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 (CD) 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.

This Plan is an update to the 2010 Health Oversight and Coordination Plan submitted by the Children's Division.

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	Coordination and collaboration in

	Dr. Sarah Garwood Dr. Claudia Preuschoff Dr. Terra Frazier Dr. Stuart Sweet	development and implementation of this Plan.
Recipients of Child Welfare Services	Gabby Zajac (Youth Board Focus Groups)	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.
Dental Health Care Experts	Dr. Ray Storm	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 February 28, 2014 is 12,125.

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 MoHealthNet computer database system contains data by claims about prescriptions, visits, diagnoses, and physicians. Children's Division staff now have clearance to obtain healthcare information from the CyberAccess System.

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 an 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 is steadily progressing with its focus on addressing trauma impact for children in foster care. A workgroup consisting of Children's Division, the Department of Mental Health, and numerous private mental health professionals and stakeholders around the state work closely to assist Children's Division identify strengths, barriers and action steps to becoming a trauma-informed agency. In March 2014, the Department of Mental Health's Director of Children's Clinical Services began a shared employment position with Children's Division to oversee Children's Division progression toward becoming a trauma-informed agency.

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 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 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 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 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.

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-informed, evidence-based practices.

D. Action Items to Address Identified Challenges and Opportunities:

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

The Healthcare Coordination Committee 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 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 commissioning the development of an Electronic Health Record (EHR).
- Maximizing EPSDT capabilities will be launched in the EHR.
- A Missouri model for health homes will be established for children and youth in foster care. The Committee is currently exploring a health home pilot specific to children in the foster care system.
- Set standard for comprehensive assessment and follow-up to occur in a medical home within 30 days.
- 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 considerations for appropriate use and oversight of psychotropic medications for foster children.
- A review of ten cases meeting specified criteria was completed by a board-certified child psychiatrist. Obtaining records was a difficult task. Of the records received, the review revealed incomplete records and, therefore, incapable of rendering sufficient data. The group is in the process of developing next steps to gain the data necessary to develop a strategic plan.
- 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.
- Review legislation mandating medication utilization review when more than two psychotropic medications are prescribed for a child, and when psychotropic medications are used for children under the age of six.

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 in treatment of mental health disorders in the foster care population.
- Include substance use assessment as part of the mental health evaluation.

- A Trauma Workgroup 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.
- Patsy Carter, PhD, Director of Children's Clinical Services with the Department of Mental Health now has a shared position with Children's Division with the purpose of guiding Children's Division to becoming a trauma-informed agency.

6. Training:

- "Foster Care 101" and "Trauma-Informed Care" trainings for pediatricians. This can be accomplished through visits to practitioners' offices.
- Begin training on care of children in foster care for residency programs in Missouri.
- Through Missouri Chapter, American Academy of Pediatrics, recruit interested network of providers.
- Trauma-informed care training provided to staff statewide.

7. Quality Assurance

- Increase the currency of immunizations and ensure recommended vaccines are explored.
- Decreased pregnancy rates for children in foster care.
- Increase the percent of children with comprehensive assessment completed in 30 days.
- Increase the percent of follow-up recommendations 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."

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 regarding 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 agency also has difficulty obtaining accurate data as staff do not regularly document in FACES (Missouri's SACWIS system) that an EPSDT screening has occurred and obtaining medical records can be challenging. Missouri has a couple different methods for capturing the percentage of children who receive these exams as required. The FACES system allows staff to input examination information, however, the state is concerned the information is not entered consistently. To gain a more accurate representation of children receiving the required initial screening and 30-day HCY assessment, a case review was performed. A review of case files was conducted for 1,575 children who entered foster care in February, March, and April of 2013 to determine if the 72-hour initial screening and 30-day comprehensive assessment were completed. The results of the review revealed the need for improvement.

As a result of this review, a memorandum was issued to all staff reinforcing the Children's Service Worker's responsibility to ensure children in CD custody receive appropriate and timely screenings, assessments, and follow-up services as needed. Staff were also instructed to emphasize to all foster, relative, and kinship resource providers the importance of obtaining these required screenings for the children in their care. Additionally, a new requirement for documenting medical information in FACES has been initiated. Staff are now required to enter the date of the child's full HCY screening and last physical exam in the appropriate fields on the FACES Medical Information screen. Supervisory staff and Quality Assurance and Quality Improvement (QA/QI) Specialists will help ensure these exams are completed and documented in FACES as required.

