**State of Utah**
**Department of Health and Human Services**
**Division of Child and Family Services**

# Healthcare Oversight and Coordination Plan
# Targeted Plan within the FFY 2020 – 2024 CFSP

**APSR 2024 Update**
**June 30, 2023**

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ATTACHMENT C.

## Introduction

The Plan for Healthcare Coordination and Oversight was reviewed, and APSR updates to the plan are presented throughout the document below.

This plan is a component of Utah Division of Child and Family Services (DCFS) FFY 2020 - 2024 Child and Family Services Plan (CFSP). The plan was developed in conjunction with the Department of Health (DOH), which became the Department of Health and Human Services (DHHS) as of July 1, 2022, and includes the Fostering Healthy Children Program (FHC) and the Medicaid agency. In addition, FHC provides healthcare coordination to ensure that medical, dental, and mental healthcare needs of children in foster care align with best practice and current research.

In 1997, DCFS entered into an agreement with DOH, now DHHS, to have registered nurses from the FHC program monitor, oversee and coordinate healthcare services for children and youth in DCFS custody. FHC nurses work in conjunction with community health partners and healthcare providers to coordinate the provision of mental, dental, and health services and resources for children and youth. FHC nurses also enter available health data in the DCFS Comprehensive Child Welfare Information System (CCWIS)/SAFE, provide consultation and health education to DCFS staff, provide healthcare training to out-of-home care providers, and attend Quality Improvement Committee meetings, or send reports to the committee. This partnership will continue to be a vital component of healthcare coordination and oversight for Utah children in foster care during the FFY 2020 - 2024 CFSP period.

To ensure that foster children are only being prescribed psychotropic medication consistent with their needs, the Utah Psychotropic Oversight Program (UPOP) was established in 2016. UPOP is a psychotropic medication oversight pilot program for children and youth in foster care. Members of UPOP include medical providers affiliated with Safe and Healthy Families, a program through Primary Children's Hospital. FHC and UPOP were consulted regarding development of this plan. Additionally, youth from the DCFS Youth Advisory Council (YAC) represent youth voice by providing input related to the process for monitoring psychotropic medications.

The State Foster Care and Kinship Administrator and the FHC Program Manager meet frequently to facilitate successful collaboration. Additionally, DCFS, FHC, and DHHS Division Administration meet quarterly to address foster children healthcare oversight and coordination, including ensuring compliance with DCFS policies.

## Schedule for Initial and Follow-up Health Screenings

DCFS Practice Guidelines outline procedures to be followed when providing children with Well Child Health Evaluations and Care (CHEC) and other medical care, dental exams, mental health services, developmental and social assessments, and immunizations. DCFS Practice Guidelines also address procedures to be followed for special medical situations.

A medical provider sees children entering custody that are ill or have signs of abuse or neglect within 24 hours. Children receive a CHEC from their medical home and primary care provider (PCP) within 30 days of removal or court ordered custody, as stated in DCFS Practice Guidelines. Where possible, the child's PCP will perform the CHEC. Also, where possible, children over the age of three receive a dental exam from their primary dentist. Every effort is made to keep children with their same healthcare providers. The CHEC schedule is based on the periodicity schedule recommendations made by the American Academy of Pediatrics.

A Mental Health Assessment (MHA) is completed within 30 days of entering state custody, and the ASQ/ASQ-SE is completed per the periodicity schedule. The MHA is completed annually for children ages five and older. The ASQ/ASQ-SE is completed according to the recommended schedule for children under five years of age. Any referrals that are made from the CHEC, dental exam, or MHA are tracked and are to be completed within 90 days, unless there is an emergent need or the physician or medical provider requests differently.

DCFS administrators and FHC nurses worked with the DCFS CCWIS Manager and DCFS Data Security personnel to make the ASQ/ASQ-SE process more efficient. The FHC program has transitioned from regular mail to an online format for sending the ASQ/ASQ-SE to foster parents, which has improved the completion and tracking rate from caregivers.

## Monitoring and Treating Health Needs

Health records are obtained for children in out-of-home care either by a health visit report form or through the treating practitioner's electronic medical records (EMR). Information collected is entered in the child's CCWIS SAFE health record, which tracks referrals and follow-up care, as needed. The FHC nurse reviews each file to identify and ensure healthcare needs are being completed. The FHC program, in accordance with established privacy and security practices, facilitates the provision of healthcare information and documentation to foster parents and medical providers.

