2025-2029 Health Care Oversight and Coordination Plan

Health Care Oversight and Coordination Plan

Section 422(b)(15)(A) of the Act requires states to develop a plan for the ongoing oversight and coordination of health care services for children in foster care (Health Care Oversight and Coordination Plan). States must develop the plan in coordination with the state title XIX (Medicaid) agency, and in consultation with pediatricians and other experts in health care, and experts in and recipients of child welfare services.

The Health Care Oversight and Coordination Plan must include an outline of all of the items listed below, enumerated in statute at section 422(b)(15)(A)(i)- (viii) of the Act:

1. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.
2. How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from the home.
3. How medical information for children in care will be updated and appropriately shared, which may include developing and implementing an electronic health record.
4. Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.
5. The oversight of prescription medications, including protocols for the appropriate use and monitoring of psychotropic medications.
6. How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.
7. The procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.
8. Steps to ensure the components of the transition plan development process required in the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.

For the 2025-2029 Child and Family Services Plan submission, states must provide a new Health Care Oversight and Coordination Plan (HCOCP). The new plan should reflect lessons learned since development of the prior plan and continue to strengthen activities to improve the health care and oversight of children and youth in foster care over the next five years. States are strongly encouraged to outline data and other measures to determine how the state can document compliance with state policies and procedures.

In developing their Health Care Coordination and Oversight Plans and in developing health services for children and youth in foster care, we particularly encourage states to continue to review and strengthen protocols for the appropriate use and monitoring of psychotropic medications for children and youth in foster care.

1. Schedule for Initial and Follow-Up Health Screenings that meet reasonable standards of medical practice.

A Medicaid benefit for children/youth is the Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The objective of EPSDT is to ensure that children under the age of 21 who are enrolled in Medicaid receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions. The State of Missouri has reviewed the requirements of the EPSDT and created/implemented the Healthy Child and Youth (HCY) program as the schedule for health screenings.

Every child is required to have a HCY exam within 30 days of entering into care which includes basic vision, hearing and dental examinations. When the 30-day HCY exam is complete the child/youth will follow the regular scheduled preventive care screenings in accordance with the child's age and medical/health/ behavioral condition.

2. How health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from the home

Identified Needs

When an HCY is complete, Children's Division staff enter the screening type and date in the Family and Children Electronic System (FACES), Missouri's Comprehensive Child Welfare Information System (CCWIS). The HCY screenings are monitored by changes in the child/youth's medical/health needs. FACES provides a notification to the case manager when a screening is due or overdue.

When a 30-day and/or an age-related screening is complete, any medical, mental health, medication, behavioral, and any other identified needs specific to the child would be documented in their individualized Social Service Plan (SSP). Each identified need would include the strategy to address the need, who will be involved to help meet the need, and the next steps. The needs would be reviewed at every home visit and at each Family Support Team (FST) meeting. FST meetings are held within 72 hours and again at 30 days from the date of the initial placement in order to manage initial placement, visitation activities, and to develop the SSP. Subsequent FST meetings are then to be held every thirty days until court adjudication. In addition, placement FSTs are to be held prior to placement moves.

The advancements in technology have initiated a review of the FACES system. The Children's Division has been conducting interviews with FACES users and is in the initial phases of developing a new CCWIS.

There are two health care provider agencies collaborating with the Managed Care Specialty Plan to assist with HCY screenings. The SSM Health Cardinal Glennon operates the Foster Healthy Children (FHC) program. The program assists with providing HCY screenings for children/youth ages 0 – 12 who are entering foster care. The Washington University administers the Supporting Positive Opportunities with Teens (SPOT) program. The SPOT operates a center serving at-risk youth with a range of services to address the health, social support, and prevention needs of youth and conducts HCY screenings. Both agencies conduct the HCY screenings in the St. Louis area only and provide coordinated healthcare services designed to decrease chronic health and psychological complications for children/youth in foster care. Children/youth located in other parts of the state are seen by their regular provider or provider available in location of placement.

