

Florida's Child and Family Services Plan 2015-2019 Health Care Oversight and Coordination Plan

Chapter VIII. Florida's Health Care Oversight and Coordination Plan

This Plan is intended to support success in wellbeing outcomes for children and youth in foster care. Title IV-B funding for programs was reauthorized by Congress and PL 112-34, the Child and Family Services Improvement and Innovation Act, was signed into law by the President on September 30, 2011. Among other requirements, the new law required the state to include, as part of the plan for ongoing oversight and coordination of health care services for children in foster care, 1) how the state will monitor and treat emotional trauma associated with a child's maltreatment and removal, and 2) protocols for the appropriate use and monitoring of psychotropic medications.

Florida recognizes the importance of a coordinated oversight and monitoring system of wellbeing for children in out-of-home care. Florida will continue to improve its system for screening, assessment, referral, monitoring and treatment of emotional trauma, behavioral health and other health care needs through the coordination of a direct partnership with the State title XIX Medicaid agency, known in Florida as the Agency for Health Care Administration (AHCA), physicians, tribes, and other state agencies as necessary. This plan addresses the following areas:

- Lessons Learned
- Continuity of Care and Coordination of Services
 - Health Care
 - Behavioral Health Care
- Schedule for Initial and Follow-Up Health Care Screenings
 - Physical Health Assessment
 - Child Protection Team Assessment
 - Comprehensive Behavioral Health Assessment
- Monitoring and Treating Identified Health Needs, Including Emotional Trauma
 - Monitoring by the Florida Agency for Health Care Administration
 - Psychotropic Medication Monitoring and Oversight
 - Other Health Care Monitoring and Oversight
 - Trauma Informed Care
- Continuity of Health Care with the Option of a Medical Home

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- Health Care Transition Planning for Youth Aging Out of Foster Care

Lessons Learned

Florida, like many states, has struggled with the continuity of and integration of health care and behavioral health care services. The limited number of providers willing to accept Medicaid has had an impact. To address the need for integration of services and continuity of care, the Department needed a Specialty Plan for Child Welfare that would ensure full integration of health and behavioral health care. This was critical to ensuring continuity of care, greater provider access, and enhanced care coordination for the child welfare population.

The opportunity for a Child Welfare Specialty Plan arose in 2011 when the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing AHCA to create the Statewide Medicaid Managed Care (SMMC) program. The Department collaborated with AHCA to draft requirements for a specialty plan for children in the child welfare system that would address their special needs. In September 2013, AHCA awarded the Child Welfare Specialty Plan to Sunshine Health; a Florida based health maintenance organization (HMO). Children's Medical Services (CMS) will continue as the statewide-managed care plan for children with special healthcare needs. Children currently enrolled in Title XXI CMS will transition to the Title XIX CMS statewide plan on August 1, 2014, if the family income is under 133% of the federal poverty level. By September 2014, all Medicaid beneficiaries will be moved into managed care.

Although all families have the right to choose their managed care plan, the majority of children in out-of-home care will be served by Sunshine Healthcare Plan, which is the Medicaid primary health insurance plan for child welfare. This plan ensures CBC lead agencies, case management, parents, and foster parents are actively involved in health care and behavioral health provider and service decisions. Sunshine Health is required to:

- Develop and maintain provider/physician networks
- Develop and maintain behavioral provider/practitioner networks
- Authorize health care treatment and pay claims
- Authorize behavioral health treatment and pay claims
- Provide medication management
- Operate call centers and help line (e.g., Nurse Wise)
- Perform quality assurance

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The Medicaid primary insurance plan for child welfare will roll out by region beginning May 1, 2014 with full roll out by September 2014.

Continuity of Care and Coordination of Services

Health Care

Families involved in child welfare must interact with multiple service delivery systems, each with its own paperwork requirements, case plans, and eligibility requirements. The integration and coordination between multiple systems is critical to ensuring the continuity of care for children in foster care. The need for greater service coordination and systems integration has become more critical as the number of families with issues linked with substance abuse and domestic violence has grown. In addition to making the system more navigable for families, greater integration allows for greater information sharing across systems, which in turn allows agencies to coordinate their efforts and to tailor services to meet unique family and child needs.

Care coordination is critical to executing agency services and ensuring effective, frequent communication and collaboration between foster care agencies (via health care management and caseworkers), birth families, foster families, and primary care physicians. The Medicaid contract for the Child Welfare Specialty Plan includes the following requirements:

1. The Child Welfare Specialty Plan Managed Care Provider shall provide care coordination and case management to enrollees appropriate to the needs of child welfare recipients. The Specialty Plan shall develop, implement and maintain an Agency-approved care coordination/case management program specific to a child welfare specialty population.
2. The Child Welfare Specialty Plan Managed Care Provider shall submit a care coordination/case management program description annually to the state Medicaid Agency, at a date specified by the Agency. The care coordination/case management program description shall, at a minimum, address:
 - a) The organization of care coordination/case management staff, including the role of qualified and trained nursing, social work and behavioral health personnel in case management processes;
 - b) Maximum caseload for case managers with an adequate number of qualified and trained case managers to meet the needs of enrollees;
 - c) Case manager selection and assignment, including protocols to ensure newly enrolled enrollees are assigned to a case manager immediately;
 - d) Protocols for initial contact with enrollees, as well as requirements for the frequency and type of ongoing minimum contacts with enrollees;

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- e) Surrogate decision-making, including protocols If the enrollee is not capable of making his/her own decisions, but does not have a legal representative or authorized representative available;
 - f) Outreach programs that make a reasonable effort to locate and/or re-engage enrollees who have been lost to follow-up care for ninety (90) calendar days or more;
 - g) Enrollee access to case managers, including provisions for access to back-up case managers as needed;
 - h) Assessment and reassessment of the acuity level and service needs of each enrollee;
 - i) Care planning for trauma-informed care that is tailored to the individual enrollee;
 - j) Coordination of care through all levels of practitioner care (primary care to specialist);
 - k) Monitoring compliance with scheduled appointments, laboratory results and medication adherence;
 - l) Coordination with and referrals to providers of behavioral health services for enrollees with co-occurring mental health and/or substance abuse disorders;
 - m) Interventions to avoid unnecessary use emergency rooms, inpatient care, and other acute care services;
 - n) Patient education to assist enrollees in better management of their health issues and the effect of trauma; and
 - o) Linking enrollees to community or other support services.
3. The Child Welfare Specialty Plan Managed Care Provider shall coordinate services with the CBCs, DCF, as well as other public or private organizations that provide services to dependent children and their families to ensure effective program coordination and no duplication of services. The Specialty Plan's care coordination/case management program description must include protocols and other mechanisms for accomplishing such program coordination. The Specialty Plan shall collaborate with the Agency and DCF to develop such protocols and other mechanisms as may be required for effective program coordination.

To address these requirements Sunshine Health has subcontracted with CBC Integrated Health, LLC, to ensure coordination of care with the child welfare Community Based Care lead agencies (CBCs). CBC Integrated Health will serve as the integrator of medical and behavioral health services including integrated quality assurance activities. Through the partnership with CBC Integrated Health, CBCs have access to

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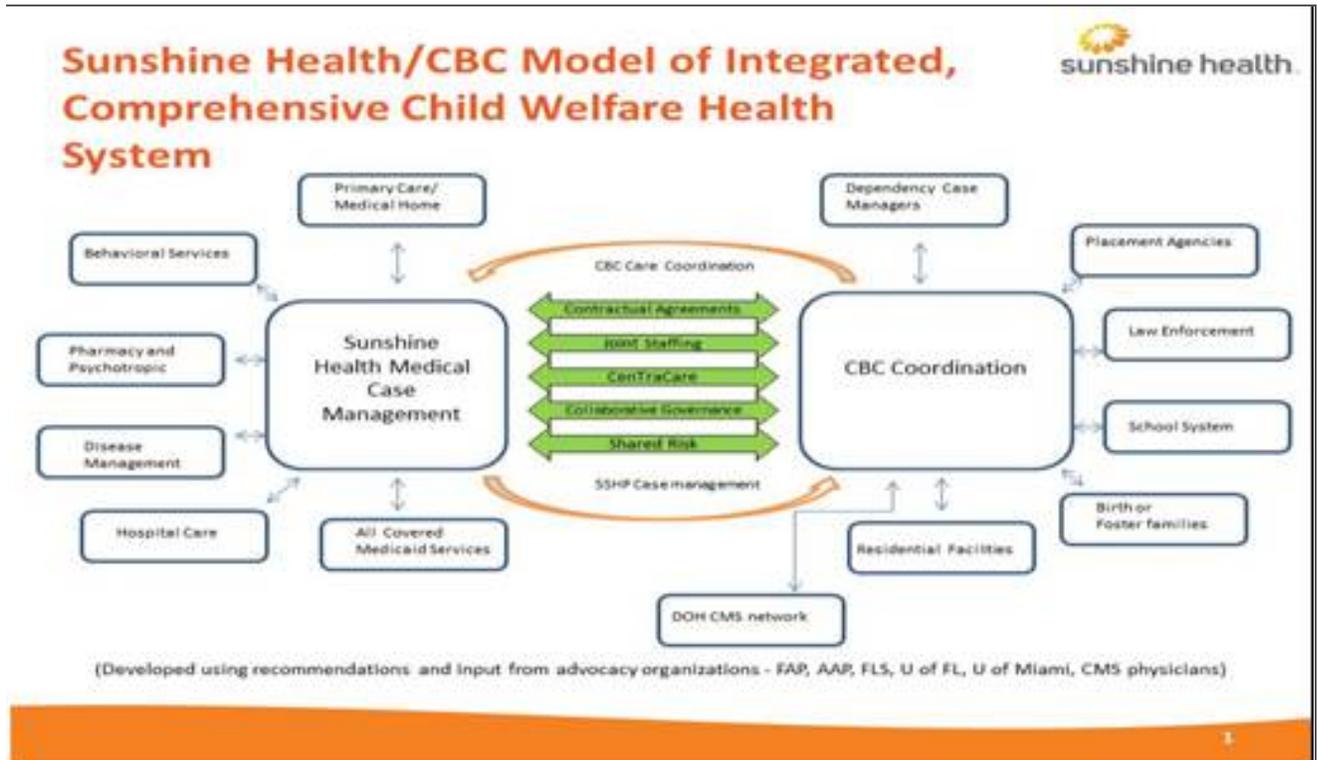
regional plan coordinators and health and behavioral health specialists. CBCs will receive funds to hire, contract, or maintain existing nurse care coordinators and behavioral health care coordinators. Additionally, there will be centralized technology and data services for CBCs that includes:

- Access to children's electronic health passport.
- Access to data and reporting from the data warehouse, which integrates health, behavioral, and FSFN data.
- Access to web applications for streamlined data collection and reporting.