## Medical Information for Children in Care—Including Electronic Health Records

Data is stored in the CCWIS SAFE database. When a child's placement changes or the child returns home, a health data report summary is provided to the family and medical providers who treat the child or youth. The report informs the physician about the child's current medications, dosage, route, and schedule; current allergies; immunizations the child has received; and special equipment the child may need.

## Continuity of Healthcare

Wherever possible, children in custody remain with their same medical home and primary care provider they had prior to entering state custody. If the child is placed at a location that prevents them from conveniently accessing that provider, the FHC nurse helps coordinate the transfer of the child's case and medical records to a new provider.

## Oversight of Prescription Medication—Including Psychotropic Medications

During the 2016 legislative session, state legislators passed SB-82 *Child Welfare Modifications,* which amended Utah Code Annotated §80-2-503.5 and allowed DCFS to establish and support a psychotropic medication oversight pilot program for children in foster care. Legislation in 2020 extended the sunset date for the psychotropic medication oversight pilot program to July 1, 2024.

The purpose of the oversight pilot program is to ensure that foster children are being prescribed psychotropic medication consistent with their needs. The statute allowed for the oversight pilot program to include, at a minimum, an Advanced Practice Registered Nurse (APRN) and a child psychiatrist. By statute, the oversight pilot program monitors foster children who meet the following criteria:

- Six years old or younger who are being prescribed one or more psychotropic medications.
- Seven years old or older who are being prescribed two or more psychotropic medications.
- Any case referred to UPOP where there is a concern or request for consultation.

DCFS collaborated with FHC and the University of Utah Department of Pediatrics to create UPOP; the program launched in January 2017 and is led by a University of Utah Health child psychiatrist. The MOU between DHHS, DCFS, and the FHC program outlines the requirements for UPOP.

All medications prescribed for a child in custody are tracked in the child's CCWIS/SAFE medical record. This record provides a history of current and past medications taken by the child. There continues to be collaboration by UPOP's APRN with the DCFS data team to track and review children and youth who are receiving support from UPOP.

In instances of an FDA medication recall or other concern, DCFS accesses a SAFE report listing children on the specific medication(s) and sends a letter and a copy of any FDA warning to the provider that prescribed the medication. The letter requests that the provider review the medication(s) with the adult who gave consent and/or oversees the child's use of the medication(s). The adjusted plan of care concerning the medication(s) is updated in the child's CCWIS/SAFE record.

Since the program began, UPOP has reviewed an average of 2,000 cases each year. As part of its efforts to provide collaboration, relationship building, and ensure safe care, UPOP communicates with prescribers, caseworkers, and DCFS teams. Cases meeting the criteria of being medically complex are reviewed. Reviews include case histories, mental health assessments, and health records; consultation is attempted with a physician, when needed.

In addition to quarterly reviews completed by UPOP, efforts continue to establish the UPOP program to align with Best Practices for Psychotropic Oversight Programs published by the American Academy of Child and Adolescent Psychiatry.

## State Policy and Procedures

UPOP is assisting DCFS to update and clarify the medication consent guidelines and policy for children in foster care to include policy for psychotropic medication consent. UPOP and DCFS are in the process of outlining appropriate medication guidelines that will become part of the state policy for foster children and be distributed to medical providers treating children in foster care across the state. Currently, UPOP utilizes Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents.

DCFS updated practice guidelines regarding a foster child or youth being prescribed psychotropic medication. The decision to prescribe shall be in consultation with the Child and Family Team and include documentation of informed consent. DCFS recently updated foster parent agreements to include this updated practice guideline. DCFS shared these psychotropic medication policy updates with contracted residential and proctor agencies.

## Oversight Process

UPOP continues to evaluate and update the oversight process to improve efficiency and effectiveness. During FFYs 2019 and 2020, efforts included working with the DCFS information technology team to facilitate documentation of UPOP quarterly reviews and consultations in the DCFS healthcare section of SAFE. With the new program ability, DCFS gained access to UPOP

reviews. Currently, ongoing collaboration is occurring to generate accurate data for reporting and performance measures. Work in this area is ongoing.

## Consultation Program

The UPOP Helpline has operated since the program's inception in 2017. Practitioners treating a child in foster care may use the helpline to consult with the UPOP team and receive advice about appropriate medications. The helpline is also available to foster parents and DCFS employees who need to discuss specific cases with a UPOP team member. UPOP receives phone calls and emails requesting consultation on specific cases. In addition to helpline calls and email requests, calls are made quarterly by UPOP psychiatrists and APRNs to prescribing providers to discuss concerning cases. These calls offer educational opportunities regarding child and adolescent psychotropic prescribing best practices and help to establish relationships with the prescribing providers for future cases. UPOP is developing a process to meet quarterly with prescribing providers who care for large numbers of foster children. The purpose of the meetings will be to review foster children's cases and collaborate on medication care plans. To increase ease of access, prescribing providers are invited to participate in DHHS Telehealth.