In addition to the HCY screenings, Children's Division an agreement with Children's Mercy Hospital to facilitate the initial 24-hour examinations for children/youth in foster care in the Clay, Jackson, and Platte counties located in the Kansas City area. Children's Division provides a list of children/youth entering Children's Division custody and in foster care to Children's Mercy Hospital staff. The Children's Mercy staff contact each resource provider of a child/youth on the list to offer a list of available medical providers who can conduct an initial 24-hour examination. The list of providers includes the Children's Mercy Hospital Foster Care Medical Clinic (FCMC). Resource providers are expected to choose freely from the list of medical providers. The Children's Mercy Hospital staff participate as necessary in scheduled multidisciplinary or collaborative discussions or meetings around individual case planning and coordination, as a result of a children/youth's medical health assessment.

Emotional Trauma

Children's Division has made the intentional commitment to be a trauma-informed system. Exposure to trauma can make it more difficult for families to distinguish between safe and unsafe situations and may lead to significant changes in their own protective and risk-taking behavior. Children/youth who have experienced trauma are at significant risk for impact on their

brain functioning, developmental trajectory, relationships, coping skills, and health outcomes. Because of the high prevalence of traumatic stress within families and children/youth who have experienced abuse and neglect, Children's Division policies and practices are created through a trauma informed perspective.

For Children's Division staff to actually help families where there has been trauma, Children's Division requires all new staff to complete four trainings. As a pre-requisite for subsequent trauma trainings, staff are required to complete the "Trauma Informed Practice" training within the 3 months of the hire date. Upon completion of this course, staff are required to complete the "Trauma 101," "Advanced Trauma Training," and "Informed Self Care" trainings. The trainings provide key concepts of trauma informed practice with a focus on the ability to define, recognize, and respond to the events, circumstances, and effects of traumatic experiences.

When the trainings are complete, the primary method for Children's Division staff to prepare for a traumatic situation is through a Team Decision Making (TDM) meeting. An initial TDM meeting is a facilitated meeting to review the threats to the child/youth's safety and to make a team decision around initial diversion placement decisions for the child/youth. Whenever feasible, the initial TDM meeting is held prior to the diversion of the child/youth in order to explore all options available to the family to mitigate the safety threat(s) and minimize trauma.

The HCY screenings include social/emotional screenings which provide an ongoing assessment of the child/youth's mental/behavioral health.

The resource provider is a vital member of the team of professionals working towards providing services for children/youth in foster care. The Children's Division has consolidated all of the various resource provider pre-service trainings into one training entitled Missouri Caregiver and Adoption Resource Education (MO C.A.RE). Foster/adopt parents must successfully complete 30 hours of training. After demonstrating that they meet the required competencies, they then can proceed to become a licensed resource provider.

The "Pre-Service" training competencies are the grouping of knowledge and skills essential for resource providers before a child/youth is placed in their home. The MO C.A.R.E. curriculum is designed to facilitate the development of relationships between prospective resource providers and co-trainers and to promote the communication necessary for the delivery of supportive services. This is accomplished through training content to assess the willingness and ability to become a resource provider who can protect and nurture children who have experienced trauma i.e., physically, sexually abused, emotionally maltreated, abandoned, and/or neglected. The MO C.A.R.E. training has an emphasis on working collaboratively with Children's Division to help address any health/medical, developmental needs and connect the child/youth to safe and nurturing lifetime relationships, with reunification with parents or kin as the primary goal.

Also, Children's Division has the National Child Traumatic Stress Network's, Resource Parent Curriculum (RPC) Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents. RPC is an eight-week program to prepare resource parents to understand how trauma affects children and enhance the skills needed to be effective in addressing behavioral symptoms in the home. Resource providers can attend the RPC conducted through community foster parenting service agencies.

3. How medical information for children in care will be updated and appropriately shared, which may include developing and implementing an electronic health record.

