 days.
- Conduct reviews for children on more than 2 psychotropic medications.

HEALTH CARE SERVICES

Early Periodic Screening, Diagnosis, and Treatment screenings

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings are known in Missouri as Healthy Children and Youth (HCY) screenings, or well-child checkups. Missouri currently utilizes the EPSDT periodicity guidelines to ensure children in care have developmental assessments as well as vision, dental, and hearing services as outlined below. However, children in CD custody from birth to age 10 are required by Missouri Statute to receive physical, developmental, and mental health screenings every six months following the initial health examination. This statute requires some children to have screenings more frequently than the EPSDT periodicity guidelines recommend. The Division had experienced challenges with the MO HealthNet Division (MHD) refusing to cover the cost of these additional screenings unless a physician determined they were medically necessary. To accommodate the Children’s Division’s statutory mandate, the MHD has agreed to cover the cost of these additional screenings under the billing code “interperiodic screenings.” Staff routinely encounter providers unfamiliar with the advanced screening schedule for foster children and providers have refused to perform the interperiodic screening. Pediatrician and Health Care Coordination Committee member, Dr. Katie Plax, has offered to educate providers on the special health care needs and advanced screening schedule of foster children through a MO Chapter, American Academy of Pediatrics Best Practices Bulletin.

The recommended periodicity schedule for HCY screenings:	
• Newborn	• 9-11 months
• By one month	• 12-14 months
• 2-3 months	• 15-17 months
• 4-5 months	• 18-23 months
• 6-8 months	• Each year, from ages 2-21

Components of a full HCY screening include:
• Health and developmental history (both physical and behavioral health)
• Complete physical exam
• Health education
• Immunizations and lab tests, as indicated
• Lead screening and testing, as indicated
• Developmental and mental health screening
• Fine motor/gross motor skills screening
• Hearing, vision, and dental screening

Each child should have an initial health examination within 24 hours of entering out-of-home care. If a provider is not readily accessible, the initial health examination must occur within 72 hours of initial

placement. The purpose of the initial examination is to determine the need for immediate medical or mental health care and assess for infectious and communicable diseases; however, the initial exam does not need to be a full HCY exam. The full HCY health exam must be completed within 30 days of the child's entry into care. It is the Children's Service Worker's responsibility to ensure children in CD custody receive the appropriate screening, assessment, and follow-up services as necessary. If health needs are identified through the initial screening or assessment, including trauma, treatment is sought immediately.

The Division faces challenges obtaining accurate data for the number of children receiving EPSDT screenings. Some children have private insurance, thus they will not be reflected in the data received from MO HealthNet. In addition, because providers have one year from the date of service to submit the bill, an indeterminate number of claims is absent from the data. Whether providers are properly billing for these visits is in question. Providers may be billing as a routine office visit instead of EPSDT, thus visits are reported incorrectly. The bulletin Dr. Katie Plax is sending out through the MO Chapter, American Academy of Pediatrics will include billing best practices so EPSDT screenings can be tracked more accurately.

Documentation

When children enter CD custody, the case manager is required by policy to obtain information regarding the child's health history. Copies of screenings and assessments are maintained in the child section of the case record. Medical information, including results of screenings and assessments, are obtained prior to FST meetings for the purpose of review and discussion. Staff also share with the team any changes in the child's medical status or unmet medical needs warranting attention. The Children's Service Worker must ensure all initial medical information is given to the resource provider within 72 hours of the child coming into care, if possible, but no later than 30 days following placement.

Trauma- Informed Practice

Children's Division recognizes exposure to trauma can impact children's physical health, emotional health, learning, behavior, and social skills. The Division, therefore, is committed to becoming a trauma-informed organization by which its policies and practices are embedded with a trauma awareness and focus. To steer the development and implementation plan for becoming a trauma-informed agency, the Children's Division partnered with the Department of Mental Health (DMH) in March 2014 to share the employed position of Patsy Carter, PhD, Director of Children's Clinical Services for DMH. In addition to assisting CD in becoming a trauma-informed agency, Dr. Carter will help build a clinical structure within the agency and provide clinical consultation services.

