Health Care Oversight and Coordination Plan

Family Services Division policies relevant to our Health Care Oversight Plan and the requirements of the Social Security Act include:

- Policy 68: Serious Physical Injury – Investigation and Case Planning
- Policy 75: Normalcy and the Reasonable and Prudent Parent Standard
- Policy 76: Supporting and Affirming LGBTQ Children & Youth
- Policy 77: Medical Care for Children and Youth in DCF Custody
- Policy 97: Case Review Committee Referrals
- Policy 137: Antipsychotic Medications for Children in the Care of DCF
- Policy 154: Children and Youth in DCF Custody Requiring Mental Health Screening, Mental Health Placement, or Psychiatric Hospitalization
- Policy 160: Supporting Adolescents in DCF Custody

We intend to continue partnering closely with staff from the Family Child Health Division (FCH) of the Vermont Department of Health (VDH), the Department of Mental Health (DMH), the Child Safe Program and their Board-Certified Child Abuse Pediatrician, key stakeholders at UVM Medical Center and Dartmouth-Hitchcock Medical Center, physicians affiliated with the American Academy of Pediatrics Vermont Chapter (AAPVT), and staff with the Vermont Child Health Improvement Program (VCHIP).

In upcoming years, we are prioritizing data-driven decision making and improvement strategies pertaining to our Health Care Oversight and Coordination Plan. Through partnership with our Vermont Medicaid agency, the Department of Vermont Health Access (DVHA), we are focusing on Quality Assurance and Performance Improvement (QAPI) measures for DCF Family Services Division relevant to child and youth health. It has been invaluable to partner with DVHA to compare datasets, develop a more accurate baseline of data based on Medicaid billing codes, and use this data to inform continuous quality improvement efforts and tests of change in practice. The existing Child Core Set of Health Care Quality Measures for VT Medicaid serves as our baseline for scorecard measures we could use to compare children and youth in DCF custody to the broader Medicaid population. As a starting point in building our scorecard, we have decided on:

Quality of Care:

- Total number of children and youth in DCF custody
- # of children in DCF custody by placement type:
    - Kinship foster home
    - Community foster home
    - Residential treatment program or other institution

Timely Access to Care:

- % of youth who receive any health care visit within 72 hours from entering DCF custody
- % of youth who are seen for a comprehensive health assessment within 30 days of entering DCF custody
- Measures from Child Core Set of Health Care Quality Measures for VT Medicaid
    - Developmental Screening in the 1st 3 Years of Life
    - Oral Evaluation as Dental Services
    - Well-Child Visits:

- Well-Child Visits in the First 30 Months of Life: First 15 Months
- Well-Child Visits in the First 30 Months of Life: 15-30 Months
- Child & Adolescent Well-Care Visits - Age 3-21

Member/Family Satisfaction:

- FSD CFSR & QCR Data
    - Of the cases reviewed that had physical health needs, the % that were found to have appropriately assessed physical health needs and provided services (CFSR Item 17)
    - Of the cases reviewed that had mental/behavioral health needs, the % that were found to have appropriately assessed mental/behavioral health needs and provided services (CFSR Item 18)

We have a longer-term vision of expanding our score card and the items included within it. We are interested in developing a broader and more holistic measure of the number and types of prescribed medications (outside of ADHD, psychotic, or antipsychotic categories). We are interested in Medicaid billing data or other means of tracking preventative and supportive mental health services for young people, rather than engagement stemming from a hospitalization or ED visit. We are curious about alternative types of therapeutic supports that fall outside of traditional "talk therapy" (i.e., art, equine, gardening, and music therapies or other mind-body practices). These options are limited within Vermont communities, particularly through traditional health insurance, yet are advocated for by young people and could improve well-being and mental health.

Based on the analysis contained within the research brief released by the HHS Office of the Assistant Secretary for Planning and Evaluation, titled "Behavioral Health Diagnoses and Treatment Services for Children Involved with the Child Welfare System", we are feeling inspired by the amount of health information extracted via Medicaid claims and we are contemplating the additional possibilities within Vermont.