The collection, storage, and retention of medical documents and information for children/youth in foster care is an important service. The Children's Division case managers and Health Information Specialist staff utilize several electronic methods to obtain medical documents. Some of the methods are:

- Biscom Fax: A secure file transfer system for medical documents from various entities through digital fax
- CIOX: A clinical data technology system that securely connects healthcare decision makers with patient medical records for agencies that are enrolled with CIOX Health
- health eXchange evolved (hXe): A centralized record management system that allows the submission of record requests directly to any healthcare provider
- ShowMeVax: Missouri's, Immunization Information System
- Cyber access: MO HealthNet (Missouri Medicaid) Billing Claims system
- Show-Me Health Information Network of Missouri (SHINE): A physician-led Health Information Network delivered in partnership with the Missouri State Medical Association
- Tiger Institute: The University of Missouri System and Oracle Cerner Health Information Network

- Envolve: The managed care specialty plan member portal
- Velatura: The secure exchange of health information across integrated networks.

The medical documents and information are uploaded to the Department of Social Services, main electronic document imaging database called "OnBase." A primary benefit of OnBase is that all information has been centralized into one secure location. The documents are uploaded through electronic mail or electronically scanned and placed in the child/youth's OnBase file using their individually assigned client, call/case, or resource provider number. The Children's Division's Security Officer oversees the administration of OnBase. This database contains an array of other service documents related to the care and services for children/youth.

Any documents with medical information may be kept in the case manager's physical case file. In order to ensure that potentially relevant documents are maintained all Children's Division's staff have been instructed to update OnBase and their physical case file upon receipt of any documents and/or information.

Medical documents and/or medical information of the child/youth in foster care can be made available to appropriate members of the child/youth's FST. Individuals who must be invited to FST meetings include:

- Youth aged 12 and older
- Parents, individuals invited by the parents
- Legal guardian for the child, Guardian ad Litem (GAL), Legal counsel for the parents
- Resource providers
- Juvenile officer
- The Court Appointed Special Advocate (CASA)
- Up to two (2) youth-chosen advisors advocate (for youth 12 and over) on behalf of the youth in regard to application of the reasonable and prudent parenting standard.

Also, other documents for sharing relevant information includes: the Initial Family Assessment, SSP, the Health Care Information Summary, Child/Family Health and Developmental Assessment, and Monthly Medical Logs. These documents contain safety assessments for the child/youth, service interventions/goals, and various medical/health information such as physician, diagnoses, medications, and allergies.

The sharing of any information is limited to pertinent medical documents and is subject to the Missouri laws and Children's Division policies regarding confidentiality, patient privacy, and access to medical records.

4. Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.)

Managed Care Health Plan

The managed care plan contract with Home State Health, a subsidiary of the Centene Corporation, has a general and specialty plan. MO HealthNet has established the specialty plan as Show Me Healthy Kids (SMHK). The SMHK specialty plan covers the child/youth's medical/health and behavioral health benefits. All children/youth in Children's Division's custody and in foster care are enrolled as members in the SMHK specialty plan.

The members are linked with a Primary Care Provider (PCP) of their choice. The PCP maintains the continuity of each member's health care by including documentation of all services provided to the member by the PCP, as well as any specialty/referral services, diagnostic reports, physical and behavioral screens.

Each SMHK member is assigned a Care Manager who is part of SMHK's Care Management Team. This Team conducts early and ongoing physical, behavioral, emotional, and developmental health assessments for each child/youth, including assessments for social determinants of health needs. These assessments, in addition to the child/youth's other health care and service treatment plans, are used to develop the child/youth specific integrated and comprehensive care plan. Children's Division and Care Management Team participants meet each month to discuss progress for specialty plan members and ways to improve services.

The SMHK Care Manager monitors the care plan every quarter to ensure the child/youth is receiving services listed in the plan. The Care Manager works with the Care Management Team members, resource family, and Children's Division case managers to discuss services and identify any gaps in care to revise the plan.