The Florida Child Welfare Specialty Plan model was developed using recommendations and input from advocacy organizations including the Florida Academy of Pediatrics, American Academy of Pediatrics, Florida Legal Services, University of Florida, University of Miami, and Children's Medical Services physicians. Creating a Child Welfare Specialty Plan within a designated HMO will result in improved care coordination, continuity of care and better health outcomes for children in the child welfare system. CBCs will have access to Medicaid claims information and nurse care coordinators and behavioral health care coordinators will monitor and track appointments to ensure children receive required health and behavioral health assessments and services. Figure 1 illustrates the integrated approach of the Medicaid primary health insurance plan.

Figure 1. Sunshine Health Integrated Model

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Sunshine Health has established a Child Welfare Advisory Council (CWAC) to obtain ongoing input from Florida stakeholders to help guide the implementation of the Child Welfare Specialty Plan and suggest improvement activities. The purpose of the CWAC is to provide advice to Sunshine Health to ensure that children in the Child Welfare system receive the medical and behavioral health care services they need in an expedited and coordinated manner and that these services are available no matter where the children relocate in the state.

The CWAC will be comprised of authorized representatives from the foster care community, representatives of CBCs, behavioral health and physical health providers, as well as the Chief Medical Officer, Senior VP of Health Services, VP of Child Welfare and Behavioral Health Medical Director. Sunshine Health's panel of Child Welfare experts will facilitate the perspective of enrollees and authorized representatives on the quality of care and services delivered by the Child Welfare Specialty Plan. They will review performance trends and goals and recommend opportunities for improvement. In addition to Sunshine Health executive leadership, the CWAC includes the following:

- Alan Abramowitz, Director, Florida Guardian Ad Litem Program
- Glen Casel, CEO, CBCs of Central Florida
- Kara Elliott-Jordan, Foster Care Parent

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- Jeff Goldhagen, M.D., Chief, Division of Community and Societal Pediatrics, University of Florida
- Julia St. Petery, M.D., Medical Director, Tallahassee Pediatric Foundation
- Mimi Graham, Ph.D., Director, Center for Prevention and Early Intervention Policy, Florida State University
- Gwen Wurm, M.D., Medical Director, Miami Children's Hospital
- Rex Northup, M.D., Medical Director, Florida Panhandle Pediatric Foundation
- Joe Rogers, COO, ChildNet Board of Directors & member of the Pediatrics Association
- Robin Rosenberg, Deputy Director, Florida Children's First
- Jennifer Takagishi, M.D., Medical Director, Children's Medical Services

Behavioral Health Care

The continuity of care and case coordination for behavioral health care services is another area that needs improvement. Case reviews many times note an abundance of services being provided to a child and family but no coordination of services or communication between service providers. The Department's Substance Abuse and Mental Health (SAMH) Program Office has made the integration of child welfare services and SAMH services a priority in their 2014-2016 strategic plan. The SAMH Program will provide content expertise on prescription drug treatment and prevention, Family Intervention Specialists (FIS), and child welfare issues related to substance abuse and mental health. The SAMH Program is also partnering with the Florida Alcohol and Drug Abuse Association to develop and deliver seven webinars to train Child Protective investigators and Family Intervention IS staff in the recognition and assessment of behavioral health disorders.

A critical part of the child welfare/behavioral health integration process is the role of FIS. As appropriate, child welfare policies and procedures have been revised to include the FIS services. Further, FIS protocols have been developed which delineate the service delivery process to this population. It is significant to note that FIS are co-located with the child welfare staff to promote communication, easy access and improved continuity of care.

Another behavioral health initiative that affects child welfare is the implementation of Managing Entities within the Substance Abuse and Mental Health program. The Department contracts for behavioral health services through regional systems of care called Managing Entities (MEs). These entities do not provide direct services; rather, they allow the Department's funding to be tailored to the specific behavioral health needs in the various regions of the State. There are seven Managing Entities that

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“develop, implement, administer, and monitor a behavioral health Safety Net” throughout the state.

In Circuit 1, monthly county-specific “Integration Meetings” are facilitated by the Circuit 1 Managing Entity (ME), Access Behavioral Health, to identify and resolve issues and improve communication among system stakeholders. These meetings routinely include stakeholders from both systems. Additionally, Circuits 2 and 14 have an ongoing relationship with the local Community-Based Care Provider. Additionally noteworthy to mention is the fact that in Circuit 14, a project with the National Center for Substance Abuse and Child Welfare (NCSACW) has been implemented which focuses on integration with Community-Based Care and SAMH. This project further strengthens the integration process between child welfare and behavioral health services.

The Department's Substance Abuse and Mental Health Program Office (SAMH) applied for and received a System of Care (SOC) Expansion Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The goals of the SAMHSA grant are to:

1. Improve the behavioral health outcomes of children and youth with serious emotional disturbances and their families
2. Support a broad-scale implementation of the SOC Expansion strategic plan
3. Expand and integrate systems of care through the creation of sustainable infrastructures and access to community based services and supports that enable children with behavioral health challenges to function better at home, in school, in the community, and throughout life.

To ensure integration, child welfare practitioners will participate with other child serving agencies, organizations, advocates and family members on the Children's Mental Health System of Care Expansion Implementation Core Advisory Team. The role of this team is to shape the strategies that pave the way for implementation of the SOC approach. Specific points of integration include:

- Assessment, screening and early intervention for very young children and their parents through integration with primary care;
- Working with Medicaid to include services that support the SOC approach such as Wraparound, respite, mobile crisis, and family (peer) support; and
- Blend or braid funding streams for supports and services not funded through Medicaid and common trainings.

In September 2012, the Department was awarded a Substance Abuse and Mental Health Association's (SAMHSA) Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant. The pilot site for this initiative will be used to promote the health and well-being of children from birth to age 8. The primary goal is to ensure

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children are developmentally on track when they enter school. Project LAUNCH's Five Core Strategies are:

1. Screening and assessment in a range of child-serving settings;
2. Integration of behavioral health into primary care settings;
3. Mental health consultation in early care and education;
4. Family strengthening and parent skills training; and
5. Enhanced home visiting through increased focus on social and emotional well-being.

Additional details about Project LAUNCH are located in Chapter V, Goals and Objectives.

Schedule for Initial and Follow-Up Health Screenings

Physical Health Assessment

There are a number of statutory and administrative code requirements that establish the policy for, and provide the direction of, medical care services for children in out of home care. Florida Statute (s. 39.407, F.S.) and Florida Administrative Code (59G-4.080-Child Health Check-up, 65C-29.008 -Initial Health Care Assessment and Medical Examination of Children alleged to be abused, neglected or abandoned, and 65C-28.003-Medical Treatment) govern Health Care Services within the Child Welfare System.

Section 39.407, Florida Statutes, authorizes the Department to provide medical screenings and follow up treatment for children removed from their homes and maintained in out-of-home placements. The Department utilizes two health care screening/assessments processes to accomplish this, the Child Health Check-up and the Comprehensive Behavioral Health Assessment (CBHA). These assessments provide recommendations for further medical, dental, and behavioral health treatment the child may need.

A child's physical health needs must be assessed within 72 hours of removal from their home. To be reimbursed by Medicaid, the provider must assess and document in the child's medical record all the required components of the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) known in Florida as the Child Health Check-Up. The components are as follows:

- Comprehensive health and developmental history (including assessment of both physical and mental health development).
- Comprehensive unclothed physical exam.

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- Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines).
- Laboratory tests (including blood level assessments appropriate for age and risk factors).
- Anticipatory Guidance/Health Education. Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.
- Vision Screening. Vision should be assessed at each screening. In infants, the history and subjective findings of the ability to regard and reach for objects, the ability to demonstrate an appropriate social smile, and to have age appropriate interaction with the examiner is sufficient. At ages four and above, objective measurement using the age-appropriate Snellen Chart, Goodlite Test, or Titmus Test should be done and recorded. If needed, a referral should be made to an ophthalmologist or optometrist.
- Dental Screening. A general assessment of the dental condition (teeth and/or gums) is obtained on all children. As indicated and beginning at age 2 years old a referral should be made to a dentist.
- Hearing Screening. A hearing test is required appropriate to the child's age and educational level. For the child under age four, hearing is determined by whatever method is normally used by a provider, including, but not limited to, a hearing kit.

The Agency for Healthcare Administration has placed the 72 hour screening requirement in all contracts for Medicaid Managed Assistance (e.g., Sunshine Health and other plans). Effective 7/1/14, the 72 hour screening will be a requirement in Florida statutes. This requirement is addressed in the Protective Custody Coverage Provisions of the managed care contract and requires the following:

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Child Health Check Up Age of Child
birth
2-4 days
2 months
4 months
6 months
9 months
12 months
15 months
18 months
Once every year for ages 2-20

a) The Managed Care Plan shall provide a physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter or the foster care program by DCF. See 65C-29.008, F.A.C.

b) The Managed Care Plan shall provide these required examinations without requiring prior authorization, or, if a non-participating provider is utilized by the Department of Children and Families, approve and process the out-of-network claim.

c) For all Child Health Check Up Screenings for children/adolescents whose enrollment and Medicaid eligibility are undetermined at the time of entry into the care and custody of DCF, and who are later determined to be enrollees at the time the examinations took place, the Managed Care Plan shall approve and process the claims. All children must have ongoing assessments following the Child Health Check-up periodicity schedule. The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5.

Child Protection Team Assessment

The Children's Medical Services Program in the Department of Health develops, maintains, and coordinates the services of multidisciplinary child protection teams throughout Florida. The teams provide specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services including, but not limited to, the following:

- a) Medical diagnosis and evaluation services, including provision or interpretation of X rays and laboratory tests, and related services.
- b) Psychological and psychiatric diagnosis and evaluation services for the child or the child's parent or parents, legal custodian or custodians, or other caregivers.
- c) Child protection team assessments that include, as appropriate, medical evaluations, medical consultations, family psychosocial interviews, specialized clinical interviews, or forensic interviews.

