2021 APSR ATTACHMENT A

**2020-2024 Health Care Oversight and Coordination Plan**

**Annual Update 2021**

Section 422(b)(15)(A) of the Social Security 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)-(vii) 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; and
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.

The first Annual Progress and Services Report (APSR) for fiscal year 2021 is due by June 30, 2020. To provide states with guidance on completion of the APSR update the U.S. Department of Health and Human Services has sent each state representative the program instructions. It is important that APSR submissions address all requirements outlined in the program instruction. The program instructions for this update are as follows:

* Describe the progress and accomplishments in implementing the state’s Health Care Oversight and Coordination Plan, including the impact protocols for the appropriate use and monitoring of psychotropic medications have had on the prescription and use of these medications among children and youth in foster care
* Indicate in the 2021 APSR if there are any changes or additions needed to the plan. In a separate Word document, provide information on the change or update to the Health Care Oversight and Coordination Plan, if any.

**1. Schedule for Initial and Follow-Up Health Screenings**

The Children's Division continues to monitor the initial health and Healthy Children and Youth (HCY) examinations for children in foster care. Each child entering foster care should receive an initial health examination within 24 hours to identify any immediate health care needs and a full HCY examination within thirty (30) days.

A point-in-time review for July 2018 and July 2019 showed an increase in the amount of completed initial health examinations. The point-in-time review for February 2019 and February 2020 showed a slight increase for the completion of initial health examinations.

A point-in-time review for July 2018 and July 2019 showed an increase in the amount of completed full HCY examinations. The point-in-time review for February 2019 and February 2020 showed an increase for the completion in full HCY examinations.

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|  | **Point-In-Time** | **July 2018** | **July 2019** | **Feb 2019** | **Feb 2020** |
| 1 | Number of Children 0-17 in Foster Care | 12853 | 12828 | 12853 | 13142 |
| 2 | Percent of Initial Health Examinations complete within twenty-four (24) hours of entering care | 36% | 39% | 39% | 40% |
| 3 | Percent of full HCY Examinations complete within thirty (30) days of entering care | 67% | 76% | 70% | 77% |

Children's Division has established a contract with Children's Mercy hospital in Kansas City to contact each resource provider of a child entering foster care in Jackson and Clay County to offer these providers a list of available medical providers for the initial 24- hour examination. The list of medical providers include Children's Mercy Hospital’s Foster Care Medical Clinic and other suitable medical providers.

Children's Division has assigned a team of Health Information Specialist (HIS) to review the completion percentages of the initial health and full HCY examinations and develop methods to improve those percentages. The HIS team members review initial health and full HCY statistics on a monthly basis to ensure the examinations are complete and have been recorded in Family and Children Electronic System (FACES) database.

**2. Monitoring and Treating Identified Health Needs, Including Emotional Trauma**

**Family and Resource Parent Engagement / Information Exchange**

Children's Division staff continue to collect, monitor and discuss the child's health care needs with the child’s family, parents and resource providers with the Child/Family Health and Developmental Assessment (CW-103), Health Care Information Summary (CD-264) and Monthly Medical Log (CD-265). Staff use the CW-103 to request information from the parent(s). Staff can assist the parent(s) with completing of the CW-103, if needed. Parent(s) are valued as an active member of the child's family support team and may provide important information about the child's health care. The resource provider completes the CD-265 form and provides this to the assigned case manager each month. This form contains information about physician/therapist visits, upcoming appointments, medical events, etc. The assigned case manager is required to gather information about the child and provide the CD-264 to resource provider at the time of the initial or subsequent placement. The CD-264 contains information about the child's current health care providers, medications, chronic/reoccurring health conditions, allergies, etc.

**Trauma Assessment Pilot with a Managed Care Organization**

Children's Division has worked diligently over the past few years to heighten staff’s trauma awareness and sensitivity needed to serve families and children involved in the child welfare system. The capacity for all staff to screen clients for trauma is a goal. The Children’s Division is considering a number of trauma-specific assessment tools and, once selected, staff will be trained on the tool’s application and how to triage outcomes to best support families and children. This will help build staff’s ability to be appropriately responsive to any traumatic experiences or triggers uncovered during such screenings.

In 2019 Children’s Division was approached by United Health Care (UHC), which is one of the state’s three Managed Care Organizations, with a request to pilot a trauma assessment tool with children served in one circuit in the state. Though UHC already provides a trauma assessment to all their foster care members, the pilot proposal created the opportunity for an escalated and more collaborative approach. For the pilot project, UHC offers additional care management and oversight for children included in the pilot area, while also administering needed trauma assessments that inform better treatment plans for children in care, and help inform CD’s next steps for a statewide trauma assessment protocol. The MO HealthNet Division, who oversees the managed care contracts, and Children’s Division sought to capitalize on the care management performance requirements included in the managed care contract that had been previously underutilized and approved the proposal.