SMHK specialty plan staff have been a valuable partner in the continuity of care for children/youth in foster/care. The SMHK staff search for and collect past medical documents and information for specialty plan members. The medical documents are uploaded into SMHK's Health Passport portal. Health Information Specialists (HIS) have access to the portal and can view and retrieve documents for specialty plan members.

Communication and Correspondence with Parents and Resource Providers about the Child/Youth's Healthcare

The Children's Division case manager is required to gather medical/health care information about the child/youth and complete the Health Care Information Summary (CD-264). The Child/Family Health and Developmental Assessment (CW-103) form is provided to the parent(s)/legal guardian for completion. Although the parent(s)/legal guardian should be primarily responsible for completing the CW-103, case managers can provide assistance to ensure the form is as accurate and complete as possible. When a child/youth has been placed in foster care for the first time since coming into the legal custody of Children's Division, the case manager will ensure that the CD-264 and CW-103 are provided to the resource provider or residential care providers within 72 hours, whenever possible; but no later than 30 days following placement.

When the child/youth is in the placement, the resource provider or residential care provider collect the documents and create a medical case file. The providers track, monitor, and document the child/youth's healthcare needs and services. Each month the providers are required to complete the Monthly Medical Logs (CD-265) and provide a copy to the case manager. If a placement change occurs, the case manager will provide to the new resource provider or residential care provider the CW-103, an updated version of CD-264, and a copy of the resource provider or residential care provider's medical case file, including all CD-265s, from the child's prior foster care placements. This information will be made available at the time of placement; but no later than 72 hours following placement.

5. The oversight of prescription medications, including protocols for the appropriate use and monitoring of psychotropic medications.

When a child/youth is in Children's Division custody, the Children's Division is required to ensure that the child/youth receive appropriate medical/health and behavioral health care. This includes emergency treatment, whenever necessary, timely examination and treatment of nonemergency injuries/illnesses, proper assessment and care of medical/health behavioral health issues, and regular preventive care. The case manager is responsible for the provision of the child/youth's medical and behavioral health services while the child/youth is in Children's Division custody. The case manager partners with the parent(s); unless, a Termination of Parental Rights has occurred, the court has issued an order preventing the parent/guardian access to the information, and/or the case manager believes that discussions with the parent(s) is contrary to the child/youth's best interests. In addition to the parent(s), the case manager can partner with the child/youth (to the extent reasonable for the child's age and understanding), resource providers, and primary health care providers. The case manager will attempt to contact these partners prior to the provision of any treatment.

An essential part of the case manager's services is the initial FST meeting and development of the SSP. During the FST meeting, the case manager is assessing the safety of the child/youth and gathering information to determine service/treatment needs. A significant part of the review for service needs is the child/youth assessment with the parent, caregiver, and/or guardian(s). The case manager must complete the Health Care Information Summary Assessment form for each child. While the parent or legal guardian should be primarily responsible for completing the Child/Family Health and Developmental Assessment form, it is the case manager's duty, even if the parent or legal guardian does assist in completion of the assessment paperwork, for ensuring that the form is as accurate and complete as possible. These forms contain a section to list the number of medications, including over-the counter medications, dosage, frequency, reason for the medications, dates when the medication started, and when it was stopped.

When these forms are complete and information is logged into FACES and the documents are uploaded to OnBase or placed in the physical file, the case manager can create the SSP to implement services that will include monitoring of the prescription medications. The case manager's supervisor may be consulted at any time and will review case status, goals, and outcomes with the case manager.

The case manager's responsibility to provide oversight of the child/youth's prescription medications includes the oversight of psychotropic medications. Children's Division provides a specific training to case managers and supervisors on

psychotropic medications within 6 months of their hire date. This training consists of topics such as the classes of psychotropic medications, Food and Drug Administration ("FDA")-approved versus off-label use of such medications, alternative forms of treatment, and Children's Division policies with respect to the approval/denial of the prescription/administration of a psychotropic medication. All case managers and supervisors are required to complete this training.