A child protection team that is evaluating a report of medical neglect and assessing the health care needs of a medically complex child is required by law to consult with a physician who has experience in treating children with the same condition.

Child protection team physicians and health care personnel provide assessments and evaluations in all of the following cases:

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- a) Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.
- b) Bruises anywhere on a child 5 years of age or under.
- c) Any report alleging sexual abuse of a child.
- d) Any sexually transmitted disease in a prepubescent child.
- e) Reported malnutrition of a child and failure of a child to thrive.
- f) Reported medical neglect of a child.
- g) Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home.
- h) Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.

These assessments do not take the place of the Child Health Check-Up or the Comprehensive Behavioral Health Assessment.

Comprehensive Behavioral Health Assessment (CBHA)

The Department recognizes the importance of early trauma screenings and assessments to help children get the treatment they need. The behavioral health needs of children, including trauma, are assessed through the CBHA. The CBHA is an in-depth and detailed assessment of a child's emotional, social, behavioral, and developmental functioning within the family home, school, and community. All children who are taken into state custody and placed in a licensed placement must receive a CBHA within 30 days. The CBHA is reimbursable under Medicaid when provided by a Medicaid Provider.

CBHAs are done on all children regardless of the reason they were removed. CBHAs are completed to provide an opportunity to identify and address needs early, prevent placement disruptions and inform the case plan and services and supports needed by the family.

The CBHA must include the completion of a standardized assessment tool to help determine the appropriate level of behavioral treatment services. For children ages 6 to 20 this tool may include, but is not limited to, the Child and Adolescent Needs and Strengths- Mental Health (CANS-MH) Assessment, and the Child and Adolescent Needs and Strengths- Comprehensive Multisystem Assessment (CANS-C). Florida Medicaid and the Department of Children and Families have approved the use of the CANS-MH and CANS-C by providers who have been certified to use these instruments.

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The CANS-C is recommended because it has an additional component to assess for trauma.

A child must be referred for a CBHA:

- a) When a child is in shelter status, the Case Manager or Child Protective Investigator (CPI), as appropriate, must refer the child for a CBHA if this assessment was not conducted prior to case transfer; or
- b) If a child is already in out-of-home care and is exhibiting emotional or behavioral issues that might result, or may have already resulted, in the child losing his or her placement, the Case Manager may refer the child for a CBHA to assist in determining services that would allow the child to maintain his or her placement. This may be done if a CBHA has not been conducted on the child within the past year; and
- c) The child has been determined to be Medicaid enrolled. If the child is not Medicaid enrolled, the CPI or Case Manager must take all steps necessary to ensure the child becomes enrolled as soon as possible, including assisting the child's caregiver to establish enrollment.

The case manager must refer the child and family for all services identified through a CBHA. The case manager has the primary responsibility throughout the case for coordinating, managing, and monitoring all aspects of the child's care and treatment. The behavioral health service needs identified through the CBHA will be considered when developing the child's case plan. The planned services must be implemented within thirty days of identification of the need. If services are not initiated within thirty days, the Case Manager must document reasons in the case file as to why services were not initiated. The Case Manager must ensure that the services begin as soon as possible. If the child is also served by the Department of Juvenile Justice (DJJ), the CPI or Case Manager must document attempts to coordinate planning and service delivery with DJJ staff.

When the case manager determines that a Behavioral Health Multidisciplinary Team is needed due to the significant behavior issues of the child, the Case Manager must convene a meeting of the team. The team must:

- a) Review all referrals for services to ensure that the child and family receive essential services to assist them in meeting the permanency goals as well as ensuring the child's safety and well-being;
- b) Provide recommendations for changes in the case plan. This information is to be placed into the Judicial Review Social Study Report (JRSSR) at least three weeks prior to each judicial review.

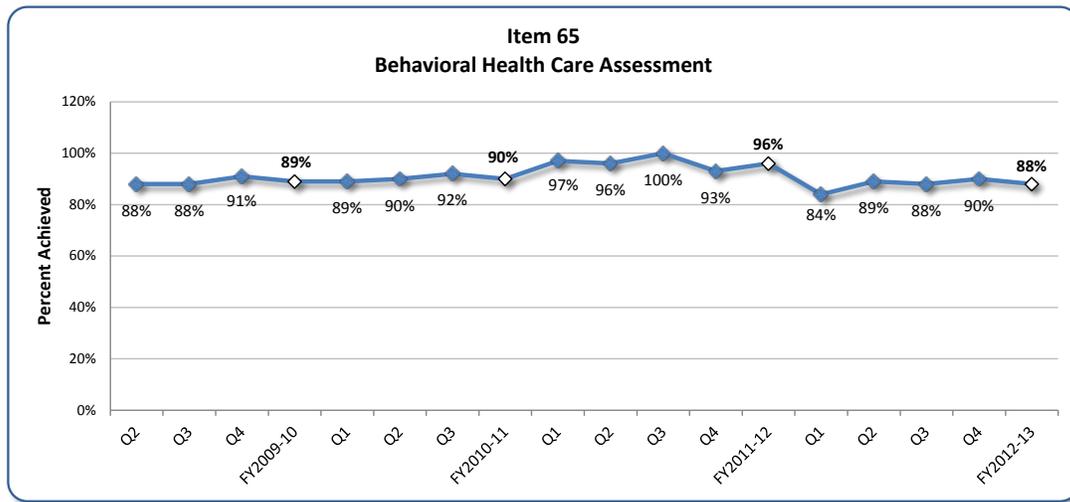
The Department uses QA case review item 65 and 66 to assess agency practice for screening, assessment, and service provision to address a child's mental and

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behavioral health needs. Figure 2 and Figure 3 depict the QA performance ratings for behavioral health assessments, on-going assessments and services while the child is in care. A four year trend between state fiscal year 2009/2010 and 2012/2013 demonstrates performance has generally remained flat.

Item 65 requires “An assessment(s) of the child’s behavioral health needs was conducted.” A Comprehensive Behavioral Health Assessment (CBHA) of the child’s behavioral health needs is required initially for all children in out-of-home care regardless if behavioral problems are identified including substance abuse. The reviewer must determine whether the agency conducted a formal or informal behavioral health assessment on the child either at the time the child entered into out-of-home or in an in-home case if the behavior health issue is relevant to the agency’s reason for involvement.

Figure 2. QA Item 65. Mental and Behavioral Assessment

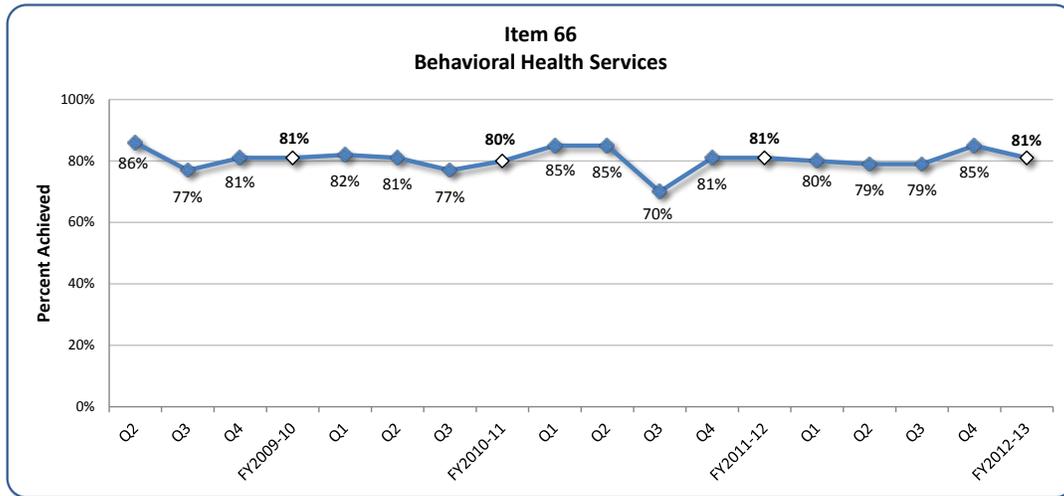


Source: DCF QA Web Portal. (FY 2012-2013; n=1,137)

Item 66 requires “Behavioral Services were provided to address the child’s identified needs.” The reviewer is tasked with determining if services were provided to address the child’s behavioral health needs. These services may include screenings and diagnostic tests to determine finite or long-term needs.

Figure 3. QA Item 66: Mental and Behavioral Health Services

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Source: DCF QA Web Portal (FY 2012-2013; n=752)

Monitoring and Treating Identified Health Needs, Including Emotional Trauma

The Department and CBC lead agencies are consistently monitoring service needs of the families in their community and using that information when assessing whether there is sufficient flexibility and service array to meet the needs of every child, including those with specialized individual needs. Quantitative and qualitative data is used to monitor efforts to assure equitable treatment of all children and families. Additionally, AHCA has developed performance measure to ensure the health care needs of children are being met.

Monitoring by the Florida Agency for Healthcare Administration

The Agency for Healthcare Administration (AHCA) will monitor performance through the contract performance measures required within the Child Welfare Specialty Plan contract. AHCA has adopted a set of quality metrics that sets targets on the metrics that equal or exceed the 75th percentile national Medicaid performance level. In addition, these metrics will be used to establish plan performance, improvement projects focusing on areas such as improved prenatal care and well child visits in the first 15 months and better preventive dental care for children. Figure 4 provides a listing of all of the performance reporting requirements for the Child Welfare Specialty Plan and standard Medicaid Managed Assistance Plans. The Child Welfare Specialty Plan must report on 24 measures from the Healthcare Effectiveness Data and Information Set (HEDIS), 6 measures from the Children's Health Insurance Program Reauthorization Act (CHIPRA) core measures, 11 measures that are agency defined, 2 measures that are HEDIS and agency defined, and one Joint Commission measure.