## Website

In 2020, UPOP launched a webpage, which is part of a larger website through the University of Utah program, Utah Pediatric Integrated Post-Trauma Services. The site offers information regarding pediatric trauma, trauma as it relates to foster children, and the use of psychotropic medications. A resource tab provides educational content and videos for medical professionals, caseworkers, and caregivers. This webpage will continue to be updated and expanded to provide additional information and resources to the community. The website can be found here: UPOP – Utah PIPS.

## Conferences and Trainings

In past years, UPOP has held conferences as part of its efforts to educate and collaborate with foster parents, prescribing providers, FHC health coordinators, caseworkers, clinical consultants, and community partners.

UPOP and Utah Foster Care Foundation (UFC) collaborated to develop training for foster parents specific to UPOP and psychotropic medications for youth in care. This training is now available for all Utah foster parents and is a part of UFC foster parent pre-service training. Additionally, the UPOP APRN has met with several residential and proctor agencies to provide education regarding psychotropic medication and youth in care.

## Ongoing Evaluation and Research

UPOP prepares a quarterly report for DCFS and FHC that provides information on reviews and meeting outcome measures. A research and evaluation component has been included in the design of UPOP. The data researcher is developing an extensive database consisting of the last four years of UPOP review data. This will allow for reporting on outcome data within the UPOP program.

## Protocols and Procedures to Ensure Appropriate Child Diagnosis

To ensure that children in foster care are not inappropriately diagnosed and placed in settings that are not foster family homes, DCFS has established protocols to review appropriateness of placement for each child prior to entering congregate care settings. Cases in which a child is placed in congregate care are reviewed on an ongoing basis while the child remains at this placement level.

Each DCFS region has an established Placement Planning Meeting (PPM). The child's caseworker is required to attend PPMs when requesting a placement with a private contract provider, including those that are not family-based settings. The purpose of the PPM is to review the child's medical, behavioral, emotional, and developmental needs to determine the appropriate placement for the child. The PPM includes staff that are experienced and knowledgeable about available wraparound and treatment services; the committee determines ways to best meet the needs of children in foster care and includes clinically licensed staff. As a part of the case staffing, the PPM reviews all assessments regarding the child's needs, including medical health, mental health, psychological, and developmental assessments, to determine the right intensity of services for the child. The caseworker must receive formal approval from the PPM prior to placing the child in a higher-level setting, which includes settings that are not foster family homes.

When considering a residential treatment placement, the PPM committee will refer the child for a Qualified Individual Assessment (QIA) to determine if that level of care is appropriate. The QIA should be completed no later than 30 days after placement. If the QIA determines that a QRTP placement is not warranted, the case must be staffed with the PPM and determine if the youth should be moved or stay in the placement. If the PPM determines that the youth should stay in the QRTP program, contrary to the QIA determination, the regional director must approve. The QIA must be reviewed by the courts within 60 days of placement.

Once a child has been placed in a high-level setting, the case must receive regular utilization reviews by PMM or by designated region staff who are clinically licensed. Utilization reviews can be done within the Child and Family Team Meeting context or with input provided by the Child and Family

Team. The reviews are required every three months for children placed in settings that are not foster family homes. The purpose of the utilization review is to examine the most current assessments and medical information about the child and ensure that the array of services is of sufficient quality and intensity to meet the child's needs. If it is determined that the services are not having the desired effect or are not appropriate for the child's needs, clinical staff work with the caseworker to determine what further assessments are needed or what services need to be

changed in order to meet the child's needs. Clinical staff also continuously review the duration the child has been in treatment services and assist the caseworker to advocate for the needs of the child to ensure the child is not inappropriately kept in residential or congregate care settings. The utilization reviews also determine when a child is ready to step-down from residential treatment or congregate care settings back into a foster family home.

In addition to regular utilization and review, children placed in QRTP placements will be reviewed by the state QRTP review committee in order to remain in their placement. For children 12 and under, the department must approve continuation of a placement when they have been in the placement for a consecutive or non-consecutive period of 6 months. For youth 13 and older, the department must approve continuation of QRTP placement when they have been in the placement for a consecutive 12 months or 18 months nonconsecutive.