Children’s Division and MO HealthNet approved UHC’s selection of the CANS Trauma (Child and Adolescent Needs and Strengths Trauma version) assessment provided by the National Child Traumatic Stress Network. UHC’s care managers are trained on the CANS Trauma assessment, how to administer it, and how the assessment can be used in subsequent treatment planning. With consideration given to circuit demographics and foster care entry rates, the 32nd Circuit – consisting of Bollinger, Cape Girardeau, and Perry counties – was selected for the pilot. The pilot began in early 2019 and includes all children who enter foster care in the 32nd Circuit and who are placed within the circuit.

Approximately 60 foster care members have participated in the pilot so far. The pilot continues, but early successes include increased awareness for CD case managers around services provided by the care management contract. With this increased knowledge, staff have voiced gaps in services provided by UHC that would be instrumental to helping families achieve case goals. For instance, the plan had previously covered non-emergency medical transportation (NEMT) to individual therapy and family therapy, but not to parenting classes. Identifying transportation as a barrier to families completing recommended or court-ordered parenting classes, this collaborative pilot resulted in UHC adding NEMT for parenting classes as a covered service to promote the child’s well-being and mental health. UHC extended this service to all enrolled members across the state as a result.

**3. Updating and Appropriately Sharing Medical Information, which may Include Developing and Implementing an Electronic Health Record**

The Children's Division staff continue to gather health care documents to update medical information in each child's record. The health care documents include, but are not limited to information on:

* Medical, surgical, dental, psychosocial treatments;
* Mental health and psychiatric assessments;
* Hospitalization or residential treatment(s);
* Current and past medications;
* Family health history;
* Service plans, health screenings/examinations; and
* Clinically indicated lab work.

The Children's Division staff continue to use the CW-103, CD-264, and CD-265 to gather and distribute health care information to parents/resource providers and other members of the family support team.

The Department of Social Services (Department) has privacy officers to process any request for sharing Protected Health Information (PHI) contained in the child's medical record. PHI is individually identifiable health information maintained or transmitted by a covered entity. The Department has implemented an information security process to be in compliance with Health Insurance Portability and Accountability Act and Missouri’s Sunshine Law requirements.

MoHealthNet and the State of Missouri's Office of Administration are collaborating with a major corporation to create a contractual arrangement to develop and maintain an electronic medical records system. The Project Plan for the proposed contract defines project activities, responsibilities, expectations, and outcomes.

The Project Plan provides a description of the nature of work required but does not provide an exhaustive list of every task or subtask necessary for project completion.  The activities in the Project Plan include:

* Project management, planning, coordination, and task integration
* Analysis of Department current state workflow, design, and configuration of the system
* Data conversion
* Training and knowledge transfer
* Build, test, and configuration of Software-as-a-Service (SaaS) technology
* System deployment
* Support

The primary outcome of the contract would be the development and maintenance of an Electronic Medical Record (EMR) integrated database. The EMR database would allow healthcare professionals to electronically store, capture and access health information.

The Missouri Medical Passport Program (MMPP) was a 16-month pilot project with a focus on providing case management staff with a portable electronic medical record.  The project was a collaboration between MO HealthNet and Children’s Division and was piloted in the 12th and 13th circuits.  The MMPP project is complete and the final report has been provided to MO HealthNet and Children’s Division project associates for review and analysis.

**4. Steps to Ensure Continuity of Health Care Services, which may Include Establishing a Medical Home**

**Health Homes**

The SSM Health Cardinal Glennon Children’s Medical Center and Creating Options and Choosing Health (COACH) Clinic through Washington University continues to provide health home services and are in the process of extending their contracts with Children's Division through 2021.

The SSM Health Cardinal Glennon project provides medical home services to children under twelve (12) years of age. During the period from November 2019 – January 31, 2020 SSM has reported that 84% of the children received an examination within thirty (30) days. Of the remaining 16% more than half had an appointment scheduled within 30 days.

The COACH clinic reports that for the period of September 1, 2019 – November 30, 2019 they averaged 13 referrals for their Supporting Positive Opportunities with Teens (SPOT) program for children ages 13-17 in St. Louis Mo. During the same time period 163 (126 current & 37 new) clients received services at the SPOT. These services include: medical services from a physician, nurse services for prescriptions, immunizations and case management services.

The health home project model contracts have been in effect since 2015. Currently, a topic of discussion has been to expand the health home model to other cities (Joplin, Springfield and Columbia) in Missouri.