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Figure 4. Core Quality Measures

HEDIS	
1	Adolescent Well Care Visits - (AWC)
2	Adults' Access to Preventive/Ambulatory Health Services - (AAP)
3	Annual Dental Visits - (ADV)
4	Antidepressant Medication Management - (AMM)
5	BMI Assessment – (ABA)
6	Breast Cancer Screening – (BCS)
7	Cervical Cancer Screening – (CCS)
8	Childhood Immunization Status – (CIS) – Combo 2 and 3
9	Comprehensive Diabetes Care – (CDC) <ul style="list-style-type: none"> · Hemoglobin A1c (HbA1c) testing · HbA1c poor control · HbA1c control (<8%) · Eye exam (retinal) performed · LDL-C screening · LDL-C control (<100 mg/dL) · Medical attention for nephropathy
10	Controlling High Blood Pressure – (CBP)
11	Follow-up Care for Children Prescribed ADHD Medication – (ADD)
12	Immunizations for Adolescents – (IMA)
13	Chlamydia Screening for Women – (CHL)
14	Pharyngitis – Appropriate Testing related to Antibiotic Dispensing – (CWP)
15	Prenatal and Postpartum Care – (PPC)
16	Use of Appropriate Medications for People With Asthma – (ASM)
17	Well-Child Visits in the First 15 Months of Life – (W15)
18	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34)

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HEDIS	
19	Children and Adolescents' Access to Primary Care - (CAP)
20	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
21	Ambulatory Care - (AMB)
22	Lead Screening in Children – (LSC)
23	Annual Monitoring for Patients on Persistent Medications
24	Plan All-Cause Readmissions
Agency-Defined	
1	Mental Health Readmission Rate – (RER)
2	Frequency of HIV Disease Monitoring Lab Tests – (CD4 and VL)
3	Highly Active Anti-Retroviral Treatment – (HAART)
4	HIV-Related Medical Visits – (HIVV)
5	Complete Oral Evaluation
6	Sealants
7	Transportation Timeliness (TRT)
8	Transportation Availability (TRA)
HEDIS & Agency-Defined	
1	Follow-Up after Hospitalization for Mental Illness – (FHM)
2	Prenatal Care Frequency (PCF)
Joint Commission	
1	Antenatal Steroids

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In addition to the Core Quality Measures listed above, the child welfare specialty plan is required to collect and report the following CHIPRA and agency defined performance measures:

CHIPRA Child Core Set	
1	HPV Vaccine for Female Adolescents – (HPV)
2	Medication Management for People with Asthma – (MMA)
3	Annual Pediatric Hemoglobin A1C Testing – (PEDHbA1C)
4	Preventive Dental Services – (PDENT)
5	Dental Treatment Services – (TDENT)
6	Developmental Screening in the First Three Years of Life – (DEVSCR)
Agency Defined	
1	Children on Higher than Recommended Doses of Antipsychotics (HRDPSY)
2	Use of Antipsychotics in Very Young Children (PSYVYC)
3	Use of Multiple Concurrent Antipsychotics in Children (CONPSY)

Source: AHCA Performance Measures

Psychotropic Medication Monitoring and Oversight

The Department works closely with AHCA to ensure oversight of psychotropic medication. The oversight of prescription medicines, including psychotropic medications, is critical to safeguard appropriate practice of management and administration of medication to children placed in out-of-home care. Medication information is required to be documented in the Florida Safe Families Network (FSFN) in data fields that can be easily queried and analyzed. Among others, the data fields include the name of the medication, the condition(s) the medication addresses, and whether or not the medication is psychotropic, and whether the medication is administered for psychiatric reasons.

The Department’s protocols for “assent” are addressed in Florida Administrative Code entitled “Assent for Psychotropic Medication Management from Youth”. These protocols require the prescribing physician to discuss the proposed course of treatment with the child, in developmentally appropriate language the child can understand. The physician must explain the risks and benefits of the prescribed medication to the child. The physician must discuss the medication proposed, the reason for the medication, and the signs or symptoms to report to caregivers. If a child of sufficient age, understanding, and maturity declines to assent to the psychotropic medication, the dependency case manager or child protective investigator will ask that Children’s Legal Services request an attorney be appointed for the child. Whenever the child requests

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the discontinuation of the psychotropic medication, and the prescribing physician refuses to order the discontinuation, the dependency case manager or child protective investigator will ask that Children's Legal Services request an attorney be appointed for the child. Children's Legal Services will notice all parties and file a motion with the court presenting the child's concerns, the physician's recommendation, and any other relevant information, pursuant to Section 39.407(3)(d)1., F.S.

AHCA Protocols, Monitoring and Oversight: There are a number of laws, administrative rules, and operating procedures that govern psychotropic medication monitoring and oversight for children in the child welfare system. Section 409.912(51), F.S., does not allow for Medicaid reimbursement for psychotropic medication without the express and informed consent of the child's parent or legal guardian. The physician must document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription.

AHCA contracts with the University of South Florida for the Medicaid Drug Therapy Management Program for Behavioral Health to maintain and develop evidence based guidelines for the use of psychotropic medications for children. This program includes the development of Florida-specific best practice guidelines and their dissemination through a variety of methods created and implemented by the prescriber community. These treatment guidelines will represent a consensus of the prescriber community and will reflect the best available scientific information.

The MDTMP also includes a claims review process and educational mailings to inform physicians of prescribing behavior that may be worth reviewing. The mailings, containing patient-specific prescription information and clinical considerations, are designed to reduce the frequency of practices that are inconsistent with the guidelines. National experts, Florida physicians, AHCA, and DCF staff meet biennially to update medication guidelines.

AHCA provides oversight through pharmacy claims, prior authorization protocols, and operation of the pediatric psychiatry consult lines. A description of these oversight activities is provided below:

1. Analysis of Pharmacy Claims by the Medicaid Drug Therapy Management Program

In response to this growth in expenditures and to concerns about the quality of prescribing of psychotherapeutic medications, the Florida Legislature created the Medicaid Drug Therapy Management Program (MDTMP) for Behavioral Health. The MDTMP is operated by the Florida Mental Health Institute at the University of South Florida under contract with the Agency for Health Care Administration, the State Medicaid Authority.

2. Prior Authorization Protocols for Children and Adolescents

The Agency for Health Care Administration requires a prior authorization review process with a clinical review or second medical opinion by a child and adolescent

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psychiatrist from the University of South Florida (USF) prior to reimbursement of an antipsychotic prescribed to a child or adolescent that is included in any of the categories below. The reviewing psychiatrist also provides comments and recommendations for the prescriber including safety monitoring recommendations such as metabolic labs and Tardive Dyskinesia screens. Prior authorization is required for the following:

- Antipsychotic Medication (Antipsychotics (also known as neuroleptics or major tranquilizers) are a class of psychiatric medication primarily used to manage psychosis (including delusions, hallucinations, or disordered thought), in particular in schizophrenia and bipolar disorder).
- Sedative/Hypnotic and Benzodiazepine Age Limits - Claims for recipients younger than the specified age limits approved by the Food and Drug Administration are denied for Medicaid reimbursement.
- Anti-Depressants for Children Under Six

3. Florida Pediatric Psychiatry Consult Hotline

This service is administered by the Florida Medicaid Drug Therapy Management Program for Behavioral Health located at the Florida Mental Health Institute (FMHI) at the University of South Florida. The Florida Pediatric Psychiatry Hotline, a network of regional children's behavioral health consultation teams, is designed to help primary care clinicians meet the needs of children with psychiatric conditions. The goals of the program are to provide consultation about psychotropic medications for children with psychiatric illness and promote a primary care clinician's and child psychiatrist's collaborative relationship. Currently there are three consultation hotlines (University of Florida Division of Child and Adolescent Psychiatry in Gainesville; University of South Florida Division of Child and Adolescent Psychiatry in the Department of Pediatrics, Rothman Center for Neuropsychiatry in St. Petersburg; and Florida International University)

4. Medicaid Pharmacy Requirements for Express and Informed Consent

Pursuant to section 409.912(51), Florida Statutes: The Agency [AHCA] may not pay for a psychotropic medication prescribed for a child in the Medicaid program without the express and informed consent of the child's parent or legal guardian. The physician shall document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription. Section 394.492(3), F.S. defines "Child" as a person from birth until the person's 13th birthday. If express and informed consent is not obtained, the dependency court judge must authorize the prescription.

Department Protocols, Monitoring, and Oversight: Department protocols are governed by 65C-35, Florida Administrative Code, which establishes department policy

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for psychotropic medication for children in out-of-home care. Children and Families Operating Procedures (CFOP 155-10 / 175/40 / 178-98) outline Department procedures for services for children in out-of-home care with behavioral health and any co-occurring substance abuse or developmental disability treatment needs. The express and informed consent or court authorization for a prescription of psychotropic medication for a child in the custody of the Department of Children and Family Services must also be obtained pursuant to section 39.407, F.S., which governs medical, psychiatric, and psychological examination and treatment of a child.

1. Weekly Management Reports

The Department of Children and Families monitors children on psychotropic medication utilizing the Florida Safe Families Network and weekly executive leadership Key Indicators Reports. A Psychotropic Medications Detailed Summary Report is run each week providing a variety of information about children in care who receive psychotropic medications. This report is utilized in the field by supervisors and managers.

2. Pre-Consent Requirements

A Pre-consent Review is mandatory for any child age 10 and under on 2 or more psychotropic medications. If the pre-consent review process is not used, a second-opinion by a child psychiatrist is mandatory. Department contracts with CBC lead agencies require a Pre-consent Review or Second Opinion. The Department contracts with the University of Florida, Division of Child and Adolescent Psychiatry to provide the Pre-Consent Review.

3. Consultation Services

The Department also contracts with the University of Florida, Division of Child and Adolescent Psychiatry, to operate the Med Consult toll free line. This service is available for caregivers and decision makers for children and youth involved in the dependency system. Callers may schedule a call with one of the Board Certified Psychiatrists to discuss psychotropic medication resources and suggested medication treatment. This service is not a second opinion, but is designed to help callers make informed decisions about medication. This service makes available the latest psychiatric medical information. This includes indicated uses and practices, Black Box Warnings, on or off label use, and precautions such as EKGs, lab work, etc. The line is used by caregivers, judges, Guardians Ad Litem, and caseworkers.

~~4. Oversight of Children on High Dose or Multiple Antipsychotics~~

~~Child Welfare QA/CQI collaborates with the University of South Florida (USF) to conduct data matches of children in out-of-home care on psychotropic medications. The University of South Florida has a contract with the Agency for Health Care Administration (AHCA) to provide analysis of anti-psychotic medication utilization. AHCA provides USF with Medicaid pharmacy data and USF, which has developed~~

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~~clinical utilization protocols, provides critical information back to AHCA about patients being prescribed potentially unsafe combinations or high dosages of anti-psychotic medications. USF analysis is currently limited to anti-psychotic medications only.~~

5.4. Contract Management Oversight

The Department's Contract Oversight Unit has designated staff who conducts contract monitoring annually at each CBC. The contract oversight unit focuses on requirements in state law and administrative code.