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

Research suggests exposure to trauma can impact children's physical health, emotional health, learning, behavior, and social skills. As an agency which provides child welfare services, CD and its contractors should be aware of the impact trauma has on children and families and should educate partners about the impact of trauma. Several groups in Missouri are exploring the use of trauma-informed practice. Following a 2012 partnership between CD and Great Circle, a stakeholder agency, trauma awareness training was piloted in four sites across the state using the National Child Traumatic Stress Network (NCTSN) curriculum. There was also a great deal of work being done in the St. Louis area to educate local child welfare staff and resource providers on trauma-informed care. Therapists in the St. Louis region are currently using the NCTSN training curriculum and assessment tools. There is value in using the curriculum and screening tools provided by the NCTSN as they were developed explicitly to assist child welfare staff achieve positive outcomes associated with the CFSR.

Based on findings from the work of these two groups, recommendations were made to and accepted by management to bring trauma-informed practice to staff and stakeholders statewide. The Division is in the development phase of its objective to becoming a trauma-informed agency. Children's Division assembled a statewide team of mental health professionals from the Department of Mental Health and a legion of stakeholder agencies to help guide this endeavor. In order to examine strengths and gaps within the agency, each of the 45 circuits in the state completed a self-assessment. The surveys uncovered clear strengths in a few circuits, particularly the metro areas, with most of the state recognizing the need for staff training and trauma-informed practitioners. A training plan is being developed for staff, resource providers, and multidisciplinary members (juvenile officers, guardians ad litem) using the NCTSN curriculum. Staff will also receive training on the use of a screening tool designed to suggest when a referral for mental health assessment or services is indicated.

To drive the development and implementation plan for becoming a trauma-informed agency, the Children's Division partnered with the Department of Mental Health (DMH) to share the employed position of Patsy Carter, PhD, Director of Children's Clinical Services, DMH. Dr. Carter assumed this shared position effective March 1, 2014. 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 Division is currently exploring two promising practices listed below.

Young children ages 0-6 have been identified at a great risk of maltreatment because their brains, which are still developing, are vulnerable. As a result, Missouri has created the Missouri Early Trauma Initiative (MET.) Some strategies for addressing the trauma of young children include:

- Increasing access to local mental health professionals trained in child specific traumas
- Supporting financial incentives/Medicaid for trauma specific evidence-based practices
- Working with higher education to increase pre-service training on trauma specific evidence-based practices

- Increasing community collaboration/coordination
- Strengthening families/protective factors/resiliency/framework for safety
- Increasing parent supports
- Encouraging a holistic model of service (prevention, health, mental health, development)

Children who have experienced trauma are more vulnerable to future trauma. Separation from a caregiver can be extremely traumatic even if abuse or neglect existed. Because brain development is critical during this young period, the Division is committed to mitigating the effects of separation trauma on young children in foster care through an initiative known as Missourians Overcoming Separation Trauma (MOST). When a child is removed from his/her home, children ages 0-8 will be assigned a home visitor. An educational and skills building approach with the provider working directly with the caregiver with a strong focus on communication between the child and caregiver will be utilized. The provider will have an individual session with the biological parents who will assist the child through the transition. This will occur in the first 30 days following removal. The caseload size should range from 8-10 children at any one time. Enhanced training for workers, supervisors, and foster parents will also be developed.

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: 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. Effective August 28, 2013, state statute was enacted which 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.

Agency and contracted staff struggle with timely transition planning. 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 is coordinating 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 had explored with MO HealthNet ways to expand access to health information for children in foster care by permitting CD staff to use CyberAccess. Only a small number of CD staff were previously authorized to acquire information from the CyberAccess system until this authorization expanded in 2013. Authorized use of the CyberAccess system has now expanded to all foster care staff, foster care supervisors, children's service specialists and circuit managers. Staff will now be able to access more readily the child's history with regard to medical and drug claim 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 has been working in collaboration 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.

