State of Connecticut

CFSP - 2020 - 2024

Health Care Oversight and Coordination Plan

The Connecticut Department of Children and Families (DCF) vision is “Partnering with communities and empowering families to raise resilient children who thrive.” The Health and Wellness Division of DCF supports children and families wellbeing by enhancing health assessments and intervention with a focus on the most vulnerable populations and empowering families to meet the medical needs of children in care. The division incorporates lessons learned from the past and works with families and communities to keep children healthy while in the custody of their parents or their foster family.

Guided by the American Academy of Pediatrics (AAP), the Child Welfare League of America (CWLA) and American Academy of Child and Adolescent Psychiatry (AACAP) best practice, DCF Health and Wellness Division collaborates with community stakeholders in establishing a system of health care services and supports, and providing consistent health oversight throughout the state. Specifically, success and sustainability require effective collaboration and partnering with other state agencies including the state's Departments of Public Health (DPH), Social Services (DSS), Mental Health and Addiction Services (DHMAS) and Developmental Services (DDS). DCF is also working with the AAP Connecticut Chapter, AACAP Connecticut Council and community providers including hospitals, clinics and private providers. Collaboration with families served by the Department and with foster families is being enhanced through partnerships with the Connecticut Alliance of Foster and Adoptive Families (CAFAF) and DPH's Medical Home Advisory Council (MHAC).

Connecticut's five-year Health Oversight and Coordination Plan builds on the principles outlined above and on strategic partnerships. The below activities are the route to achieve the agency's goals as well as meeting "Fostering Connections" expectations. The efforts focus on three components: 1) program development, 2) policy and practice: development, refinement, implementation and education, and 3) outcomes and results-based accountability: data development and continuous quality improvement.

As described below, DCF relies on both internal and external professionals to achieve the goals of improving outcomes and optimizing the health of children in our care. Key internal resources include:

- Regional Resource Group (RRG) nurses who are available in each DCF Area Office (AO) and Region to support child specific issues as well as AO education and support;
- Central Office nurses who, in addition to supporting AOs, provide training to foster parents and congregate care facilities on safe medication administration and caring for children with complex medical needs;
- Health Advocates who assist with issues relating to health insurance and accessing services;
- Substance Abuse experts who support both child specific and AO practice;
- Psychologists and Clinical Social Workers with expertise in trauma;
- Centralized Medication Consent Unit (CMCU) APRNs and Psychiatrists who oversee all psychotropic medications for children in care (additional detail below); and
- Clinicians in the RRGs who assist with planning for children with behavioral health needs.

<u>Health and Wellness Policy and Practice Guide: Translating Policy into Practice:</u>
DCF has recently revised and enhanced its Health and Wellness policy and practice guide (Health Care Standards and Practice For Children and Youth in Care, revised February 2019) to improve outcomes for children and families who have engaged with the Department. The guide sets expectations for routine care and health supervision informed by the AAP's "Fostering Health" guidelines and CWLA's "Standards of Excellence for Health Care Services for Children in Out-of-Home Care". The guide is divided in four sections addressing health care standards for 1. Youth and children in DCF care 2. Children and youth in placed in Foster care 3. Children and youth placed in congregate care facility and 4. Medication management of youth. These standards continue to include:

- A multidisciplinary evaluation (MDE) within 30 days of placement;
- Ongoing routine health care consistent with Medicaid EPSDT and AAP Bright Futures;
- Medication Oversight and Psychotropic Medication Consent;
- Care of children with complex medical needs.

Strategies for improving outcomes and achieving the goals of policy and practice include the following activities and initiatives:

- Education:
    - Providing education on the revised Health and Wellness policy and practice guide:
        - Area Office staff training will be provided through a partnership between RRG nurses and Central Office Health & Wellness Division staff;
        - Partner with CAFAF to provide training to foster parents on the revised policy and practice guide through the already developed "Fostering Health for Children in Foster Care" curriculum that has become part of their pre-licensure training. The training has been reviewed by foster parents through a piloted presentation. CAFAF will assist with monitoring to ensure that the training meets foster parent needs and will assist with any needed modifications to the training based on feedback;
        - Congregate care facility staff will be trained by Health and Wellness in the agencies Health and Wellness policy and practice guide especially as it is related to medication administration and meeting of the health needs of youth in their care.
    - Providing education to DCF staff about pediatric health issues especially those areas affecting children in foster care. Topics include: routine health care and supervision including EPSDT screening, immunizations, dental care, trauma, child development, gender identity and human trafficking with a goal of ensuring that AO staff receive ongoing routine training and updates on topics important to children in foster care and child welfare. Standardized curricula will be developed by Health and Wellness Division staff with training scheduling and regional specificity of content managed by DCF's Regional Resource Group (RRG) nurses;
    - Developing a SharePoint and on line "library of trainings" including PowerPoint presentations and resources.