To ensure that children who are deemed medically fragile or needy receive the extra support and services required for their medical conditions, Utah utilizes a special stipend payment that can be provided to foster families as a supplement to their foster care reimbursement. Each child in foster care is regularly assessed by the FHC nurse and provided with an acuity score for their medical needs. The frequency of the assessment is determined by the intensity of the child's medical needs. The FHC program has defined the level of acuity score as well as what diagnoses and needs the child must have in order to qualify for the medically fragile or medically needy stipend. When a child meets the criteria outlined by FHC, the determination to provide the additional stipend is made within the context of the Child and Family Team Meeting. DCFS policy requires that the needs of children who qualify for the medically needy or medically fragile designation are reviewed by the Child and Family Team on a quarterly basis or more frequently, as needed. The reviews are conducted in order to ensure that the foster family and the child are receiving the necessary resources to meet the child's medical needs.

For children that are developmentally disabled, DCFS currently has a Memorandum of Understanding with the Utah Division of Services for People with Disabilities (DSPD) that allows children in foster care who qualify to access the Medicaid Waiver for Intellectual Disabilities Supports and Services. This allows children who qualify for enrollment in the Medicaid waiver to remain in a community-based foster family home or group home with the habilitative supports and services the child needs. In order to qualify for the waiver, children in foster care must meet the DSPD criteria for an intellectual disability and have demonstrated limitations or impairment in areas of functioning and daily life. If the child's needs are of sufficient intensity, the child will be granted enrollment for Medicaid waiver services. Once a child is enrolled in the waiver, DCFS pays the state match for Medicaid waiver services until DCFS custody ends; however, the child retains Medicaid waiver enrollment for life. This ensures that if the child is returned home, moved to an adoptive family, or moved to another foster home, the child will maintain access to the habilitative support services they need.

## Healthcare Needs of Youth Aging Out of Foster Care

### Notification for Youth of Options for Health Insurance

DCFS Practice Guidelines state, "The Child and Family Team will develop a specific exit plan that includes personal connections, continuing support services, housing, health insurance, vocational and educational goals, workforce supports, and employment."

Similarly, DCFS Practice Guidelines also state that the Child and Family Team will "Discuss the purposes, uses, and costs of credit, insurance, and risk management" with youth.

### Appointment of a Healthcare Proxy

Practice Guideline 303.7.2 A.9.d.1 Prior to Exiting, states that caseworkers are responsible for carrying out the following tasks to help youth prepare to exit foster care:

"Ensure that each youth meets with a nurse to learn skills of self-management regarding their individualized healthcare needs, medication management, use of their Medicaid card, and how to access medical, dental, and mental health services. In addition, the nurse will provide information and education about the importance of having a healthcare power of attorney or healthcare proxy. If desired, the nurse can provide the youth with assistance in executing the document."

Similarly, Practice Guideline 303.7.2.B.1.L. states that the Child and Family Team will help the youth:

"Understand proper health and mental health awareness and maintenance. Ensure that youth receiving TAL services and/or education and training vouchers and those who are aging out of foster care have information and education about the importance of having a healthcare power of attorney or healthcare proxy and to provide the youth with the option to execute such a document."

### Medicaid Coverage for Former Foster Youth

DHHS offers two Medicaid options for youth who have aged out of foster care. First, the Former Foster Care Individuals Medicaid program "provides full Medicaid coverage to individuals who: (1) are age 18 to 26, (2) were concurrently enrolled in Medicaid and foster care at some point during the foster care period in which they turned age 18 , (3) were in the custody of DHHS with DCFS as the lead or case management agency, an Indian tribe, or under the state's responsibility with the Catholic Community Services Foster Care for Unaccompanied Minor Refugees, or the equivalent of these agencies throughout the United States, when foster care ended." Individuals in the custody of Juvenile Justice Youth Services are not eligible. There are no income or asset limits that eligible applicants are required to meet, and retroactive coverage is allowed.

Additionally, Medicaid provided through the Foster Care Independent Living option is "available to youth through age 21 when they age out of foster care, if they receive Independent Living Services through DCFS. This is an option for former foster care youth who do not meet the eligibility criteria for the Former Foster Care Individuals program through age 26."

DCFS continues to support the YAC, which adds a much needed youth voice to the child welfare system. The Adolescent Services Program Administrator regularly meets with the YAC. Through the YAC, youth discuss issues that impact their lives and set goals and objectives that are designed to resolve problems they face, including healthcare issues. Additionally, with assistance from DCFS administrators, the YAC informs policies and procedures involving youth support.

## MOU with Fostering Healthy Children

DCFS completed an MOU with the FHC program. The MOU is in place from July 1, 2020, to June 30, 2025. The MOU addresses information sharing, Medicaid payment expectations, skilled professional medical personnel, and maintaining average nurse caseloads.