6.5. Client Level Medication Administration and Monitoring by Foster Parents

The monitoring of the use of psychotropic medication provided to children will be a joint responsibility among the prescribing physician, caregiver, dependency case manager or child protective investigator, and the supervisor. The dependency case manager or child protective investigator is responsible for implementing the medication plan developed by the prescribing physician. Florida Administrative Code requires that psychotropic medications be administered only by the child's caregivers. Children who are age and developmentally appropriate must be given the choice to self-administer medication under the supervision of the caregiver or school personnel. All information is included in the child's Resource Record. Results of evaluations and tests will be reported to Children's Legal Services, all parties, and the prescribing physician.

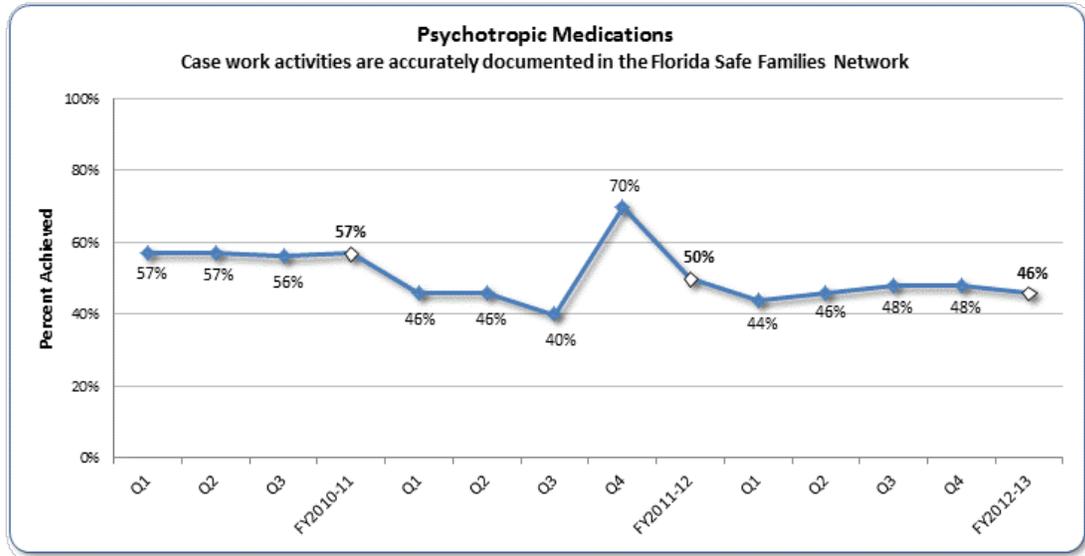
7.6. Monitoring Data Integrity of Psychotropic Medication in FSFN

The Department's quality assurance staff monitor practice related to psychotropic medication and continue to see a difference between practice and documentation. It is mandatory for child protective investigators and case managers to enter psychotropic medication information in the Medication Information page of FSFN. The "Dosage," "Reason for Medication," and "Instructions/Additional Comments" sections are all free form text fields where notes specific to the medication can be written. The documentation reflects that care work activities related to Psychotropic medication is not accurately document in FSFN.

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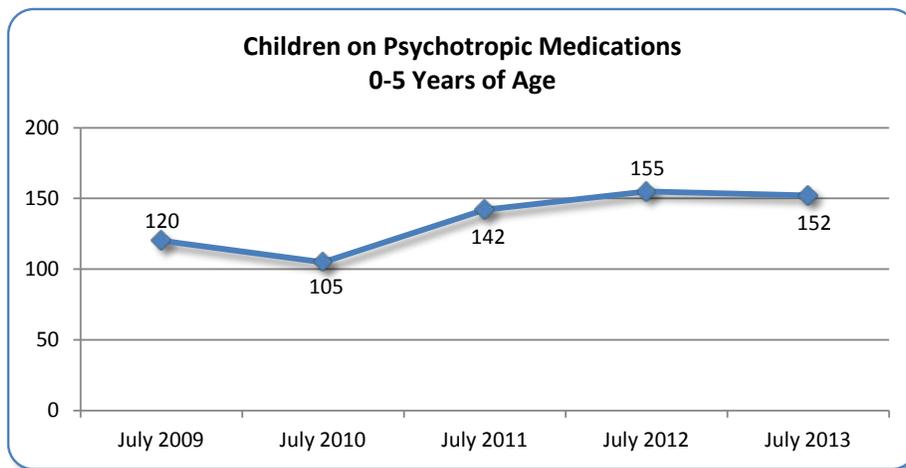
Figure 5. Psychotropic Medication, Ages 5 - 17



Source: FSFN Psychotropic Medication Reports

In 2009, Florida embarked on a major initiative to reduce psychotropic medication use for children in out-of-home care. The four figures below demonstrate a substantial decline for all age groups except the age 0-5 population. For this age group, the number of children on psychotropic medication has risen. The contributing factors for the apparent rise must be fully understood; for example, Florida monitors psychotropic medication usage for all conditions, not just behavioral health – including seizure disorders, brain injury, etc. Furthermore, the younger portion (ages 6-12) of the total group aged 5 – 17 appears to also be rising, though not yet above baseline. This is cause for further analysis.

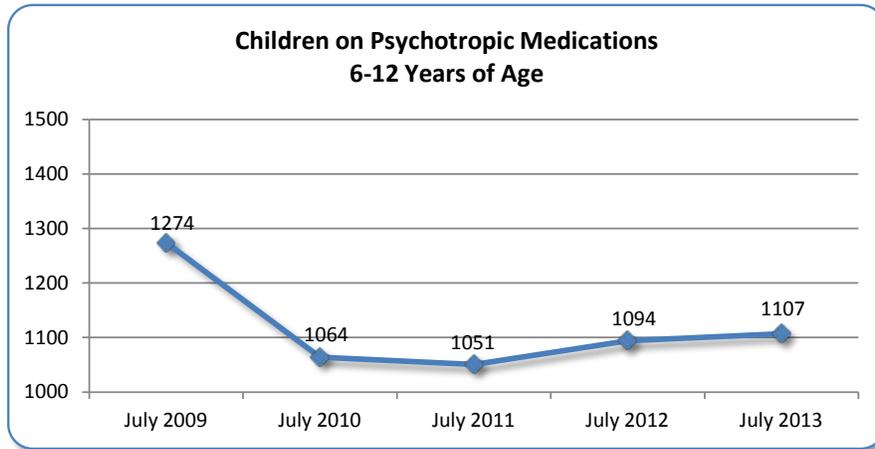
Figure 6. Psychotropic Medication, Ages 0-5



Source: FSFN Psychotropic Medication Reports

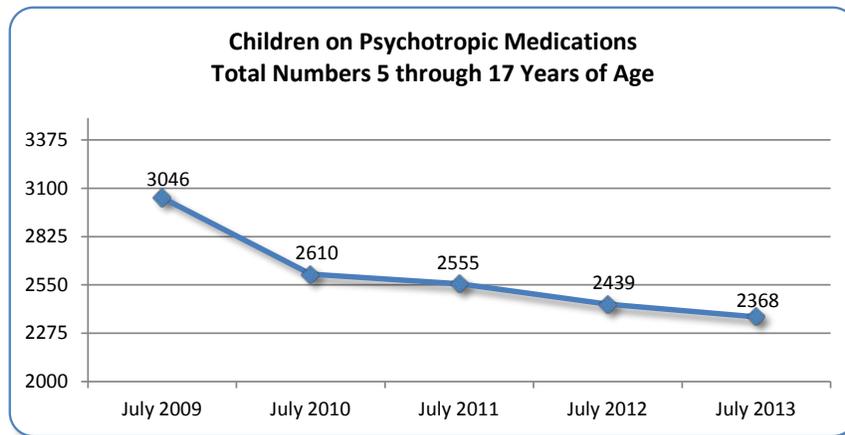
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Figure 7. Psychotropic Medication: Ages 6-12



Source: FSFN Psychotropic Medication Reports

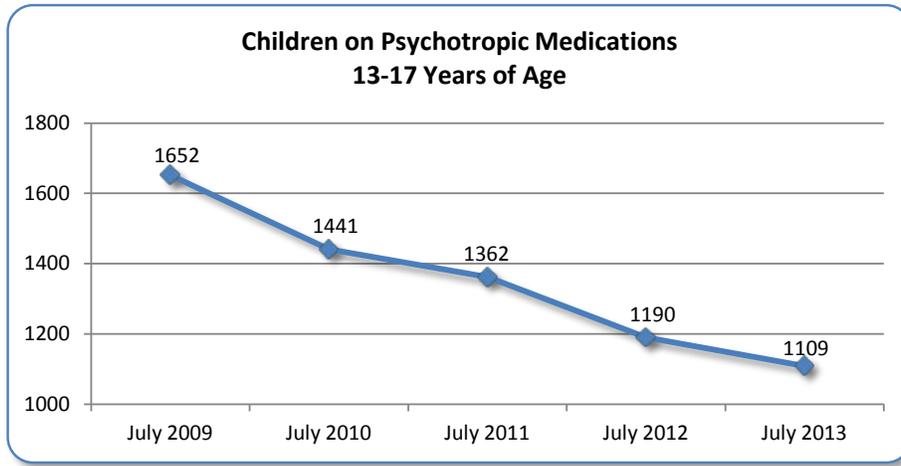
Figure 8. Psychotropic Medication, Ages 5 - 17



Source: FSFN Psychotropic Medication Reports

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Figure 9. Psychotropic Medication: Ages 13-17



Source: FSFN Psychotropic Medication Reports

Other Health Care Monitoring and Oversight

The Department of Children and Families assesses lead agency performance utilizing the data from the Florida Safe Families Network and data from Quality Assurance (QA) case reviews conducted by the child welfare quality assurance staff. If performance is declining or the CBC is performing poorly, Department leadership engages in a discussion of the measure as part regional operations. Additionally, CBC CQI staff may discuss the factors that may be contributing to the decline or poor performance and the CBC's plans to address them. A CBC may also choose to include the improvement planning for this item as part of their Annual CQI Plan.