- Continuing the partnership with DSS to ensure children receive timely quality health services:
    - Health Advocates and Medical Assistance Unit continue to ensure that all children in DCF's care are enrolled in Medicaid;
    - Heath Advocate continues and expands usage of claims data to track receipt of routine and disease-specific health services that can inform the child's foster placement, Primary Care Provider, case plan and Administrative Case Review.
    - Health Advocates also support the Area Office staff in helping families to navigate their private health insurance and support families to make referrals to the Office of the Health Advocate.
- Engage workgroups to review, optimize and implement practice standards
    - Work with partners within and outside the agency to develop an initial health screen policy for children with specific medical concerns, after a child enters care, and is conducted by the child's PCP.

- Consulting with medical and nonmedical professionals is essential to best outcomes for children and families. DCF's participation in workgroups and committees facilitates communication and collaboration on programs and processes affecting children in its care. Formal and informal communication are facilitated through partnerships with stakeholders. Recently intensified efforts are occurring to partner with professionals in pediatrics and psychiatry. Specific strategies for ensuring consultation are as follows:
    - Health and Wellness Division Nursing to standardize nursing practice and optimize use of RRG and CO nurses and supports.
    - Continued availability of CMCU Psychiatrists and the Director of Pediatrics for direct consultation on child-specific issues and program development;
    - Maintenance of the Medical Review Board (MRB), which provides recommendations to the Commissioner in matters concerning the medical care and treatment of children in the care and custody of DCF when their health situations are exceptionally complex or present other ethical and/or legal issues;

    - Continued participation in workgroups and committees. Examples include:
        - DPH Medical Home
        - Medical Home Advisory Council (MHAC), Medicaid Program Oversight Committee (MAPOC), Hartford
        - Care Coordination Collaborative (HCCC), and Psychotropic Medication Advisory Council (PMAC).
- Continuing policies and practices to support the medical needs of youth aging out of DCF care.
    - Continue to assist youths who were in foster care at age 18 and who are receiving Medicaid to continue receiving medical care benefits though their 26th birthday.
    - Continue to assist youth to connect with Husky programs that offer supports to help create stability for youth aging out of DCF care including but not limited to appointment reminders, education about medical conditions, and arranging transportation.

DCF's Enhanced Multidisciplinary Evaluations (MDEs):

Since 1985, DCF required Multidisciplinary Evaluation (MDE) within 30 days for children entering care. Over time this process has evolved from a pilot project to a statewide contracted service. MDEs include medical, dental, mental health, developmental and trauma screening components and are performed by contracted providers serving each of the agency's Regions and Area Offices. Expansion of MDE criteria to include all children entering care including those re-entering DCF and, if appropriate, voluntary services. In the last year, DCF and its MDE clinic contracted providers collaborated and developed a standard online teaching tool for new medical and behavioral health providers as well as a guideline for clinic coordinators. Also, monthly meeting with the Department and providers of the MDE to continue and enhance the process that best supports children, caregivers and biological parents and DCF and leads to a quality report that informs case planning. Specific strategies included in the MDE practice guide and new teaching tool are as follows:

- Standardization of the MDE report across the all MDE providers;
- Expansion and standardization of mental health and developmental screens e.g. Ages and Stages, and trauma screenings, which includes a trauma screen for children 3 years old and older;
- Standardization of follow up and further evaluation base on MDE behavioral health recommendations to ensure appropriate behavioral health diagnosis.
- Standardization of recommendations to facilitate their integration into a child's case plan and utilization at Administrative Case Review;
- Protocols for ensuring communication of MDE summary findings and recommendations to a child's primary care provider (PCP) and his/her placement/caregiver;
- Rigorous QI/QA system with RBA outcomes and the development of a mechanism for standardized data collection;
- Training of AO staff by DCF MDE liaisons and MDE clinic providers.