We intend to continue participating in the Psychotropic Medications Quality Improvement Collaborative (PMQIC), with a goal of improving the use of psychotropic medication among children and youth in foster care. The study estimates and evaluates the following nine PMQIC common measures:

1. Percentage of children in foster care on any psychotropic medication,
2. Percentage of children in foster care on a specific class of medication,
3. Percentage of children in foster care on more than one psychotropic medication from the same class simultaneously for 90 days or more (defined above as co-pharmacy),
4. Percentage of children in foster care on 2 psychotropic medications; 3 psychotropic medications and 4 plus psychotropic medications (regardless of their drug class) simultaneously for 90 days or more,
5. Percentage of children in foster care < 6 years old on any psychotropic medication,
6. Percentage of children in foster care < 6 years on 2; 3 and 4 plus psychotropic medications (regardless of their drug class) simultaneously for 90 days or more,
7. Percentage of children in foster care < 6 years old on any antipsychotic medication,
8. Percentage of children in foster care on more than one antipsychotic simultaneously for 45 days or more,
9. Percentage of children in foster care who are continuously on an antipsychotic for more than 1 year.

Further, we are in the preliminary phases of exploring how The Vermont Child Psychiatry Access Program (VTCPAP) may be utilized for the purposes of FSD staff consultation guided by Policy 137: Antipsychotic Medications for Children in the Care of DCF. VTCPAP provides a novel and innovative way to approach mental health, where their team of licensed clinical social workers and board-certified child and adolescent

psychiatrists provide free, immediate support and psychiatric consultation to primary care providers (PCPs) who, in turn, provide care to their pediatric patients in need of mental health treatment.

Historical Summary of our Work & Collaboration

In the early 2000s, a memorandum of understanding (MOU) between DCF and the VDH/division of FCH was established. This MOU identified a nurse based at each of the 12 local VDH district offices who would obtain health information on each child entering custody in a timely manner and share that information in the form of a *Health Information Questionnaire (HIQ)* with DCF. The MOU permits DCF to notify the FCH nurses within 3 business days when a child enters foster care in their district. A release is provided that authorizes the FCH nurse to communicate with the child's medical home. If the medical home is unknown, the nurse can determine the most likely medical home using Medicaid claims and/or the immunization registry. The FCH nurse often sends an HIQ to the medical home to gather the most up-to-date medical and dental information. The HIQ is entered into FSDNet, DCF's electronic record, within 30 days. If the child has any immediate health needs, or scheduled appointments, the FCH Nurse provides this information to the DCF Family Services Worker directly.

In 2020, VCHIP engaged in a project with DCF and VDH's FCH division to assess processes, successes, and opportunities for improvement for medical care as children enter foster care. As part of this work, VCHIP interviewed FCH nurses, DCF district administrative assistants, medical providers, and foster parents to determine current processes.

FCH nurses in each VDH district and almost all DCF district administrative assistants were interviewed to assess how the FCH nurse was notified when a child enters custody, and how the FCH nurse interacted with medical homes to gather information needed to complete the HIQ for each child entering custody. VCHIP learned there was great variability among the DCF districts and FCH nurses. There were different workflows and expectations, different mechanisms for notifying the FCH nurse when a child came into custody, and different levels of FCH nurse interaction with the medical home. Some DCF offices provided timely notification when children entered foster care, while others did not. Some FCH nurses worked closely with medical homes, some only interacted with the medical records department to obtain information. Some FCH nurses interacted with foster parents directly to answer medical questions and facilitate appointments with the medical home, and some did not. Most FCH nurses were interested in clarification about role expectations and scope of their work.

Fourteen medical providers across the state were interviewed about their patients entering foster care (with collaboration from Dr. James Metz and two pediatric residents). VCHIP learned that most (11) of the providers were not aware when their patients entered DCF custody. Most (12) were not aware of the AAP guidelines or did not have protocols in place to follow the guidelines, and the length of time until children were seen after entering foster care was variable, especially for adolescents. Providers were rarely informed of the reason for custody and felt that information was essential to being able to provide appropriate care for the child. However, all providers felt responsible for these patients, and felt that these patients should remain in their medical homes whenever possible.