A high-level management tool for monitoring healthcare status is the FSFN monthly healthcare report. This is a management report that provides leadership point in time performance in four areas:

1. **Medical/Mental Health Record in FSFN:** This is the percent of children in OHC for whom a Medical/Mental Health record had been created in FSFN. The Medical/Mental Health record must be in the current active case to which the primary worker is assigned. The numerator is the count of children in OHC who have a Medical/Mental Health record created in FSFN. The denominator is the sum of all children in OHC greater than 5 days and those children in OHC 5 days or less that have a Medical/Mental Health record created in FSFN.
2. **Medical Service in the Last 12 Months:** This is the percent of children in OHC who have received a Medical Service within the last 12 months, according to documentation in FSFN. The numerator is the count of children in OHC who have received a Medical Service in the last 12 months. The denominator is the sum of all children in OHC greater than 5 days and those children in OHC 5 days or less that have received a Medical Service in the last 12 months.

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3. **Dental Service in the Last 7 Months:** This is the percent of children in OHC who have received a Dental Service within the last 7 months, according to documentation in FSFN. The numerator is the count of children in OHC who are 3 or older and have received a Dental Service in the last 7 months. The denominator is the sum of all children 3 and older in OHC greater than 6 months and those children 3 and older in OHC less than 6 months who have received a Dental Service in the last 7 months.

4. **Immunizations Up to Date:** This is the percent of children in OHC whose immunizations are up to date, according to documentation in FSFN. The numerator the count of children in OHC whose immunizations are up to date. The denominator is the sum of all children in OHC greater than 5 days and those children in OHC 5 days or less whose immunizations are up to date.

Figure 10 is an example of this monthly report: "Health Information in FSFN for Children in OHC on 3/31/2014, Statewide and by Community Based Care Lead Agency"

Figure 10. Health Information in FSFN Example Report

Lead Agency	Children in OHC 3/31/2014	Medical/Mental Health Record in FSFN			Medical Service in the Last 12 Months			Dental Service in the Last 7 Months			Immunizations Up to Date		
		(Baseline) 5/18/2011	3/31/2014	% Change	(Baseline) 5/18/2011	3/31/2014	% Change	(Baseline) 5/18/2011	3/31/2014	% Change	(Baseline) 5/18/2011	3/31/2014	% Change
Big Bend CBC	667	96.8%	100.0%	3.2%	2.1%	94.5%	92.3%	0.0%	89.8%	89.8%	34.4%	99.1%	64.7%
Brevard Family Partnership	489	89.5%	100.0%	10.5%	38.2%	97.5%	59.4%	35.3%	96.4%	61.1%	42.4%	98.2%	55.8%
CBC of Central Florida	1128	76.3%	100.0%	23.7%	7.1%	97.4%	90.3%	4.1%	98.0%	94.0%	33.3%	98.1%	64.9%
CBC of Central Florida (Seminole)	239	97.8%	100.0%	2.2%	6.1%	95.8%	89.7%	1.5%	95.9%	94.5%	41.4%	98.7%	57.4%
ChildNet Inc	1758	97.7%	100.0%	2.3%	86.1%	98.9%	12.8%	37.8%	94.9%	57.1%	68.4%	99.5%	31.1%
ChildNet Palm Beach	1109	93.1%	100.0%	6.9%	26.0%	97.0%	71.0%	15.8%	92.0%	76.1%	73.8%	99.5%	25.7%
Childrens Network of SW Florida	1055	95.0%	100.0%	5.0%	74.3%	96.8%	22.5%	29.4%	87.6%	58.2%	76.4%	97.1%	20.7%
Community Partnership for Children	626	78.7%	100.0%	21.3%	12.0%	95.4%	83.4%	3.2%	85.7%	82.5%	35.8%	98.4%	62.6%
Devereux CBC	645	83.8%	100.0%	16.2%	2.8%	95.2%	92.4%	1.8%	91.0%	89.2%	34.4%	99.4%	65.0%
Eckerd Community Alternatives Inc	1613	78.7%	100.0%	21.3%	6.5%	98.9%	92.4%	3.4%	97.7%	94.2%	45.5%	99.9%	54.4%
Eckerd Community Hillsborough	1653	83.6%	100.0%	16.4%	8.7%	98.5%	89.8%	1.0%	96.7%	95.8%	50.3%	99.2%	48.9%
Families First Network	932	96.2%	100.0%	3.8%	41.4%	97.6%	56.2%	47.0%	94.7%	47.8%	71.3%	98.8%	27.5%
Family Integrity Program	90	87.3%	100.0%	12.7%	59.8%	97.8%	38.0%	44.6%	98.3%	53.7%	44.1%	100.0%	55.9%
Family Support Services	769	58.3%	100.0%	41.7%	4.5%	97.4%	92.9%	2.6%	93.3%	90.7%	29.0%	97.9%	68.9%
Heartland for Children, Inc	971	68.3%	100.0%	31.7%	26.4%	97.4%	71.1%	16.6%	90.6%	74.1%	41.9%	99.9%	58.0%
Kids Central, Inc.	998	98.1%	99.9%	1.8%	55.0%	96.4%	41.4%	47.9%	94.1%	46.1%	73.8%	99.2%	25.4%
Kids First of Florida Inc.	182	94.9%	100.0%	5.1%	30.6%	97.8%	67.2%	7.8%	88.9%	81.1%	40.7%	97.8%	57.1%
Our Kids Inc	1932	98.5%	99.9%	1.4%	91.2%	95.8%	4.6%	57.9%	83.5%	25.6%	77.2%	95.7%	18.5%
Partnership for Strong Families	621	99.3%	98.9%	-0.4%	65.4%	96.3%	30.9%	31.6%	87.9%	56.3%	81.2%	97.2%	16.0%
Safe Children Coalition	649	92.8%	100.0%	7.2%	35.3%	99.8%	64.5%	7.8%	93.9%	86.1%	43.6%	99.8%	56.2%
Statewide	18126	85.7%	99.9%	14.2%	30.2%	97.3%	67.1%	14.8%	92.5%	77.6%	48.7%	98.6%	49.9%

Source: Florida Safe Families Network Data Repository as of March 31, 2014

The tables and graphs below illustrate performance for the past four state fiscal years in the area of screening, assessment, and services.

Performance in the area of Screening and Assessment is monitored utilizing FSFN and QA items. According to the documentation in FSFN, the EPSDT screening within three days is only taking place in 27.17% of the cases. The QA case file review data indicates a much higher percentage (83%). This may indicate data is not being entered into

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FSFN. The Child Welfare Specialty Plan will have a performance measure tied to EPSDT screening and therefore we anticipate substantial improvement in this area during the next eighteen months.

Table 1. Percent of Children with an EPSDT Medical Service within Three Days of Removal Date (SFY 2009-2010 through 2012-2013).

State Fiscal Year	Total Removals	Removals w/ EPSDT w/in Three Days	Percent w/ EPSDT
2009-2010	14811	948	6.40%
2010-2011	15897	1804	11.35%
2011-2012	16654	2792	16.76%
2012-2013	14584	3963	27.17%

Source: Florida Safe Families Network Data Repository as of April 8, 2014

Note: Removals lasting less than 24 hours are excluded from this analysis. An EPSDT Medical Service is considered to have been within three days of the removal date if the medical service date entered into FSFN is less than or equal to the removal date plus three days. For example, a child removed January 1 would be counted as having an EPSDT Medical Service within three days if the medical service date was on or before January 4 but on or after January 1. A medical service date PRIOR to the removal date is not considered for this analysis.

Table 2. Percent of Children with Immunizations Up To Date, SFY 2010 – 2013 (Point in Time Children in Out-of-Home Care on June 30)

As Of Date	Children in Out-of-Home Care	Children w/ Immunizations Up To Date	Percent w/ Immunizations Up To Date
June 30, 2010	18420	12541	68.08%
June 30, 2011	19060	18086	94.89%
June 30, 2012	19534	19420	99.42%
June 30, 2013	17578	17531	99.73%

Source: Florida Safe Families Network Data Repository as of April 8, 2014

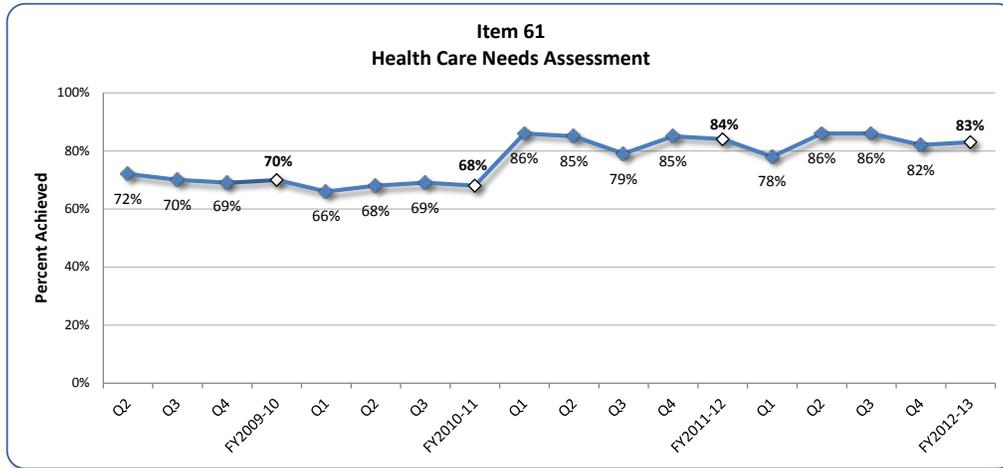
Note: Children are included if they are in Out-of-Home Care as of the end of the day on June 30th of the appropriate year. Children are considered as having their Immunizations Up to Date if the Immunizations Up to Date checkbox is "checked" on the Medical Profile tab of the Medical Mental Health module.

QA Item 61 requires “The child’s health care needs are assessed initially and on an ongoing basis through periodic health screening services conducted during the period under review.” For children in out-of-home care, a child’s physical health needs must be assessed within 72 hours if he/she is removed from the home, or if health issues are the reason why the dependency system has intervened. Reviewers are tasked with determining if there is evidence in the case file that, during the period under review, the agency arranged for an assessment of the child(ren)’s health care needs; both initially (if the child entered foster care during the period under review), or on an ongoing basis through periodic health and dental screening services conducted during the period under review.

Figure 11 illustrates the QA performance ratings for the health needs assessment (Child Health Check-up) and on-going assessments. A four year trend demonstrates a 13% improvement in assessments between state fiscal year 2009/2010 and 2012/2013.