In addition to the psychotropic medications training, Children's Division requires the case manager to complete a training within 6 months of their hire date that focuses on obtaining sufficient information about a psychotropic medication(s) and treatment, prior to approving or denying the prescription/administration of any psychotropic medication for a child/youth in foster care. The case manager cannot approve or deny the prescription/administration of a psychotropic medication until they have completed this and the psychotropic medications training. Obtaining sufficient information includes, but is not limited to,

- The results of the behavioral health/psychiatric evaluation of the child including the child's diagnosis or diagnoses, along with the target symptoms to be addressed by the medication.
- An explanation of the purpose of the medication, the anticipated duration of treatment, and its expected results.
- The short and long-term risks and possible benefits associated with the medication and any combination of medications prescribed, including the nature and possible occurrence of any adverse effects and/or irreversible symptoms.
- Any required follow-up appointments or monitoring and the prognosis without an intervention, including the probable physical and/or behavioral health consequences of not approving the medication.

Every child/youth prescribed/administered a psychotropic medication for ongoing use (more than a single dose) is required to have, documented in their case record, monitoring appointments with a prescriber at least every 3 months, or more frequently if indicated by the prescriber. The approval for a psychotropic medication is valid for 1 year. Every 90 days the case manager is required to review if the child/youth has experienced any adverse effects and whether the symptoms for which the drug was prescribed have been addressed.

Health Information Specialist Unit

The use of psychotropic medications for children/youth in foster care has received nationwide attention. In an effort to provide a specific group of staff to review the use of psychotropic medications for children/youth in foster care, the Children's Division has established the Health Information Specialists (HIS) Unit. The HIS Unit has 12 Health Information Specialists and has been separated into 2 teams. Each HIS team is under the supervision of an HIS Unit manager. Each team member has been assigned a specific circuit/region within the State to assist Children's Division staff with questions about psychotropic medications.

Each month HIS staff receive and review various reports that contain the prescribed medications for a child/youth in foster care. The reports are utilized to track and monitor the prescription and administration of any medications. The review of psychotropic medications is conducted through the Automatic, Mandatory, and Secondary reviews.

The Automatic reviews have specific criteria that if a child/youth meets that criteria can generate a psychotropic medication review that will include a review of the prescription medications. The Automatic reviews are initiated and conducted by the Statewide Clinical Consultant on a quarterly basis.

The Mandatory reviews are initiated by the case manager when a psychotropic medication meets the Mandatory review criteria, and the case manager is requesting a review prior to approving or denying the prescription/administration of a psychotropic medication.

A Secondary review would be conducted if the case manager has concerns about psychotropic medications being prescribed and/or the parent or child/youth disagrees with a case manager's informed consent decision. A member of the child/youth's FST, i.e., resource provider, guardian ad litem, court appointed special advocate, or the juvenile officer can request a Secondary Review. When a psychotropic medication meets the Mandatory review criteria or there is a request for a Secondary review, the case manager will contact the HIS staff member assigned to their circuit/region who will review the request and send a referral to the Statewide Clinical Consultant for a medication review, if needed.

The HIS Unit staff provide support for the case managers and supervisors pertaining to the psychotropic medication reviews and the prescription/administration of psychotropic medications for children/youth in foster care.

The Statewide Clinical Consultant

The "Statewide Clinical Consultant" refers to the entity Children's Division has contracted with to coordinate the medical and behavioral aspects of pediatric care for children/youth in Children's Division's custody and in foster care. The "Statewide Clinical Consultant" is the "Center for Excellence in CHILD Well-Being (CFE)." A function of the CFE is psychotropic medication reviews. All referrals for a Mandatory or Secondary psychotropic medication reviews are sent to CFE. The Automatic reviews are conducted by CFE on a quarterly basis. The experts in the CFE are board-certified child and adolescent psychiatrist, registered nurses, and clinical psychologist. The clinical findings and recommendations of CFE's psychotropic medication reviews are provided to the case manager and supervisor. The case manager reviews the CFE's information and any other pertinent information to determine if the prescription/administration of the psychotropic medication will be approved or denied.