Plans for continued support and enhancement of the MDE include the following steps:

- Implementation of the revised and enhanced MDE practice guide, documentation forms and the new teaching modules;
- Development of a process for the integration of new and/or revised mental health scales;
- Provide training and education to Regional Office (RO) staff about the new guide and how it supports and improves planning for children in care. MDE contracted providers and representatives from DCF RO and Central Office have worked together on the development of training material and will partner in presentations to AO staff;
- Continue with quarterly MDE meetings of MDE clinic providers and DCF representatives;
- Implement data collection and QA mechanisms and a toolkit with yearly QA team reviews of each MDE clinic and RO practice. Components of QA team review include review of randomly selected MDE reports

and care plans to assess quality of assessment and recommendations and the incorporation of latter into the case plan;
- Continual partnership with MDE clinics
- Developing and incorporating Fetal Alcohol Spectrum Disorders Screening as part of the MDE process

"Healthy Mouths, Healthy Kids" Initiative:
The "Healthy Mouths, Healthy Kids" initiative is a cooperative interagency project among DCF, DSS and the Connecticut Dental Health Partnership [note: CTDHP is DSS' ASO for dental care]. The objective of the project is to ensure that children in DCF care receive oral health care services at an established dental home beginning at age one but no later than age three to achieve optimal oral health. Through regular oral health evaluations, the prevalence of dental disease and adverse oral habits can be reduced. This also will be accomplished through routine dental check-ups every six months.

There are two parts to this project:
1. DCF Health Advocates and CTDHP collaborated on the development of a presentation to heighten awareness for RO staff about the oral health needs of children in DCF care. The presentation is a total of 15 minutes: 8-10 minutes of content followed by a brief question and answer period. Information is also provided on resources available to RO staff;
2. The second part of the project involved the report to Senior Leadership the percentage of children in care who had routine, recommended, oral healthcare in the last six months. A database developed through an MOU with CTDHP identify children who are overdue for routine dental care (not having had a dental check-up every six months). The database identifies the date of the last exam and dental office name and phone number.

The 'Healthy Mouths, Healthy Kids' project plan includes:
- Continued quarterly data sharing activities;
- Expanding training to foster parents and other placements;
- Ongoing data assessment and problem solving at both RO and state levels with modifications or revisions of project plan if needed in order to achieve goals.
- DCF Health Advocates to share with ROs data specific to their offices as well as be available to assist social workers and facilitate referrals to CTDHP

DPH Medical Home Care Coordination Collaborative (HCCC):
For the last nine years DCF has been a member of the Connecticut Care Coordination Collaborative (HCCC), a DPH-funded medical home initiative focused on care coordination, efficiency and a holistic approach to health and well-being. The HCCC mission is to serve families and child health care providers in the greater Hartford area by:
- Identifying and maximizing the full range of resources available;
- Supporting care coordinators in obtaining the care and services needed by children and their families.

The HCCC also seeks to understand health and human service delivery systems in order to: promote wellness, support the medical home, assist families in negotiating these systems and document the gaps and barriers that families experience. Participants from DCF include AO social workers and RRG nurses, Health Advocates and members of the Central Office Medically Complex Unit. Community-based participants include: representatives from CHN, the Behavioral Health Partnership (BHP), and the CTDHP (DSS's Medicaid ASOs for medical, mental health and dental care). Additional partners include CT Family Support Network, Connecticut Children's Medical Center's Special Kids
Support Center (SKSC) and the United Way 2-1-1/Child Development Infoline (CDI). Discussions from these meetings have:

- Led to the identification of resources and strategies to improve services to better meet the needs of children and families in DCF care;
- Facilitated communication across sectors that have provided effective and efficient linkage to services for children and families;
- Resulted in the development of partnerships that assist beyond the collaborative.

Future strategies include:

- Continued participation by CO and RO representatives on the Regional Care Collaboratives;
- Partner with Regional Care Collaboratives to develop shared care coordination models across agencies.

ACCESS-Mental Health CT:

ACCESS-MH CT is a model that provides telephonic psychiatric consultations by child and adolescent psychiatrists to Primary Care Physicians in the state for all children under 19 years of age regardless of insurance coverage. The program was implemented in June 2014 and allows for face-to-face consultations when a telephonic consultation with a child psychiatrist and/or clinician is not able to completely address the PCP's questions. Care coordinators and family peer specialists assist in obtaining identified services. There are three "hub" providers contracted to provide the services. Each hub is comprised of a child psychiatrist, behavioral health clinician, family peer specialist and a care coordinator. The hours of operation are from 9 a.m. - 5 p.m. Monday through Friday.