The initial phase of implementation is to ensure staff have a shared foundation of trauma awareness. The Division has elected to train staff using the NCTSN *Child Welfare Trauma Training Toolkit* curriculum. A group of select staff and contracted providers received NCTSN *Child Welfare Trauma Training Toolkit* train-the-trainer in September 2014 and will train all staff in their respective regions with a projected completion date of CY15. Future training sessions will incorporate resource providers and multidisciplinary members (juvenile officers, guardians ad litem).

Children ages 0-6 are identified to be at greater risk of maltreatment, and children who have experienced trauma are more vulnerable to future trauma. In response, Missouri has created the Missouri Early Trauma Initiative (MET) to explore strategies to address the trauma these young children endure. Understanding children in foster care can experience separation trauma at the time of removal from their caregiver or when transitioning between placements, MET created the Missourians Overcoming Separation Trauma (MOST) initiative. This initiative focuses on mitigating the impact of separation trauma on children in foster care ages 0-8 by utilizing a home visitor model in an educational and skills building approach with the caregiver and resource provider. There was money in the proposed budget for this initiative; however, the program was not funded this year. The Division is still committed to addressing separation trauma whether through exploring other funding sources or developing an alternative means to address separation trauma.

Transition Planning

The goal of transition planning is to identify and arrange for anticipated service needs for older youth who will soon be exiting from foster care. Youth who have a comprehensive plan are better equipped to transition successfully from foster care to self-sufficiency. To prepare youth for their exit from the foster care system, the case manager or service worker meet with the youth to develop a personalized transition plan 90 days prior to release from custody. Youth are educated on the importance of designating another individual to make health care treatment decisions on their behalf if they become unable to participate in such decisions and the youth does not have, or does not want, a relative who would otherwise be authorized under law to make those decisions. This can be done by a health care power of attorney, health care proxy, or other similar document recognized by state law and youth should be educated as to how to execute such a document if the youth wants to do so. In February 2013, a memorandum was issued to staff introducing policy and procedures for assisting youth in need of services transitioning from alternative care to adult guardianship and/or conservatorship or supported living through another agency such as Department of Mental Health (DMH) or Department of Health and Senior Services (DHSS).

Each youth is provided an exit packet prior to exiting from care. The exit packet must contain information regarding the following: eligibility for extended MO HealthNet coverage, durable power of attorney for health care and health care directive, services available through the Chafee Aftercare Program, the Education and Training Voucher (ETV) program, National Youth in Transition Database activities, and additional resources germane to the youth's geographic area such as services for disabilities, childcare, and public assistance programs. On August 28, 2013, state statute extended medical coverage for former foster youth up to age 26. The new law includes youth who were in foster care under the responsibility of the state of Missouri at the age of eighteen, or at any time during the thirty-day period preceding their eighteenth birthday. Recently added to the exit packet for youth under the age of twenty-one is a brochure on re-entry. Effective August 28, 2013, youth who exited care after the age of 18, but are not yet 21 years old, may elect to return to care under Missouri Senate Bill 205. The brochure outlines information on eligibility, the process for requesting re-entry, services available to youth re-entering care, and general expectations for transition planning. County offices

were instructed to display the brochure in commonplace locations throughout the community to promote awareness.

It is imperative staff, youth and other Family Support Team members discuss transition planning well in advance of the youth's impending exit so a well-informed and practical transition plan can be developed.

Coordination

The Children Division coordinates with DMH and MO HealthNet Division (State Medicaid agency) to provide consistent comprehensive care to each child in a foster care placement. The work, ongoing with both of these departments, is designed to meet physical, mental health, and dental care needs for children in the foster care system. It is proposed this coordination can be achieved by utilizing the electronic data, having a review done by medical staff as well as a protocol for use of this information for every child as a part of routine reviews and case planning.

