HEALTH CARE OVERSIGHT AND COORDINATION PLAN

Section 422(b)(15)(A) of the act requires states to develop a plan for the ongoing oversight and coordination of health care services for children in foster care. States must develop the plan in coordination with the state Title XIX (Medicaid) agency, and in consultation with pediatricians and other experts in health care, and experts in and recipients of child welfare services.

Virginia has endeavored in the last five years to strengthen both the provision of health care services and the state's ability to provide oversight and coordination. For example, the implementation of the psychotropic medication oversight protocol represents several years of effort to develop mechanisms to capture and review data regarding the prescription of psychotropic medications, and to improve coordination between DMAS and VDSS. However, current limitations in the child welfare database (OASIS) create significant barriers to comprehensive oversight, especially in terms of meaningful data sharing with DMAS. Additionally, inconsistent practice at the LDSS level is an ongoing concern. Turnover, vacancies, and staff with limited child welfare experience affect the degree to which children in foster care receive all of the health care services that are available to them, and will be a challenge to overcome in the implementation of the psychotropic medication protocol. Consistent, accurate, and timely documentation, as well as availability of records, also affect both VDSS's and DMAS's ability to evaluate the degree to which children in care in Virginia receive health care services as expected.

In response to these concerns, which were also identified in the 2018 Joint Legislative Audit and Review Committee (JLARC) report, "Improving Virginia's Foster Care System" (http://jlarc.virginia.gov/2018-foster-care.asp), the 2019 General Assembly and Governor of Virginia passed, funded, and enacted a foster care omnibus bill (SB 1339) which addressed the majority of the recommendations of the report. In regards to the health care of children in foster care, the legislation requires VDSS to establish a director of foster care health and safety. VDSS has developed a job description that specifies that candidates will be licensed medical professionals, ideally physicians with prescribing privileges, familiarity with the effects of trauma, and experience working with children. This position will be responsible for identifying LDSS that fail to provide foster care services in a manner that complies with applicable laws and regulations that ensure the health, safety, and well-being of all children in foster care. Among other responsibilities, the director will ensure that LDSS remedy any failures in practice (e.g., the provision of physical, mental, and behavioral health screenings and services, and oversight of psychotropic medication use) and track health outcomes for children in care. VDSS anticipates that under the director, the advisory committee for the health plan will be re-assessed and re-invigorated, perhaps through the re-establishment of a separate health plan advisory committee, which would facilitate more direct input from pediatricians and other experts in health care.

The Director of Foster Care Health and Safety is currently unfilled. After several months during which no applications for the position were received, a scan of other state agencies salary ranges for similar positions was completed. It was determined that the salary posted was unlikely to be attractive. An adjustment to the posting was made on October 7, 2019 to increase the potential starting salary to the maximum amount funded by the Budget Allocation. In an attempt to further reach the medical community, the position has been posted to the American Public Services Health Association. To date, there have been a total of three applicants that have applied for the position, none of which have been

determined to meet the minimum qualifications. VDSS continues to advertise and recruit for this position until the COVID 19 pandemic. The budget crisis the state is experiencing as a results of the pandemic has led to a hiring freeze. (**Strategic Plan Permanency 5.1**)

Additionally, the foster care omnibus bill established two additional regional consultant positions in each office, permitting VDSS to significantly increase the level of technical assistance, support, and ongoing case work review at the LDSS level. There are now three permanency consultants in each region. This additional capacity at the regional level will permit VDSS to support LDSS through regular, intentional provision of technical assistance towards improving health care services for children in foster care. It is also anticipated that this targeted attention, in combination with the implementation of the mobility solution, will result in more accurate and timely data becoming available.

The working relationship between DMAS and VDSS is positive and collaborative. As new technologies and processes are developed, this relationship will continue to evolve, but will remain the cornerstone of efforts to improve health outcomes. (**Strategic Plan Permanency 5.2**) DMAS contracts with an External Quality Review Organization (EQRO), which conducts (as an optional external quality review (EQR) task under the Centers for Medicare & Medicaid Services (CMS) Medicaid guidelines) an annual focused study that provides quantitative information about children and adolescents placed in foster care and receiving medical services through Medicaid managed-care service delivery. Information from this annual study will continue to be used to determine the extent to which children in foster care are receiving the expected preventive and therapeutic medical care. In addition to the more general plan to continue to improve health care and oversight for children in foster care over the next five years previously outlined, Virginia is also making efforts in specific areas. The current status of these efforts and areas which will be strengthened in coming years are described in the following section.

A Schedule For Initial And Follow-Up Health Screenings That Meet Reasonable Standards Of Medical Practice

VDSS has incorporated a schedule for medical, dental, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening activities that is consistent with DMAS recommendations for all children. These appointments are now documented in OASIS, which will permit monitoring of compliance with the expectations by LDSS supervisors, regional consultants, and VDSS. Due dates for medical appointments have been incorporated into the reminders that are generated through COMPASS|Mobile. The reminders are displayed on the service worker's dashboard 30 days prior to the due date to ensure that appointments are scheduled timely. DMAS EPSDT screenings occur according to the American Academy of Pediatrics policy statements and clinical guidelines. Another resource for preventive health guidelines is the AAP-compatible "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents."