VCHIP met with DCF-FSD's Foster Parent Workgroup and conducted a focus group of 5 foster parents to determine what they saw as the major medical issues for children entering foster care. Many of the foster parents were not informed about the medical home as a child entered custody. Medications were not always provided, and when they were, information about the correct dosing, reason for giving, and potential side effects were not always available. Refills of missing medications were often difficult to obtain. Many

experienced difficulties making an initial medical appointment for a child, reporting that they were often told by the front desk staff that the child already had a health supervision visit and did not need to be seen. Most foster parents said there was great benefit in having access to the child's Electronic Health Record. Foster parents noted not all providers recognize and/or understand the purpose of the medical authorization form and that office visits with the medical provider are needed for foster parents to get all important information to care for the child and their medical needs.

VCHIP engaged two large pediatric practices in southern Vermont in quality improvement to increase the number of children entering foster care who had a comprehensive health assessment within 30 days. Initial barriers included a lack of awareness of the AAP guidelines for initial care of children entering custody, and lack of office systems to notify the pediatric provider and to reach out to the foster parent to schedule a comprehensive health assessment. Some practices required legal documentation of foster placement before being able to reach out. Some practices found it more efficient to see the child for a health supervision visit but were not always able to schedule that within 30 days due to Medicaid restrictions for payment. Care coordination and the generation of care plans were variable at each practice, as criteria for care coordination differed, and not all providers recognized children in foster care as children with special health care needs. VCHIP learned that timely notification by DCF and the FCH nurse typically led to more children seen for a comprehensive health assessment. Direct communication with an identified point person(s) at the practice (often a care coordinator) was important to the process, and often led to timely outreach to foster parents to help with immediate medical issues. Adolescents were less likely to receive timely care in the medical home. Change of placement and residential placements could be the reason for this. Lack of notification of change of placement also led to missed appointments.

Foster Care Learning Collaborative Affinity Group (Now Foster Care QI Monthly Team Meeting)

Vermont was selected to take part in a CMS *Foster Care Learning Collaborative Affinity Group* titled "Improving Timely Healthcare for Children and Youth in Foster Care," which ran from August 2021 through August 2023, and focused on the comprehensive health assessment. The project was supported by Mathematica and the Center for Health Care Strategies. The Vermont team consisted of representatives from the Department of Vermont Health Access (DVHA), Department for Children and Families (DCF), Division of Family Child Health (FCH, formerly Maternal Child Health) of the Vermont Department of Health (VDH), and the Vermont Child Health Improvement Program (VCHIP). The Vermont team and ten other state teams met together remotely every month and engaged in monthly individualized quality improvement coaching sessions. Vermont selected an aim of increasing by 10% the number of children and youth receiving a comprehensive health assessment within 30 days of entering custody.