6. How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

Children's Division has a significant number of active workgroups, committees, subcommittees, projects, programs, and formal collaborations with various focus points. The groups are:

- Children's Mental Health Collaborative
- Behavioral Health Workgroup
- Foster Care ECHO
- Community Partners Meeting St. Louis
- Local Systems of Care

The Children's Mental Health Collaborative has brought together representatives from the Department of Social Services (DSS) and the Department of Mental Health (DMH) to respond to the lack of accessibility of mental/behavioral health care services for children/youth. Group participants include representation from clinicians within statewide hospital, residential facilities providers, clinicians representing community resource providers, Missouri Behavioral Health Council, Missouri Juvenile Justice Association, Missouri Hospital Association and state department leaders. This group is focusing on the workforce issue, data, better tracking of children/youth in hospital settings, treatment needs, accountability in accessing resources, treatment gaps, case analysis to better determine trends, and addressing treatment and placement barriers. The Children's Mental Health Collaborative recognized a need for further evaluation of Missouri's Behavioral System and, through identifying that need, a contract was secured with The Center for Healthcare Strategies to perform an environmental scan of Missouri by collecting data from DSS, DMH, and Missouri's courts as well as conducting numerous stakeholder interviews to provide a thorough assessment and recommendations for how to better structure Missouri's resources for mental and behavioral healthcare for children and create a more effective systems of care. The results will be reported to Children's Mental Health Collaborative. Children's Division is working with the group on strategic planning.

The Behavioral Health Workgroup is chaired by a doctor of philosophy and licensed clinical social worker who is a Clinical Consultant & Assistant Professional Practice Professor of Psychiatry with CFE. This workgroup includes pediatricians, psychiatrists, and representatives from behavioral health, and has the following areas of focus:

1. To increase and improve the Intensive In-home Services program training.
2. To reduce Autism Spectrum Disorder (ASD) diagnosis and referral to service wait times for foster youth by following the DMH Missouri Autism Guideline Initiative's (MAGI) guidance for tiered evaluation.
3. To enhance continuity of care for foster youth discharging from residential treatment services and transitioning back to community-based services.

The Foster Care Extending Community Health Outcomes (ECHO) is the model that is followed, and the focus is on the healthcare needs of foster care children/youth. The group consists of a team of medical experts as well as participants and is open to anyone. Meetings have a case presentation and then a didactic presentation. The ECHO group meets monthly with a break in the summer months. Also, ECHO provides a SharePoint site of resources and recommendations that are provided within ECHO as another way to offer education/support from and to medical professionals.

The Community Partners Meeting St. Louis is a local partnership meeting between Children's Division, medical providers i.e., physicians, physician assistants, nurse practitioners, etc., and contract providers in the St. Louis area. The topics

discussed include healthcare data, relevant legislation, and the importance of other medical/health and behavioral health needs.

A Local System of Care (SOC) is a group of public and private organizations, providing formal and informal supports, who share core values about how to help support the mental health needs of children/youth and families. A core value of an SOC is to increase access to effective services e.g., by removing barriers. The intent of the SOC is to provide a framework and philosophy to guide service systems and service delivery. Since the SOC's are locally controlled there can be variations in the presentation of formal and informal supports. Some of the local SOC's perform specific case presentations that offer preventative interventions.

Psychotropic Medication Advisory Committee

The Psychotropic Medication Advisory Committee (PMAC) is a valuable partner in the efforts to obtain current information about the medical/health and behavioral health issues facing children/youth in Children's Division custody. The primary purpose of the PMAC is to provide professional and technical consultation and policy advice to the MO HealthNet and Children's Division on the development and implementation of policy pertaining to the administration of psychotropic medications to children/youth in foster care. The PMAC members are:

1. The Director of Children's Division and MO HealthNet
2. A representative of the Statewide Clinical Consultant and the Missouri Department of Mental Health
3. A child and adolescent psychiatrist, who is an employee of the Statewide Clinical Consultant
4. A child and adolescent psychiatrist who is not an employee of the Statewide Clinical Consultant
5. A mental health provider with experience working with children and adolescents, who is an employee of the Statewide Clinical Consultant
6. A pediatrician
7. An individual with expertise in management of electronic health records
8. Three foster children above the age of 13
9. A current Resource Provider
10. An attorney who represents children/youth in Children's Division foster care
11. An attorney who represents parents of children/youth in Children's Division foster care
12. A pharmacist with expertise in psychotropic medication
13. Any other representatives that have information and/or expertise that can contribute to the work of the PMAC i.e., Managed Care Pharmacy Director, Director of Youth Programs and Services, Chief Executive Officers, and Vice Presidents of Regulatory and Clinical Affairs.

The PMAC meetings are conducted on a quarterly basis and are attended by the PMAC members and PMAC participants. The PMAC members/participants receive a WebEx invitation with the agenda, the previous meeting minutes, and any documents that would be part of the PMAC meeting. A copy of each agenda was published as required by Missouri Sunshine Law on a State of Missouri's website to serve as a notice to the public of the meeting and the topics. The topics have ranged from inpatient hospital protocols, informed consent, and updates from the subcommittees generated from the PMAC. These subcommittees are the Clinical and Education and Collaboration.

Clinical Subcommittee

The Clinical subcommittee of the PMAC developed the Excessive Dosage Guidelines (EDG) in 2020. The members of this subcommittee include: a child and adolescent psychiatrist, two pharmacists, a child psychiatrist, and a mental health provider with experience working with children and adolescents. The subcommittee members review and collaborate with the University of Missouri Kansas City's pharmacy department to update the EDG on an annual basis. The reviews include an evaluation of advancements in medical science, the development of new medications, changing clinical practice, and psychotropic medication(s) that do not have FDA-approved pediatric or adult dosage guidelines or is prescribed for an "off-label" use. The EDG list the maximum allowable dosage for a psychotropic medication. The Guidelines contains the following tabs:

- Drug Listing: Lists trade names and Psychotropic Medications.
- Maximum Dose: Food and Drug Administration (FDA) approval or PMAC recommendation
- Details: Lists information that was utilized to create the Excessive Dosage Guidelines.
- Literature Review: Two documents that contain the Pediatric Psychopharmacology Dose Recommendations.
- Definitions: Lists the meaning of words and abbreviations contained in the Excessive Dosage Guidelines and contains links to convert medication dosages that are prescribed and administered based on the weight of the child.

The EDG is a tool for case managers and supervisors to determine if a child/youth's prescription/administration of any psychotropic medication(s) exceeds the dosage limit.

7. The procedures and protocols the State has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.

The Missouri Department of Social Services implemented the Family First Prevention Services Act (FFSPA) in October 2021. The FFSPA priority outcomes are: safely reducing the number of children/youth entering foster care, increasing statewide accessibility to prevention services, and enhancing community collaboration to strengthen family supports.

Safely reducing the number of children/youth entering foster care

The FFPSA target populations are:

- Children/youth identified as needing services through an active investigation or assessment, or are already receiving services by the state agency, to include non-court and court involved cases.
- Children/youth involved in a newborn crisis assessment where the mother or child had a positive toxicology screening during pregnancy or at the time of birth.
- Children/youth, including pre- or post-natal infants, of pregnant or parenting youth currently in foster care or who have exited foster care within the past five years.
- Children/youth who have exited foster care through reunification, guardianship, or adoption within the past five years and are at risk of disruption.
- Siblings of children/youth in foster care who still reside in the family home with identified safety concerns and are at risk of entering foster care.

Prevention

Prevention services are available through FFSPA to help children/youth who have been identified in the target populations and are at risk of entering foster care. FFSPA can help children and their parents/caregivers access services and supports to safely keep them together. Prevention services include: mental health treatment services, substance use disorder prevention and treatment services, and in-home parent skill-based programs. Services offered within each of these categories must be identified and approved in the state's prevention plan to qualify for partial reimbursement of funds.