Health plans are required to make every reasonable effort to assure that foster care children receive a visit to their assigned primary care provider within 30 days of enrollment in the health plans. They educate and inform members who are not complying with the EPSDT periodicity and immunization schedule. Additionally, receipt of data through DMAS confirms that children in foster care are generally receiving medical and dental exams consistent with the standards that DMAS and VDSS have established.

The SFY 2018-2019 Foster Care Focused Study demonstrated that foster children have higher rates of healthcare utilization than comparable non-foster children for most study indicators. Study findings show that rate differences between the groups were greatest among dental measures, where the rates of foster children having annual dental visits and preventive dental services were over 20 percentage point higher than the rates for non-foster children.

Overall Study Indicator Results for Foster Children and the Non-Foster Comparison Group

Measure	Foster Children Rate (Percent)	Non-Foster Children Rate (Percent)	*p*
Primary Care			
Children and Adolescents' Annual Access to Primary Care Practitioners (PCPs)	96.8	93.9	<0.001*
Oral Health			
Annual Dental Visit	87.4	66.9	<0.001*
Preventive Dental Services	82.5	60.0	<0.001*
Behavioral Health			
7-Day Follow-Up After Hospitalization for Mental Illness	37.6	47.2	0.07
30-Day Follow-Up After Emergency Department (ED) Visit for Mental Illness	94.9	90.9	0.63
Metabolic Monitoring for Children and Adolescents on Antipsychotics	36.2	30.6	0.47
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	87.8	68.4	0.05
Initiation of Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication within 1 Month	86.8	70.9	0.02*
Initiation of Follow-Up Care for Children Prescribed ADHD Medication within 2 Months	96.7	89.3	<0.001*
Initiation of Follow-Up Care for Children Prescribed ADHD Medication within 3 Months	97.8	94.2	<0.001*
Initiation of Follow-Up Care for Children Prescribed ADHD Medication within 6 Months	98.9	97.1	0.21
Initiation of Follow-Up Care for Children Prescribed ADHD Medication within 9 Months	100.0	99.0	0.33
Substance Abuse			
30-Day Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence†	28.6	33.3	0.74
Initiation of AOD Abuse or Dependence Treatment	35.3	42.9	0.71
Engagement of AOD Abuse or Dependence Treatment	15.7	2.9	0.79
Reproductive Health			
Chlamydia Screening Among Women	24.3	20.4	0.43
Most Effective or Moderately Effective Method of Contraceptive Care	57.7	46.7	0.004*
Long-Acting Reversible Method of Contraceptive Care	9.8	3.9	0.003*
Respiratory Health			
Asthma Medication Ratio	92.6	75.9	0.03*

Concerns were noted in the 2018 JLARC report about children in foster care not always receiving required health services: "Evidence also shows that children do not always receive required health screenings, and the proportion of children in foster care in Virginia who did not receive required screenings in fiscal 2016 was higher than in some other states." The DMAS foster care-focused annual

study has found that across all study years, findings from medical record review indicators have consistently pointed to weaknesses in comprehensive documentation of health history and well-child services among children in foster care. For example, if the child received initial medical care while still covered under her parents' insurance and then changed providers, medical record documentation from prior care may not be available in the DMAS claims and encounters data. Annual rate differences in record submission volume have heavily affected medical record review findings for expected well-child visits and expected immunizations. However, low indicator results reflect providers' submission of records with limited or partial documentation as well. Consequently, relatively low indicator rates underscore the challenges associated with obtaining comprehensive medical records for children in foster care, and results should be interpreted with caution.

VDSS and DMAS will continue to work together to ensure that children are receiving services as expected and data are available to effectively monitor service provision.

How Health Needs Identified Through Screenings Will Be Monitored And Treated, Including Emotional Trauma Associated With A Child's Maltreatment And Removal From Home

Virginia continues to utilize family engagement, FPMs, the foster care service plan, FAPT, the individualized family services plan, and utilization management to inform decision-making, service planning, implementation, and monitoring of services identified during screenings and assessments. The LDSS service worker continues to play a central and essential role in managing services for the child or youth in foster care.

Information on a wraparound approach and intensive care coordination was added to the foster care chapter of the VDSS *Child and Family Services Manual*. DBHDS, DMAS, and/or OCS provide trainings on these two approaches and implementing systems of care.

Across Virginia, communities are embracing trauma-Informed care, including two LDSS in the Richmond area that are currently engaged in the use the trauma toolkit (NCTSN) towards piloting a community-wide, trauma-informed system of care. Last year, Voices for Virginia's Children hosted a trauma summit for advocates, clinicians, public agency staff, and legislators to increase awareness and enhance opportunities for advocacy around improving system responsiveness to trauma, the availability of high-quality trauma services, and prevention of secondary traumatization among service staff. Additionally, training on trauma-informed care is now mandated for all foster care service workers.