**Managed Care Plans – Care Management and Care Coordination**

The new Managed Care contract released May 1, 2017 requires increased care management and care coordination for enrolled members. All children in foster care receive care management services through his/her managed care plan. The contract requires the health plan care managers to work with the child’s primary care provider in developing care plans for patients to ensure continuity and coordination of care. In the event a child is transitioning to a different managed care plan, the contract requires the new plan to continue services authorized by the previous plan for up to sixty calendar days and precludes the new plan from reducing services until the new plan conducts an assessment supporting service reduction.

Care Management services are intended to improve patient care and coordination, improve health outcomes, reduce inappropriate services and inpatient hospitalizations, and to better educate providers and members. The health plan must work with the child’s resource parents to ensure the child receives all required examinations and health care visits/interventions within the timeframes defined by Children’s Division and determined by the child’s needs, including all HCY/EPSDT well-child exams.

Children’s Division is working with the managed care plans to promote care management. The plans report some resistance from resource parents when contacted to complete the initial health assessment. While some resource parents do not fully appreciate the support provided by care management services, others feels it is a duplication of services they already receive or they do not need the support. The Children’s Division and MO HealthNet Division support that all children and youth in foster care, who are enrolled in a managed care plan, will receive care management services. The plans have collaborated on informational material to educate resource parents on the care management services provided by the contract and how those complement, or even exceed, services the child may be receiving already. Once the materials are finalized, approved, and published, Children’s Division will disseminate to all resource parents, CD staff, and CD contracted case management staff.

**5. Oversight of Prescription Medications, Including Protocols for the Appropriate Use and Monitoring of Psychotropic Medications**

**Psychotropic Medications Monitoring Training**

The Children's Division has revised the psychotropic medications and informed consent trainings. The psychotropic medications training includes the following topics:

* The definition and classes of Psychotropic Medications;
* Food and Drug Administration (FDA)-approved versus off-label use of such medications;
* The possible risks, benefits, and interactions of such medications; and
* Alternative forms of treatment.

The purpose of the revision was to provide specific training instructions to Children's Division and contracted foster care case managers who manage a foster care caseload. Staff who provide informed consent for psychotropic medications were required to complete the training by November 20, 2019. As of February 2020, 99% of all Children's Division and 88% of all contracted foster care staff have completed the psychotropic medication training.

**MO HealthNet Clinical Protocols**

Children’s Division continues to work with the MO HealthNet Division and Department of Mental Health to address the appropriate use and monitoring of psychotropic medications for children and youth in out-of-home care through their clinical protocol edits program.

The MO HealthNet pharmacy system monitors and reviews psychotropic medications for a child age nine (9) and under who have been prescribed an atypical antipsychotic and/or five (5) or more psychotropic medications.

The MO HealthNet Division reports these system edits continue to decrease in the number of requests from prescribers for an antipsychotic for a child under age nine.

**Psychotropic Medication Advisory Committee**

In September 2019, Children's Division began appointing members to the Psychotropic Medication Advisory Committee (PMAC). The purpose of the PMAC is to provide professional/technical consultation to the Children's Division and MoHealthNet Division on the development and implementation of policy pertaining to the administration of psychotropic medications to children in foster care. The required members of the PMAC include the following:

* Director of Children's Division and/or such staff members as appropriate;
* Director of MoHealthNet Division and/or such staff members as appropriate;
* Representative(s) of the Statewide Clinical Consultant;
* Child and adolescent psychiatrist, who may also be an employee of the Statewide Clinical Consultant;
* Child and adolescent psychiatrist who is *not* an employee of the Statewide Clinical Consultant (and who may be located outside of the state);
* Licensed psychologist or other mental health provider with experience working with children and adolescents, who may also be an employee of the Statewide
* Clinical Consultant;
* Pediatrician;
* Representative appointed by the Director of the Missouri Department of Mental Health;
* Individual with expertise in management of electronic health records;
* At least three foster children above the age of 13;
* Current Resource Provider;
* Attorney who represents children in foster care;
* Attorney who represents parents of children in Children's Division foster care; and
* Pharmacist and/or a pharmacologist with expertise in Psychotropic Medication.

The PMAC is required to meet on a quarterly basis and prepare an annual report on the work of the PMAC. The PMAC has reviewed topics such as the administration of psychotropic medications during an inpatient hospital visit and a maximum dosage review for psychotropic medications prescribed to children in foster care.

**Clinical Sub-Committee**

In December 2019, a clinical sub-committee was created from the PMAC members to review maximum dosage guidelines and develop an "Excessive Dosage Criteria" guideline for Children's Division staff. The required members of the clinical sub-committee include the following:

* Qualified Psychiatrist;
* Pharmacist and/or pharmacologist;
* Representative of the Statewide Clinical Consultant;
* Pediatrician; and a
* Licensed psychologist or other mental health provider with experience working with children and adolescents*.*

The review of the "Excessive Dosage Criteria" would be for psychotropic medication(s) that do not have FDA-approved pediatric or adult dosage guidelines or is prescribed for an "off-label" use. The clinical sub-committee has reviewed several state programs and is in the process of developing an "Excessive Dosage Criteria" draft to present to the PMAC for review and recommendations.