The Children's Division, MO HealthNet Division, and Division of Youth Services co-facilitate the Healthcare Coordination Committee (HCC). The HCC is comprised of physicians, pediatricians, dentists, 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. The committee plans to educate healthcare professionals and case management staff on the importance of collaboration and continuity of care for foster youth. Priority focus for the committee includes:

- Timely comprehensive assessments
- Health homes
- Pediatric and dental consultants staffed by MO HealthNet
- A health information system and the importance of having accurate data
- Older youth education regarding continued insurance coverage
- Service array

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.

Psychotropic Medications

Properly prescribing and monitoring psychotropic medication for children in foster care is an important component of health care coordination. The Children's Division, the Department of Mental Health, and the MO HealthNet Division, comprise a workgroup that meets at least quarterly to examine the use of psychotropic medications for children in foster care. 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 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. A child psychiatrist will review the records of children meeting the established criteria and offer recommendations regarding the use of psychotropic medications to the prescriber. If the prescriber is in agreement, no further steps are required. If the prescriber wishes to discuss the recommendations with the reviewer, a phone call will be arranged by the reviewer. If the prescriber does not respond to the request for records or attempt to discuss recommendations, these situations will be handled on a case- by-case basis.

To initiate the second opinion process, data was collected on the number of children meeting the criteria. Of the number of children in foster care who fit into one of these two categories, the workgroup decided to begin the review process with ten cases. In February 2013, a letter was sent to each child's prescribing psychiatrist summarizing the concern and requesting the prescriber submit the child's medical records to the workgroup's board-certified psychiatrist, Dr. Laine Young-Walker, for review.

Upon initial review, Dr. Young-Walker discovered eight of the records were too incomplete to perform a thorough and meaningful review. Supplemental information was requested on those cases with minimal response. Of the complete records reviewed, one provider documented a plan to decrease two medications with no timeframe specified, and another provider documented previous attempts to decrease the child's medication resulting in significant deterioration.

This introductory review provided fewer qualitative results than anticipated, but important lessons were learned for the next round of reviews. The workgroup is refining the records request letter to be more inclusive and clear on what information is needed from the provider. Request letters will be sent by certified mail to provide a tracking mechanism and to represent a request of higher priority. Most children reviewed had a succession of providers, impeding the process of gathering comprehensive records, and complicating the coordination of care. The quality of care was, therefore, difficult to assess. Future review cycles will account for these variables.

Aside from the second opinion process, the Division continues in the development phase of an agency monitoring protocol for psychotropic medications. In addition to introduction of the informed consent policy, the Division is exploring other ways to educate staff on the appropriate use and monitoring of psychotropic medications for children in care. The last report described the Division's intent to research other states' policy and procedure for monitoring psychotropic medications. The research has been completed, but due to competing priorities, no new policy specifically addressing psychotropic medications has been implemented. The Division will resume this work in the coming year.

Informed Consent

Relative to the work of the psychotropic medications workgroup, the Division developed and instituted policy in September 2013 regarding informed consent. The policy explains informed consent to staff and empowers them to ask appropriate questions of medical and therapeutic professionals when conducting assessments and accessing treatment for children in foster care. In deciding whether or not to consent to treatment, staff should consult with healthcare providers to obtain the following information:

- Diagnosis for which the treatment/medication is prescribed
- Nature of the medication, treatment, test, or procedure
- Name of the medication, including both generic and brand names
- Dosage and frequency of medication
- Expected benefits
- Possible risks and side effects
- Availability of alternatives
- Prognosis with and without proposed intervention

Health Homes

In January 2012, the community mental health home model was introduced to staff, foster parents, and treatment providers. A health home employs a wraparound approach to the delivery of health care services by utilizing a network of healthcare professionals who work collaboratively to assist in identifying medical and mental health needs and to provide services to adults and children to meet those needs. The primary care health home phase was implemented in February 2012. Some eligible children and adults were automatically enrolled, yet not all foster children meet the narrow eligibility criteria.

To cater to the unique needs of foster children, the Children's Division and MO HealthNet Division are in the early stages of developing a health home model specific to children in foster care. The model will be piloted in select locations prior to statewide implementation.