From July 1, 2018 to April 30, 2019, utilization was as follows:

- 1,226 youth and their families
- Male 54.07% (663); Female 45.92% (563)
- 11.9% (146) DCF involved
- 4714 total consults (with 40.94% (1,930) of the consults involving youth with HUSKY)
- 97.59% (1,379) of the initial calls from the PCP were answered within 30 minutes
- PCP satisfaction rate: 4.99 out of 5

Centralized Medication Consent Unit (CMCU):

The CMCU, staffed by nurse practitioners and child psychiatrists, is responsible for making decisions on all psychotropic medications recommended by a provider for a DCF-committed child/youth. In addition, the unit maintains the policies, practice requirements and guidelines regarding the use of all psychotropic medications in DCF-committed children. These guidelines and requirements are developed in collaboration with the Psychotropic Medication Advisory Council (PMAC), a DCF organized council composed of public and private physicians, clinicians, nurses, family members and pharmacists. PMAC meets regularly to: recommend psychotropic medication dosing and monitoring guidelines and requirements; collect and review adverse drug reaction reports; and conduct routine pharmacy utilization reviews.

Next Steps:

- Ongoing review of the medication request forms to include the new mandatory monitoring requirements;
- Update the CMCU website;
- Drug utilization studies will be reviewed in PMAC and any ramifications for DCF policies/protocols will be managed by the CMCU staff;
- As ACCESS-MH CT begins consulting with PCPs on psychotropic medication management issues, CMCU will work closely with the consultation teams to ensure that the requirements for DCF-committed youth are followed.

Licensure and Certification Workgroup:

This initiative is a multi-agencies collaboration established by the state legislature that requires the Office of Policy and Management to convene a workgroup to conduct a review of the certification and licensure processes of certain non-profit community providers, and study potential efficiencies. Membership consists of six representatives of non-profit community providers and representatives from the DCF, Developmental Services and Public Health. The DCF

medication administration program is included in this initiative as the workgroup to looks to develop one state-wide program for the certification of non-licensed staff to administer medications.

Next Steps

- Develop uniform statewide training for non-licensed staff to administer medication.
- Develop and implement joint oversight and reports.

Health Information and Documentation: The "Health Passport" and Health Reports:

It is important that DCF maintains current health records for all children in its care and that they are readily available to best support children. The revised policy and practice guide requires that all placements maintain a current health passport which consists of a Medical Alert (LINK Medical Icon), Report of Health Visits, Caregiver Log of Visits to Provider, the child's Medicaid Insurance Card, a copy of the Consent for Routine Care with the instruction sheets explaining the DCF consent process, and immunization records. As developed, the Health Passport system, including the process for updates through the report of health visits forms, facilitates the monitoring and oversight of all aspects of a child's health including medication details. Representatives from CT AAP assisted with the drafting of the content of the Health Passport. DCF is in the process of developing its new Statewide Automated Child Welfare Information System (SACWIS). As envisioned, the new SACWIS system will further support documentation through inclusion of a "health report" system that captures the elements of the Health Passport including the health summary (Medical Alert), report of health visit, and immunization record. The Health and Wellness Division is currently working with the IT department to develop health components of the SACWIS including information contained in the Health Passport. The expectation is that all placements will have a readily accessible, portable copy of the Health Passport which accompanies the child on every visit and whenever he/she travels.

The foundation of the Health Passport is the "Medical Alert" and builds on work of Health Resource and Services Administration's (HRSA) Maternal Child Health Bureau Title V aimed at improving outcomes for children and youth with special health care needs (CYSHCN). Notably, the AAP considers all children in foster care to be children with special health needs. The goal of the Medical Alert is to provide a format for capturing information about a child's current medical issues, treatments, medications, as well as provider names and contact information. As with CYSHCN, the goal is to ensure that children get the care they need. AO social workers and nurses are responsible for ensuring that the Medical Alert is current.

The "Report of Health Visit" completed by providers at each health visit, informs the placement and RO social worker of any changes in care. Changes in care may require further follow-up, modification of the "health summary" or other action steps. Completed for all health visits, the Report of Health Visit ensures that DCF is informed of all changes and permits tracking of medications, referrals, status of conditions and any necessary follow-up.

The DCF plan for enhancing medical information and documentation includes:

- Educating stakeholders in the component and usage of the health passport, including working with a primary care provider group to incorporate the electronic visit summary into the medical profile.
- Informing DCF planning on the new SACWIS/CTKind program and planned "Health Report". Elements include:
    - Incorporation of Health Passport elements including Health Medical Alert and Report of Health Visits;
    - A secure portal to permit community providers to make updates to the Health Report and Report of Health Visits;
- Completing development of a data development plan that will ensure a mechanism of ongoing tracking of child specific health information and population health data and outcomes;
- The Development of Regional Systems of Care: Partnership with Connecticut's Chapter of the American Academy of Pediatrics (AAP)