**The Statewide Clinical Consultant**

The Center for Excellence in CHILD Well-being (The Center) has extended its contract and will continue to be the Statewide Clinical Consultant for the Children’s Division. The Center's primary function continues to be coordinating oversight for the appropriate use and monitoring of psychotropic medications prescribed to children in foster care. The Center's utilizes data from the Care Management Technologies *ProAct Advantage* tool to monitor quality indicators for best practices and alerts staff of children/youth hitting benchmarks falling outside of best practice.

The Center has reported that during the fourth quarter of 2019, 128 consultation requests were received from Children's Division. Of that 128, 88 were medication reviews, 36 were case consultations and 4 were physical health consultations.

**Heightened Trauma Awareness for Resource Parents**

In working toward becoming a trauma-informed organization, Children’s Division is training resource parents on the National Child Traumatic Stress Network’s Resource Parent Curriculum (RPC) *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents*. Some resource parents may have become too accustomed to seeking pharmacological interventions to address a child’s behaviors. The new informed consent policy implemented in September 2018 requires that before a child is evaluated for psychotropic medication, they or their caregivers must first have attempted non-pharmacological interventions. Should these interventions prove ineffective or insufficient, the child may be recommended for a psychiatric evaluation if referred by a mental health professional. This policy revision reinforces the need to strengthen resource parents’ readiness to meet the unique needs of children in foster care. The eight-week RPC workshop prepares resource parents to understand how trauma affects children so resource parents, in turn, are more skilled and effective in addressing behavioral symptoms in the home. Understanding behaviors are not always symptoms of underlying mental health disorders can impact the tendency to seek pharmacological interventions. Although the goal is to train all current and newly licensed resource parents on the RPC curriculum, there is an insufficient number of facilitators statewide to develop a training plan or timeline for completion. Until there is statewide facilitator capacity, the training will not be required. In the meantime, to build enthusiasm around the program, the Children’s Division is currently motivating resource parents’ voluntary participation through active promotion and peer endorsement.

**6. Consulting with and Involving Physicians or Other Appropriate Medical or Non-Medical Professionals in Assessing the Health and Well-Being of Children and in Determining Appropriate Medical Treatment**

**Health Care Oversight and Coordination Committee**

The Health Care Oversight and Coordination Committee (HCCC) continues to meet quarterly and is comprised of medical and non-medical professionals, as well as state agency representatives. The focus of the HCCC is to review health care services provided to children in foster care and recommend innovative plans and strategies to maintain and/or improve those services.

During the HCCC meeting on February 14, 2020 the primary topic was the presentation of the Health Care Coordination Committee's Health Outcomes Workgroup report. The report contained recommendations to improve health care services in the following areas:

* Immunizations
* HCY Examinations
* Health Homes
* Health Information Sharing

The Health Outcomes Workgroup report has been sent to the Children’s Division administration for a comprehensive review and analysis.

**7. Procedures and Protocols Established to Ensure Children are not Inappropriately Diagnosed (Family First Prevention Services Act)**

Children/youth in CD custody continue to be evaluated by qualified medical and behavioral health clinicians using age-appropriate, evidence-based, and validated assessment tools. Each child's diagnoses are reviewed by the assigned case manager and family support team to guide in the development of the child's treatment plan. If there is a question and/or concern about the accuracy of a diagnosis the assigned case manager can initiate a referral to the Statewide Clinical Consultant (The Center). The Center will provide their findings and recommendations to assigned case manager who will be required to follow-up with the child's health care provider.

**8. Health Care Transition Planning for Youth Aging Out of Foster Care**

The goal of transition planning is to identify and arrange for anticipated service needs for older youth who will soon be exiting foster care. Youth who have a comprehensive plan are better equipped to transition successfully from foster care to self-sufficiency. It is imperative for staff, youth, and other Family Support Team members to discuss transition planning well in advance of the youth’s impending exit so a well-informed and practical transition plan can be developed.

To prepare youth for their exit from the foster care system, the Children’s Service Worker meets with the youth 90 days prior to release from custody to develop a personalized transition plan. 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.

Policy and procedures exist for assisting youth in need of services transitioning from alternative care to adult guardianship 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 Chafee Aftercare; the Education and Training Voucher (ETV) program; National Youth in Transition Database activities; request to re-enter foster care; 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 to age 26. The statute 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. In SFY20, this was extended to include youth who transitioned out of care from another state and are now residing in Missouri. 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.