The Division is committed to designing a centralized, comprehensive medical record and is exploring the ability to create this record from existing systems with MO HealthNet and DMH through use of CyberAccess, a web-based program that maintains medical history for MO HealthNet recipients. The Division successfully collaborated with MO HealthNet to expand access to health information for children in foster care by authorizing all foster care staff, foster care supervisors, children's service specialists and circuit managers to use CyberAccess. Staff can now access more readily the child's history with regard to medical and drug claims history, procedures, diagnoses, the names of professionals who prescribed medication, and the pharmacies which filled prescriptions.

The Division works with a group of experts who assist in ensuring best health care planning and follow through for children in foster care. The Division currently confers with MO HealthNet consultants when specific assessments or guidance on appropriate medical treatment is necessary. Children's Division had been working with MO HealthNet to establish staff positions for a pediatrician and dentist who will be available to provide the Division with professional health care consultation and guidance. Missouri's increased attention to the oversight of psychotropic medications for foster children has pushed the Division to advocate for MO HealthNet staffing a psychiatrist in place of a pediatrician. This dialogue is current and ongoing.

The Children's Division, MO HealthNet Division, and Division of Youth Services co-facilitate the Health Care Coordination Committee (HCCC). The HCCC is comprised of physicians, pediatricians, therapists, foster youth, private case management contracted staff, and representatives from CD, MHD, DMH, and the Department of Health and Senior Services. The committee was created in March 2010 to discuss oversight and coordination of health care services to foster youth, including physical, mental health, and dental care, as outlined in P.L. 110-351. Priority focus for the committee includes:

- Timely comprehensive assessments
- Health homes

- Psychiatry and dental consultants staffed by MO HealthNet
- A health information system and the importance of having accurate data
- Service array
- Psychotropic medication oversight and prescribing practices

At each quarterly meeting, the committee discusses these mutual priorities and implementation plans, assigning specific tasks to committee members and external partners as needed to fulfill each task. The committee is ambitious and has resolved to identify projects and key health metrics to create more of an outcomes-based collaboration. To better streamline the committee's focus and strategic plan, the Division will seek the assistance of a facilitator.

Psychotropic Medications

Properly prescribing and monitoring psychotropic medication for children in foster care is an important component of health care coordination. While medication can serve an important role in the therapeutic process, oversight is necessary when addressing the needs of children who have experienced maltreatment. The Children's Division, the Department of Mental Health (DMH), and the MO HealthNet Division (MHD), formed a workgroup in 2012 that met quarterly to examine the use of psychotropic medications for children in foster care.

Having identified areas of most concern, the workgroup developed a second opinion process for children prescribed two or more antipsychotics, or five or more psychotropic medications to review appropriateness and elicit trends. The second opinion process was initiated in February 2013 by collecting data on a sample of children meeting the established criteria. The workgroup's board-certified psychiatrist, Dr. Laine Young-Walker, was prepared to review the medical records and offer recommendations to the prescriber. This introductory review provided fewer qualitative results than anticipated, in part, because prescriber responses were slow and records were often incomplete. The MO HealthNet Division has recently advised it will promote the second opinion process by recouping funding for a prescriber's failure to comply with a records request.

Although the Division is not currently implementing this second opinion process, discussions continue about how best to monitor psychotropic medications while work continues on forming a more effective and meaningful review protocol. The Children's Division and MHD are exploring a monitoring method by which MHD will program an edit for antipsychotic medications prescribed for all children in Missouri. Specifically, MHD is considering raising the prior authorization requirement for antipsychotic prescriptions for children under the age of six to any child under age ten. The MO HealthNet Division is also contemplating removing Oppositional Defiant Disorder as a qualifying diagnosis for children of any age. Additionally, Children's Division and MHD are examining prescribing practices in the state's residential treatment programs. The programs' Chief Executive Officers (CEOs) will be provided ongoing reports of their psychiatrists' prescribing practices for children in state custody. The CEO will be informed where their psychiatrists' practice falls within best practice guidelines and alerted to any identified practice concerns.