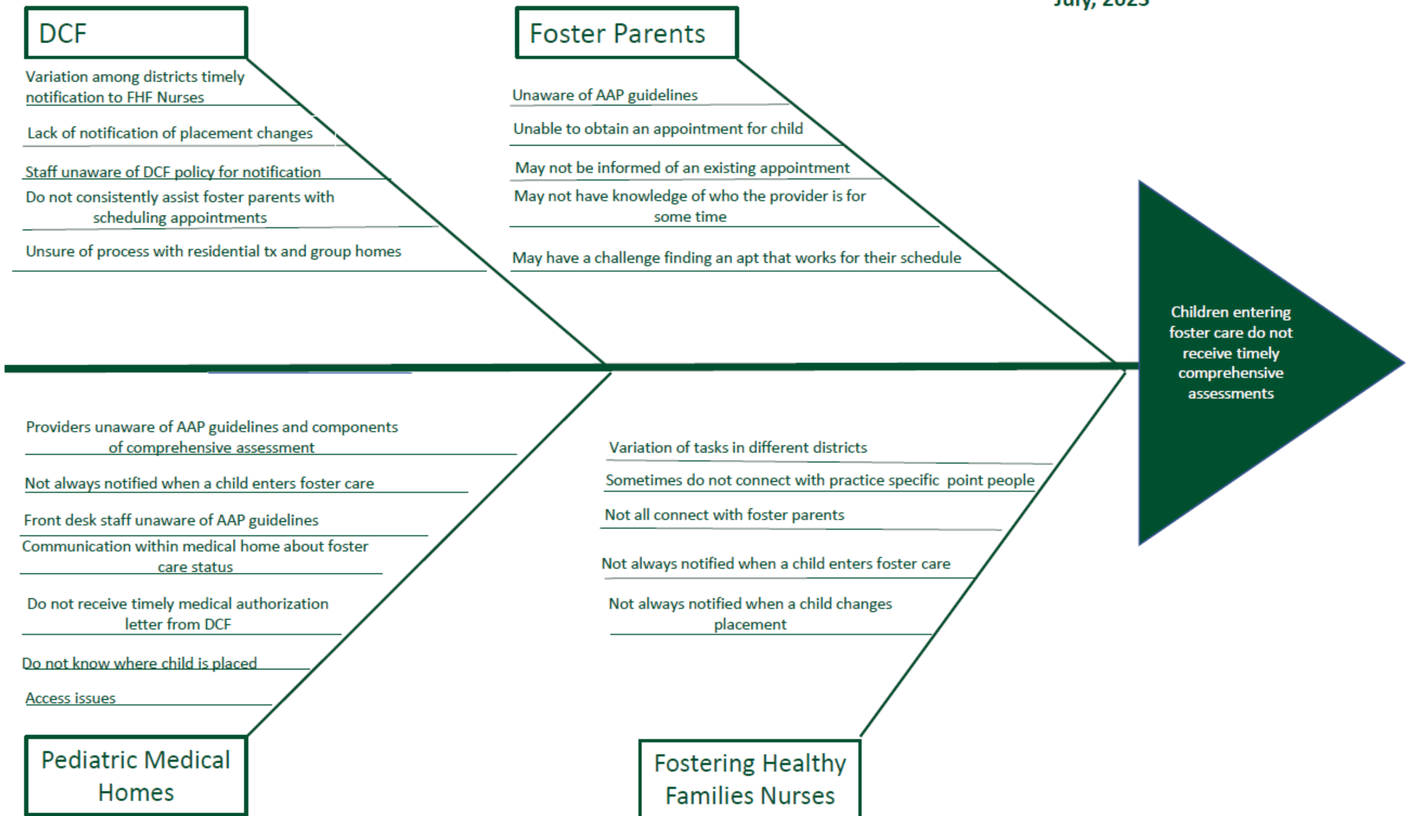
When the CMS Affinity Group began, the Vermont team already had some clear ideas of what needed to be done. The Vermont team began by assessing available data to determine the baseline of children entering foster care who received a comprehensive assessment within 30 days. Identifying children entering foster care proved to be a challenge, as the flagging system in Medicaid is complicated. To track children and youth entering foster care, DCF provided a file to DVHA so they could match the child in Medicaid. Some children were not able to be matched so the data is incomplete. Once identified, Medicaid claims data was utilized. Since there is no CPT code for a comprehensive health assessment for children entering custody, a proxy was determined. Claims data analyzed included E&M CPT codes for office visits lasting 30 minutes or longer and well visit codes by primary care providers. The data analyzed included children who entered custody during the calendar year period and were enrolled in Medicaid for 30 or more days following the date of custody entry. Infants in the NICU were included in the denominator, although they could not have had any office

visits. Data was stratified by child age for the years 2019, 2020 and 2021. Baseline data is listed below. Note that the COVID pandemic resulted in lower numbers of children entering foster care in VT.