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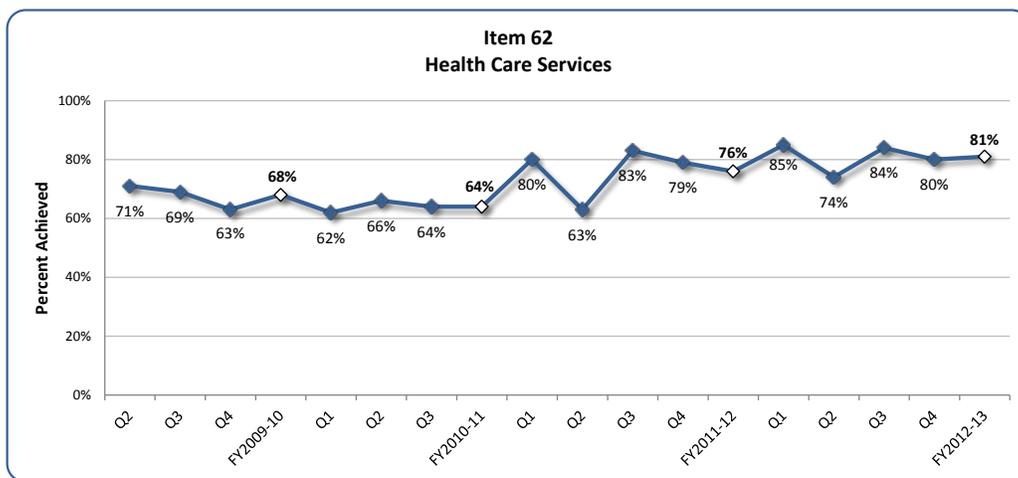
Figure 11. QA Item 61. Health Care Needs Assessment



Source: DCF QA Web Portal (FY 2012-2013; n= 1,149)

Item 62 requires “Services are provided to address the child’s identified physical health needs.” Reviewers are tasked with determining if health care services were obtained to address the child’s identified physical health needs. For out-of-home cases only, the reviewer must determine if the case plan addressed health care needs and the case file reflected services to address identified needs. For in-home cases with an identified physical health care need relevant to the agency’s involvement, the reviewer must determine if the need was appropriately addressed. As shown in Figure 12, a four year trend demonstrates 10% improvement in service delivery between state fiscal year 2009/2010 and 2012/2013.

Figure 12. QA Item 62. Health Care Services

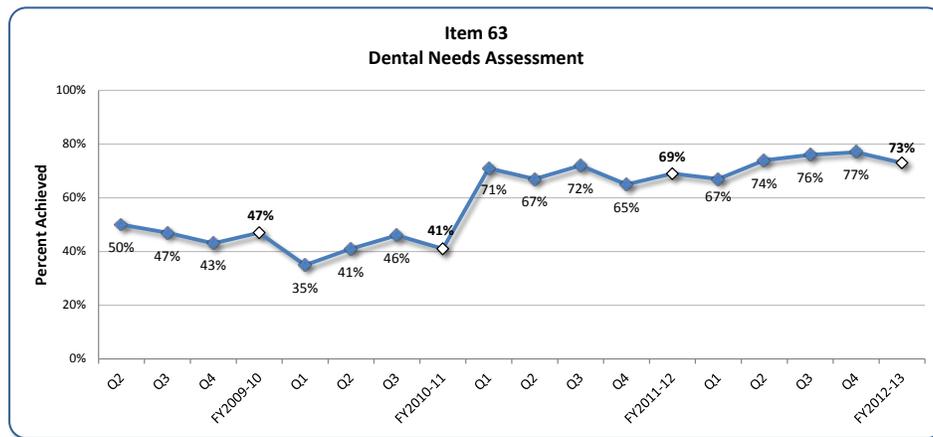


Source: DCF QA Web Portal (FY 2012-2013; n=496)

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Item 63 requires “The child’s dental health needs were assessed upon entry into out-of-home care and on an ongoing basis through periodic screening services.” Reviewers must determine if there is evidence that, during the period under review, the agency arranged for assessment of the child(ren)’s dental needs both initially (if the child entered foster care during the period under review), or on an ongoing basis through periodic dental screening services conducted during the period under review. **A four year trend demonstrates a 23% improvement in service delivery between state fiscal year 2009/2010 and 2012/2013, as shown in Figure 13.**

Figure 13. QA Item 63. Dental Needs Assessment

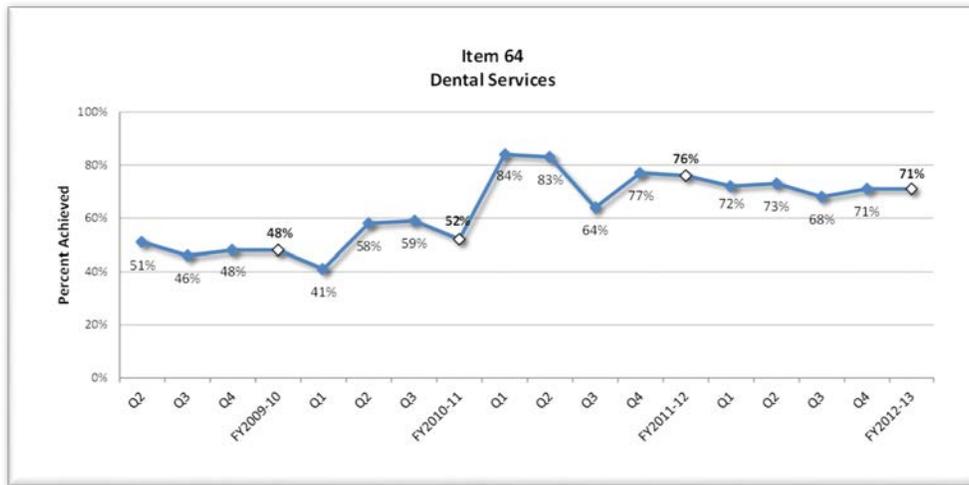


Source: DCF QA Web Portal (FY 2012-2013; n= 835)

Item 64 requires “Services are provided to address the child’s identified dental health needs.” Services are required to address the child’s dental health needs once the needs are identified. The reviewer must assess this standard based on the child(ren)’s dental health needs and whether services were provided to address those needs during the period under review. Documentation must reflect that the services agency followed-up on treatment plans that the doctor ordered. A four year trend (figure 14) demonstrates a 20% improvement in service delivery between state fiscal year 2009/2010 and 2012/2013.

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Figure 14. QA Item 64. Dental Services



Source: DCF QA Web Portal (FY 2012-2013; n=364)

Trauma-Informed Care

Child traumatic stress occurs when children and adolescents are exposed to traumatic events or situations that overwhelm their ability to cope. Usually such events threaten the life or physical integrity of the child or of someone close to the child, or involve witnessing an occurrence of similar threat happen to someone else. Traumatic events can evoke powerful emotional and psychological reactions such as an overwhelming sense of terror, helplessness, and horror. In the aftermath of trauma, children may struggle with intrusive images related to the traumatic events, may be unable to sleep or have nightmares, and may find it difficult to concentrate or take in new information. Research has shown that trauma significantly increases the risk of behavioral health problems, difficulties with social relationships and behavior, physical illness, and poor school performance. Thus, child welfare systems are likely to find that the children served have problems related to trauma and need specialized help.¹

Florida is working to improve its system of “trauma-informed care” to ensure children experiencing trauma are quickly recognized and treated. The state uses standardized assessments as detailed earlier as part of the CBHA and CANS-C. CBCs have developed and implemented treatment and service interventions that reflect strong partnerships and networks. The Child Welfare Pre-service Curriculum includes training to help professionals identify and address childhood trauma. In April 2014, the Florida Association for Infant Mental Health sponsored a conference “Many Paths to Enhancing Parent-Child Relationships- *Innovative Approaches to Providing Infant Mental Health*,

¹Child Traumatic Stress: What Every Policymaker Should Know This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). *A Guide from the National Child Traumatic Stress Network*
http://www.nctsn.org/sites/default/files/assets/pdfs/PolicyGuide_CTS2008.pdf

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Home Visiting, and Part C Services" which highlighted trauma informed care. Examples of trauma informed care services provided through Community-Based Care lead agencies include:

Heartland for Children - Operates from the philosophical position that services are provided in a family centered and youth guided environment using the principles of Emotional Regulatory Healing (ERH), trauma informed care, family centered practice and normalcy for children. These include all foster care, substance abuse, domestic violence, behavioral health, and case management services.

Their philosophical orientation toward a family centered, trauma sensitive, and strength-based approach is essential for success. This messaging begins with training in pre-service classes and continues during in-service training opportunities for all HFC staff and subcontracted providers. HFC has initiated several strategies to ensure client rights and dignity are respected throughout our agency and the System of Care. Examples include identifying languages spoken by staff in subcontracted agencies, and working through HFC's Client Relations Specialist to coordinate resolution of issues.

In order to meet the needs of parents and children in the most meaningful way possible, HFC has embraced and supported a Trauma Focused and Trauma Informed Care model of service delivery for the past 5 years. Engaging some of the most notable national figures in brain trauma and its effects, HFC has provided trainings for not only contacted providers, but also for all stakeholders in our system of care. In their pursuit to create a trauma-informed service environment through which parents can heal, HFC has taken a strong role in reforming the behavioral health services offered within our community. They did this in two ways - as an advocate and as a "parent."

First, through their role as an advocate, they educated local behavioral health leadership on trauma and the Adverse Childhood Experiences (ACE) study², distributed publications related to trauma, and extended invitations to workshops intended to create a call to action. They brought their staff in to do both general and intensive trainings to provide the tools and paradigm needed to deliver effective clinical services to our children and families. Through their role as a "parent" responsible for the well-being of a child, we shopped for competent and effective services to meet the needs of children. This created competition within the behavioral health arena.