The prevention services are offered through evidence-based programs that require the program to have reliable and valid outcome measures. A focus for preventive services is providing trauma informed care. The preventive services must be delivered under an organizational treatment framework that centers on trauma and adheres to principles of trauma-informed approaches and interventions. Missouri is presently planning for initial roll out of prevention services in pilot site locations. The Children's Division goal is to keep children/youth safe at home with their family, when possible. In situations where this is not possible, FFPSA aims to keep children/youth in a family-like setting. To help with this goal, the Children's Division has made substantial efforts to create and maintain several placement options. These options include:

- Family foster home, including relative homes, Treatment Foster Care homes
- Kinship Navigator services to support relative/kinship homes
- Placements for pregnant and/or parenting youth
- Independent living programs for youth over the age of 18
- Placements for youth at risk and/or victims of human trafficking
- Family-based residential treatment facilities for substance use disorder

Support

If a child requires a higher level of support and would benefit from a non-family like setting, a qualified individual must assess a child to determine if placement in a family setting or in residential treatment is the most effective and appropriate option to meet the needs of the youth. If a child is identified to require a higher level of support from a non-family like setting, a Qualified Residential Treatment Programs (QRTP) is a short-term placement option. FFPSA puts additional

restrictions and higher accountability to make sure the placement is temporary, focused on the child/youth's specific needs, and provides plans for after discharge to help the youth successfully return to their family and community.

A QRTP must be licensed and accredited, utilize a trauma-informed treatment model, and have access to a registered nurse 24 hours a day 7 days a week. Within 30 days of placement in a QRTP an assessment must be completed by a qualified individual to determine if this setting is in the child's best interest.

8. Steps to ensure the components of the transition plan development process required in the Act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.

For youth in foster care, who can neither return home nor be adopted, independence becomes a factual circumstance. The earlier the youth's needs are addressed, the greater the youth's chances for successful transition. The Children's Division case manager's role is to ensure that the youth is involved in all phases of transition/exit planning for their future and to facilitate the youth taking advantage of opportunities provided for them. The youth's participation in the Older Youth program can assist with a smooth transition to self-sufficiency.

In Missouri, the Older Youth Program incorporates the Foster Care Independence Act of 1999, a federal legislation, which introduced the John H. Chafee Foster Care Independence Program in each state. The Older Youth Program allows Children's Division the ability to offer services and financial help to young adults trying to develop their skills, education, and independence. Assistance for youth transitioning out of foster care is performed through the "Chafee Foster Care Program for Successful Transition to Adulthood." Participation in this program requires the development of a transition/exit plan for "Aftercare" services to help the youth become an independent adult. The youth must be between the ages of 18 and 23 and have left foster care on or after their 18th birthday to participant in the Chafee program. Services are meant to be short-term and are available as a safety net to help when: it is not realistic to stay in Children's Division custody after age 18, the youth has asked to leave Children's Division custody after turning 18 and has an approved transition/exit plan, or juvenile/family court has automatically terminated jurisdiction on or after age 18.

Youth aging out of Children's Division's custody and want Children's Division services can complete a Chafee Program Support application. When the application has been received by the Children's Division, the youth will be connected to an Older Youth Transition Specialist who will connect the youth with a local Chafee Provider. The Chafee Provider will work on the transition/exit plan with the youth to identify and arrange for anticipated services.

A significant part of arranging services is securing health care coverage. If the youth was in foster care at least 30 days before their 18th birthday or later and are not yet 26 years old, they are eligible for free healthcare coverage through Missouri Medicaid, (MO HealthNet), regardless of how much money the youth makes or what the youth owns. To enroll the Chafee Provider will need the youth's current address to obtain a MO HealthNet ID card. The youth will be assigned a Managed Care Health plan and receive a separate ID card from the health plan. The youth must bring both of these cards to every appointment. The health care coverage includes: routine/emergency medical care, routine dental cleaning/vision exams, individual counseling, and prescription coverage with no co-pay.