Comprehensive Assessment Data

	2019			2020			2021		
Classification	Number of Children	Comprehensive Assessment (0-30 days)	Any Visit (0-30 days)	Number of Children	Comprehensive Assessment (0-30 days)	Any Visit (0-30 days)	Number of Children	Comprehensive Assessment (0-30 days)	Any Visit (0-30 days)
Infant (0-1)	**113**	**73%**	**81%**	**91**	**80%**	**85%**	**63**	**75%**	**79%**
Young Childhood (1-4)	**179**	**39%**	**53%**	**108**	**44%**	**55%**	**121**	**46%**	**62%**
Late Childhood (5-11)	**197**	**25%**	**37%**	**159**	**25%**	**31%**	**167**	**40%**	**50%**
Adolescent (12-17)	**230**	**21%**	**30%**	**166**	**16%**	**20%**	**153**	**31%**	**35%**
Eighteen and Older	**0**			**0**			**12**	**17%**	**25%**
All Districts Total	**719**	**35%**	**45%**	**524**	**36%**	**42%**	**516**	**42%**	**52%**

Using QI frameworks and a key driver diagram, drivers were identified (below).



One identified barrier to following recommendations by the AAP for comprehensive assessments and an enhanced visit schedule was Medicaid payment. VT Medicaid allows for only one well-visit per year for children aged 3 and older. The Affinity Group was able to work with DVHA to have additional well visits and

screening covered, in alignment with AAP guidelines, when the code Z 62.21 (child in foster care) is used. A coding guide was created: "Billing for Services: Children/Youth in Foster Care".

Vermont Medicaid

Billing for Services: Children/Youth in Foster Care*

New Patient	Established Patient

These code sets are designed for evaluation & management of the child to address specific issues/concerns as needed. Code according to medical decision making (MDM) or time.

Problem-Focused Visits (New Patient)

99203	30-44 min
99204	45-49 min
99205	60-75 min

Problem-Focused Visits (Established Patient)

99213	15-24 min
99214	25-39 min
99215	40-54 min

These code sets are designed for the periodic evaluation & management that is reflective of the age of the child.

Periodic Preventative Visits 99381-99385

Periodic Preventative Visits 99391-99395

Other evaluation & management codes may be used as appropriate for the services provided and the scope of practice of the healthcare provider.

These services may include counseling, risk factor reduction, behavior change intervention, as well as chronic care management.

Screenings & Assessments

96110 - Developmental screening (eg, developmental milestone survey, speech and language delay screen)

96127 - Brief emotional/behavioral assessment (eg, depression inventory, ADHD scale)

96160 - Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal)

Other screening or assessment codes may be used as appropriate. Include scoring and documentation for each standardized instrument used.

Modifiers & Diagnosis Codes

The use of modifiers may be necessary to indicate that the services are indeed separate, and both were performed.

Z62.21 – Child in welfare custody*

May use this code as a secondary diagnosis for ALL encounters.

For questions, please contact your Gainwell Representative

Utilize the most appropriate and detailed diagnosis code. Refer to the ICD-10 DX code set and the AAP Coding Fact Sheet for Treating Trauma.

The Vermont team identified a DCF district that was interested in engaging with community practices. Process flow mapping was completed with DCF district leadership, the administrative lead and the FCH nurse to identify steps in the practice notification process when a child enters foster care. This mapping revealed opportunities to test strategies that could improve the process. The district designed a joint letter from DCF

and the FCH nurse to be sent to practices when a patient entered foster care. This letter included the foster parent and Family Services Worker (FSW) contact information, caregiver authorization form, release of information to interact with the FCH nurse, AAP recommendations, and the coding and billing guide. This letter is a call to action for the practice to contact the foster parent and schedule an appointment, and contains the information needed to legally do so. Results of the tests of change showed that early notification and contact with the foster parent often led to scheduling the comprehensive health assessments within 30 days. Barriers to the assessment included youth changing placement and entering residential care. Some family medicine practices did not respond to the letter. The strategy of sending this joint letter to practices has been spread to additional DCF districts.