CBC Central Florida - CBHA assessors recommend appropriate counseling/play therapy for children as indicated. The CBC insures that any counseling recommendations are followed. Foster parents and group home staff have received multiple trainings on trauma informed care practices and are better equipped to address behavioral symptoms that children manifest, based on their age, heightening the caregivers sensitivity to the youth. During Family Service Team staffings the needs of the child are a continual discussion, as well as in the monthly supervisor consultation with staff. Placement Support staffings can be called at any time, as well. The local child advocacy

²Centers for Disease Control and Kaiser Permanente – ongoing. <http://acestudy.org/>

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centers offer trauma therapy and play therapy for children that have been victims of severe physical and sexual abuse, and referrals are made by the assigned child advocate in those cases where the Child Protection Team (CPT) has seen or interviewed the children

Family Support Services of North Florida - The trauma needs of children are recognized and taken into consideration throughout the child's experience in out-of-home care. These are the three most common methods:

1. Transition Trauma Therapists may accompany CPI when a removal is imminent. The therapist remains assigned to the child to and provides services to mitigate the impact of the trauma related to removal.
2. The licensed staff that perform Comprehensive Behavioral Health Assessments (CBHA) are all trauma-trained.
3. All therapists that provide ongoing services to children in care: individual therapists, Therapeutic Behavioral Overlay Specialists (TBOS), and Special Therapeutic Foster Care (STFC) providers are all trauma-trained.

Devereux- To ensure that clients receive the most appropriate level and type of care possible, the available history of every family is reviewed by a team of highly experienced child welfare professionals to attempt accurate root-cause analysis. Dependent upon the current traumatic situation coupled with any historical trauma, clients are referred to community providers that have staff members trained to address those specific needs using the most current professionally-recognized techniques. At the time of referral, the Case Manager submits to the selected provider all pertinent, explanatory documentation and information for review prior to an initial assessment or intake. When possible the Case Manager is closely involved in treatment planning and subsequent reviews. All clients are assessed for the least-intrusive treatment while maintaining the integrity of the therapeutic process. Should more intensive therapeutic measures be necessary, a Multi-Disciplinary Team is assembled to thoroughly discuss the history and current status of the child and determine the best course of action that would be the least intrusive. At all stages, the child's personal history of trauma is paramount in the decision-making process and guides each chosen service and provider.

Eckerd - Eckerd works in partnership with local managing entity Central Florida Behavioral Health to ensure trauma needs are met. Eckerd further participates in a regional multidisciplinary trauma focused workgroup including the judiciary, University of South Florida Staff, and Eckerd leadership to identify areas of need. The workgroup is implementing a regional CBHA assessment tool to identify and recommend services to redress the traumatic experiences of children in care. Trauma training is periodically provided to all caseworkers and providers in the system of care as a result of this workgroup. Eckerd Hillsborough launched the Professional Parenting curriculum with an enhanced trauma focus including emotional regulatory healing as a key component

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in 2012. This has been recognized as a best practice and has been picked up by 4 additional CBC's statewide since that time.

Kids First of Florida - Contracts with the local community behavioral health provider for trauma therapy services for children and their families/caregivers at removal, placement changes (when needed), and in response to other traumatic events/needs (as deemed appropriate).

Kids Central - Insures that the trauma needs of children are being met in several ways. Initially, the CBHA Reviewer identifies trauma, as well as therapeutic needs of children, and notifies the Children's Mental Health Specialist so that services can be coordinated expediently. Kids Central also has a Behavior Specialist in the Placement Department that intervenes during crises in foster homes in an attempt to maintain stable placement and thus reduce additional trauma to already fragile children. Also, a tiered rate structure is currently being developed that uses an assessment tool to identify special needs of children to insure they are placed in the appropriate home that can meet all their needs.

Kids Central contracts with the local community behavioral health provider for trauma therapy services for children and their families/caregivers at removal, placement changes (when needed), and in response to other traumatic events/needs (as deemed appropriate).

Brevard Family Partnership -BFP has three levels of family foster homes to include traditional and enhanced therapeutic settings to meet the needs of children. All children in out of home care will be referred for a CBHA. CBHAs are reviewed for content of the child's emotional, behavioral, social and developmental functioning as well as for recommendation of services, needs and placement. Services may be initiated based on the recommendations. The BFP Child Placing Agency will assign a therapist (if one is not already working with the child) on any cases in which it has been determined that child has behavioral health care needs. If a child's needs require a higher level of care or more intensive, specialized service the case will be staffed in a Clinical Review. Clinical Reviews involve the review of children in licensed out of home care to determine the need for both an increased or decreased level of care. Recommendations are based upon medical necessity criteria and are intended to provide guidance for other services options and interventions in the event that Specialized Therapeutic Foster Care (STFC) and Specialized Therapeutic Group Home Care (TGC) are not recommended.

Families First Network - In DCF judicial circuit 1, all staff, including line staff, have either received training in Trauma Informed Care or are in the process of getting the training. Line staff training will be included as a workshop in this year's FFN conference in May.

- Trauma Informed Behavioral Health Policies and Procedures have been created.

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- All Behavioral Health Providers assess for trauma upon intake.
- The Steering Committee meets quarterly to stay abreast of new developments in trauma treatment and cascades information out to the various agencies.

The Families First Network conference in May 2014 will feature Ms. Tonier Cain, a nationally known trauma advocate. The Steering Committee was instrumental in bringing her to the workshop and several of the participating agencies donated funds to pay her speaking fee.

Community Partnership for Children - Case plan development considers, recognizes, and responds to the impact of traumatic stress on the children and family. The provision of trauma-informed services will be addressed when developing the case plan in coordination with the family. Consideration will be provided for comprehensive assessment and individualized interventions designed to promote healing, foster hope and increase resilience. When appropriate and available, trauma-informed services will be utilized that include culturally appropriate, evidence-based assessment and treatment of traumatic stress and associated behavioral health symptoms. Trauma-informed services will be utilized that recognize the children's and family's need to be respected, informed, connected and hopeful regarding their treatment. Services will be utilized that are sensitive and responsive and that prevent re-victimization, abuse and trauma as a result of the care or intervention provided whenever possible.

Sharing Medical Information, With the Option For An Electronic Health Record

The Department issued Implementation Guidelines for Substance Abuse and Mental Health Coordination and Integration to Child Welfare's Community-Based Care (CBC) organizations. These guidelines ensure that the new community-based organizations and the district level substance abuse and mental health program offices work together to ensure the best outcomes for the children and families we serve. Circuit Substance Abuse and Mental Health Program Offices provide status reports to the Department's Mental Health and Substance Abuse Program Offices related to successes and challenges in collaboration during the CBC implementation. Policy Working Agreement (PWA) between Substance Abuse, Mental Health and Community-Based Care Program were executed.

Department policy mandates development of a standardized record, the Child Resource Record, which is maintained for every child entering out-of-home care. The Child Resource Record must contain copies of the basic legal, demographic, available and accessible educational, and available and accessible medical, dental, vision, and psychological information pertaining to a specific child, as well as any documents necessary for a child to receive medical treatment and educational services. This record goes with the child to his/her placement and to every health appointment so it can be updated. The child's current health records, including the name of the physician and/or therapist, and a list of the child's medications and dosages must be furnished to the

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court in the Judicial Review Social Study Reports (JRSSR) and be captured the Florida Safe Families Network (FSFN).

The Department of Children and Families also administers the Florida Safe Families Network (FSFN) which is the statewide automated child welfare information system (SACWIS). The design of FSFN allows authorized users access to any child welfare record within the system; however, some information screens are limited to certain users based on their level of security clearance. This feature creates a virtual record that multiple users can access and review. Furthermore, the Department has granted read-only access to Dependency Judges and Guardians ad Litem so that they also have access to child's dependency case record. This design of the system allows for information sharing to interested parties in a much easier manner.

Continuity of Health Care Services, With the Option of A Medical Home

Public Law 110-351 required that child welfare agencies consult with pediatricians, public health nurses and other health care experts in plan development and it required the participation of experts in and recipients of child welfare services, including parents. As addressed earlier, creating a Child Welfare Specialty Plan within a designated HMO will result in improved care coordination, continuity of care and better health outcomes for children in the child welfare system. CBCs will have access to Medicaid claims information and nurse care coordinators and behavioral health care coordinators will monitor and track appointments to ensure children receive required health and behavioral health assessments and services.

Healthcare Transition Planning for Youth Aging Out of Foster Care

The Patient Protection and Affordable Care Act signed into law in March 2010, strengthens the health care services requirements under the Fostering Connections Act. Section 2955(a) of the Act requires that the transition plan for each youth aging out of foster care include information about the importance of designating someone to make health care treatment decisions on behalf of the youth, should the youth be unable to do so and should the youth not have a relative who would be so designated under state or tribal law, or should the youth not want to have the relative make such decisions.

The transition plan must be developed during the 90-day period prior to the time the youth ages out of care. As case plans and transition plans are developed or updated, case managers must ensure that youth in out-of-home care receiving independent living services and youth who age out of care are given information about the importance of designating another person to make health care treatment decisions on their behalf should the youth or young adult become unable to make these decisions and the young person does not want a relative to make these decisions. It is also incumbent upon case managers to inform youth in care and youth who age out of care about options for health insurance. The Department developed a Health Care Surrogate Designation form for providers to utilize to assist youth.

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Each judicial review and social summary report (JRSSR) for youth in out-of-home care should include a status on the delivery of this information. In addition to the health and education information that is required as part of each child's resource record (65C-30.011, F.A.C.), case managers must provide youth with information specific to their physical and behavioral health care needs. Each Community-Based Care lead agency and case management organization is required to ensure local policy and practice abides by these federal requirements.

Youth age 18 and older will not qualify for the Child Welfare Specialty Plan. These youth will be provided guidance on selecting a Medicaid managed care plan of their choice.

Youth aging out of foster care need targeted transition planning to ensure continuity of health care. This is especially important as Florida transitions to Medicaid managed care. Managed care offers youth a variety of choices and they will need to understand how to navigate the system for selecting a plan. Therefore, health and behavioral health care planning are essential elements of transition planning activities. The Department requires a transition plan be developed during the 90-day period prior to the time the youth ages out of care. Additionally, youth are provided information about the importance of designating another person to make health care treatment decisions on their behalf should the youth or young adult become unable to make these decisions and the young person does not want a relative to make these decisions.

- Section 409.1451 (9), Florida Statutes, MEDICAL ASSISTANCE FOR YOUNG ADULTS FORMERLY IN CARE.—The department or community-based care lead agency shall document that eligible young adults are enrolled in Medicaid under s. 409.903(4).
- 1. Section 39.6251(4)(b), Florida Statutes requires the Department to establish a permanency goal of transition from licensed care to independent living for young adults ages 18-23 who choose to remain in care is transition from licensed care to independent living. Before approving the residential setting in which the young adult will live, the department or community-based care lead agency must ensure that the young adult will be provided with a level of supervision consistent with his or her individual education, **health care needs**, permanency plan, and independent living goals as assessed by the department or lead agency with input from the young adult.