Proposed Plan for Vermont in the Years Ahead

As a result of the CMS Affinity Group, VT has identified the following steps to spread success to all districts in VT:

- Structure communication between the DCF district administrative person and the FCH nurse. Meet at least every 6 months, ideally more often to fine tune the communication.
- Send the joint letter from DCF and the FCH nurse to the appropriate medical home within 3 business days of a child entering custody, ideally as soon as possible.
- Send the letter to a point person designated by the practice, usually a care coordinator, who can contact the foster parent as soon as possible to answer medical questions and facilitate scheduling the appointment for the comprehensive health assessment with the appropriate medical provider, ideally within 30 days, and coordinate any specialty care needed.
- Be in touch with the medical homes in the district before the process begins, so they will be aware of the AAP guidelines, and can choose a point person for their practice.
- Follow data to determine success and pinpoint gaps.

Lessons Learned from Activity to Date

- Pediatric practices VCHIP contacted want to care for their patients in foster care, but not all were familiar with the AAP guidelines.
- Patients from a particular practice enter foster care intermittently, so establishing a consistent workflow can be challenging.
- Youth are receiving lower rates of comprehensive health assessments than younger children, which can be due in part to more frequent change of placements including residential placements.
- Failure to notify medical homes of foster care placement changes can result in children missing needed medical care.
- Confidentiality of court proceedings can impact information shared with medical providers.
- The system is fragile. The process is often dependent upon one individual at each site (DCF administrative assistant, FCH nurse, practice point person), and redundancies are not built into the system.

Next Steps/Considerations

- Prioritize healthcare for children in foster care along with child safety. Same-day notification of the medical home when a child enters custody, along with timely notification of placement change, would ensure the best medical care for children entering foster care (DCF).

- Continue working with medical homes, including family medicine practices, across the state to facilitate usage of the AAP guidelines (comprehensive health assessment, care coordination, enhanced health care visit schedule) (VCHIP).
- Develop more robust care coordination for children in foster care (including usage of shared plans of care) to ensure consistent medical care. Care coordination by DCF or managed care organizations has shown to be effective in other states for children entering custody (primary care providers).
- Clarify the role of the FCH nurse across districts. Additional time or personnel may be necessary, especially in some of the larger districts (FCH).
- Investigate why youth in foster care have significantly lower rates of comprehensive health assessments in medical homes compared with younger age groups (VCHIP in collaboration with DCF and FCH).
- Track health, dental health, and mental health outcome data for children and youth in foster care. Process improvement with the Medicaid flagging system used when children enter custody could assist in identification of foster children within claims (VCHIP in collaboration with DVHA, DCF, FCH).

Vermont Child Health Improvement Program (VCHIP) Scope of Work

VCHIP's new scope of work for the next year includes the following goals, informed by the projects and collaboration detailed above.

Enhancing Medical Care and Care Coordination for Youth Entering Foster Care

Goals

Data obtained while participating in the CMS Affinity Group, *Improving Timely Health Care for Children and Youth in Foster Care,* revealed that Vermont children, particularly adolescents, entering foster care are not receiving timely comprehensive visits in their medical home. This project promotes children and youth having a comprehensive assessment within 30 days of entering foster care as recommended American Academy of Pediatrics (AAP).

- Promote identified system changes that could improve the number of children and youth entering custody receiving a comprehensive medical evaluation resulting in a plan of care that includes medical, developmental/behavioral/mental, and oral health.
- Work to ensure that Medicaid-eligible children and youth entering the custody of the Department for Children and Families (DCF) have high-quality care in medical homes guided by the recommendations from the AAP.
- Facilitate recommended enhanced well visits and care coordination for children and youth in foster care.

Project Description

The AAP classifies children in foster care as a population of children with special health care needs. Most children and youth in foster care have been abused, neglected, or have experienced prenatal harm, which places them at higher risk for developing poor health outcomes. The AAP issued a policy statement with recommendations regarding ensuring high-quality health services and care coordination in a timely manner for children entering foster or kinship care.

The Vermont Child Health Improvement Program (VCHIP) team will collaborate with DCF-FSD, Family Services Division and Family and Child Health Coordinators (FCHC), Department of Vermont Health Access (DVHA), pediatricians, other pediatric medical providers, and collaborators to address identified barriers for

children to obtain a comprehensive assessment within 30 days and enhanced medical visits as recommended by the AAP.

Specific Activities
Technical Assistance and Data Analysis

- Draw on information gleaned from previous participation in the CMS Affinity Group *Improving Timely Health Care for Children and Youth in Foster Care* and quality improvement activities to offer pediatric and family medicine practices in Vermont support and technical assistance in providing comprehensive medical assessments for children and youth entering custody within 30 days, in collaboration with DCF and FCHC when possible. Activities under this work may include:
    - Undertaking process flow mapping and creating new workflows.
    - Identifying a person or team within the practice to coordinate appointments, communicate with providers, foster parents and DCF.
    - Facilitating care plans/ care conferences for children in DCF custody to include foster parents/parents/DCF, and when appropriate, parents and youth.
- Participate in a data subgroup with DVHA, DCF, DMH and UVMMC Child Psychiatry to assist with creating Vermont score cards for rates of comprehensive visits within 30 days for children and youth entering DCF custody, and other measures as identified by the team.
- Manage, analyze, and summarize data from the youth online survey assessing perceptions of primary care visits for youth in custody.
- Request, analyze, and summarize data from Vermont's All-Payer Claims Data (VHCURES) to identify patients whose Medicaid coverage indicates time in custody in calendar year 2022. We will measure the percentage of patients with time in custody who had a well-care visit in the same year.

Coordination Across State Agencies and Activities

- Meet regularly with DCF-FSD to establish pathways for providing clinical expertise and technical assistance.
- Meet with FCHC as needed to collaborate on promotion of comprehensive medical evaluations, medical care following the AAP recommendations, coordination with DCF-FSD and medical homes.
- Connect with state entities and agencies to explore collaboration that supports children and youth entering foster care to obtain comprehensive medical evaluations and to receive enhanced health supervision visits as recommended by the AAP.
- Coordinate an event with FCHCs and DCF-FSD that will offer information about why medical care for children and youth entering foster care is critical and to offer a venue for shared peer learning of successful strategies for timely notification and collaboration with the FHF Nurses and medical homes.
- Work to connect appropriate staff at residential placements for children and youth with FCHCs and medical home care managers to provide coordinated care.
- Encourage change to current DCF and FCHCs workflow to include Family Educational Rights and Privacy Act (FERPA) releases for the FCHCs to obtain and provide important medical information to the school nurses, DCF and foster parents.
- Explore how caregivers of children and youth in foster care are made aware of recommended preventive care covered by their EPSDT benefit.

Focus on Youth

- Provide education to pediatric primary care providers and skilled medical professionals that focuses on challenges facing youth in foster care.

- In collaboration with the Youth Advisory, Foster Parent Work Group, and other community partners, continue to engage with youth who have lived experience in the foster care system to provide recommendations for more inclusive and accessible health care.

Deliverables / Products:

- Progress report of coordinated work with FCHCs and DCF-FSD. (December 2024)
- Materials created for foster parents and youth about recommended healthcare. (March 2025)
- One-page summary of online survey responses including number of respondents, percent of respondents with well-care visits, and summaries of up to three closed-response items. (June 2025)

Timeline

i. Planning Phase (*July/2024 – September/2024)*
ii. Implementation Phase (*October/2024 – June/2025)*
iii. Results and Analysis (*March/2025 – June/2025)*

Family Partnership and Engagement

Collaborate with DCF's youth and foster parent advisory groups on the following topics:

- How to increase youth involvement in health care.
- Ensuring children and youth obtain medical care they are entitled to through EPSDT benefits and additional AAP recommendations.

Performance Measures to be delivered by the End of the Grant

1. Engage two medical homes in quality improvement work to increase comprehensive assessments for children entering foster care.
2. Create educational materials and resources provided to residential programs that identify recommended medical care for children and youth in foster care, as well as FHF Nurses role and contact information.