Virginia's Child and Adolescent Needs and Strengths (CANS) assessment is the mandatory uniform assessment instrument for all children age birth to 18 and their families who receive services funded by the CSA (§ 2.2-5209 Code of Virginia). The local family assessment and planning teams (FAPT) use the CANS to help plan, make decisions, and manage services at both an individual and system of care level. CANS helps:

- Identify the strengths and needs of the child, youth, and family;
- Enhance communication among participants working with the child, youth, and family;
- Identify children and youth who require and are referred for in-depth assessments, including assessments for health and behavioral health needs. CANS also has a domain for assessing trauma;
- Guide and inform service planning with the child, youth, and family;
- Capture data to track progress on child and family outcomes; and
- Identify service gaps and promote resource development.

The CANS assessment is mandated for all children in foster care on an at least annual basis, regardless of whether they are receiving CSA services.

Additionally, the Virginia CANS has been revised to include additional items related to trauma and child welfare. The revised version of the CANS adds disruptions in caregiving as a form of trauma that a child may experience, and requires that the trauma module is completed for all children in foster care. Guidance was developed which directs LDSS to utilize the trauma module, as well as various behavioral indicators captured in the CANS, as a screening tool to determine when a child in foster care should be referred for additional trauma assessment and/or services. Revisions in the CANS online system include a child-specific report, to make possible the evaluation of a child's progress over time, and a permanency planning report, to make possible the evaluation of a family's or caretaker's progress over time.

Foster care children are classified in Virginia Medicaid as children and youth with special health care needs (CYSHCN), as defined by HRSA and CMS. Health plans have designated foster care coordinators responsible for ensuring that foster care children receive health assessments and medical, dental, and behavioral health visits. Health plans refer members for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected during screenings. Plans provide other medically necessary health care, diagnostic services, treatment, and measures as needed to correct or ameliorate defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child's current level of functioning or prevent the child's medical condition from getting worse. Plans coordinate the unique needs of children in the foster care system and those who were adopted, through the provision of trauma-informed case management services to coordinate care efforts for children.

As Virginia moves forward with the CFSR PIP and implementation of FFPSA, issues previously identified relative to inconsistent availability, accessibility, and quality service across all communities in Virginia will be an area of focus. VDSS will continue to explore opportunities to partner with DBHDS, OCS, DJJ, and DMAS towards improving the adequacy of Virginia's service array.

How Medical Information For Children In Care Will Be Updated And Appropriately Shared, Which May Include Developing And Implementing An Electronic Health Record

VDSS continues to defer to larger efforts in Virginia to implement electronic medical records (EMRs) as described subsequently, rather than create a separate electronic health record for children in foster care.

In the interim, until the EMR for children in Medicaid is established, OASIS has been revised to permit LDSS service workers to gather known health information on the child and the child's birth family from health care providers, caregivers, Managed Care Organizations (MCO), and other entities in one place. The worker can then appropriately share this information with caregivers and health care providers.

Virginia is now able to identify children in foster care or children receiving adoption assistance in the Medicaid management information system (MMIS). This allows the aggregate reporting of data, divided by MCO region, on children in foster care. Two aid categories are now used to identify youth in foster care and youth receiving adoption assistance. VDSS also uses data available in OASIS and reports in SafeMeasures® to monitor agency practices and child indicators.

The implementation of COMPASS|Mobile has had a significant effect on the availability of medical information for children in foster care. Service workers have access to historical information as needed during appointments, and are able to update the official case record while in the doctor's office. More readily available, accurate, timely, and comprehensive medical information can then be appropriately shared.

Steps To Ensure Continuity Of Health Care Services, Which May Include Establishing A Medical Home For Every Child In Care

A major element of Virginia's health care oversight plan is that the MCOs are responsible for ensuring continuity of health care services. The MCO contract with DMAS requires that the MCO shall have a primary care network that includes contracting with all area health departments, major hospitals, CSBs, federally qualified health centers and rural health clinics, and the top 50 percent of utilized primary-care providers, OB/GYNs, and pediatricians in both rural and urban areas.

The MCO's pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The MCO shall submit to DMAS prior to signing the initial contract, upon revision or on request, referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

Health plans conduct health assessments for each child within 60 days of enrollment into the health plan. Heath plans also provide care coordination for CYSHCN among the multiple providers, agencies, advocates, and funding sources serving CYSHCN.

Health plans assure the availability of providers who are experienced in serving children and youth with special needs and provide a medical home that is accessible, comprehensive, coordinated, and compassionate. To ensure there is no interruption of any covered services for enrollees, health plans have policies and procedures to ensure transition of care for all enrollees.

The Oversight Of Prescription Medicines, Including Protocols For The Appropriate Use And Monitoring Of Psychotropic Medications

VDSS has continued to work towards reducing the unnecessary or inappropriate prescription of psychotropic medication to children in foster care through two primary strategies. The first involves raising awareness and improving LDSS practice regarding the monitoring of psychotropic medication prescribed to children in foster care. The second involves partnering with DMAS to incorporate the medical review of psychotropic prescriptions, when appropriate, through requirements established in their contracts with the MCOs.

LDSS staff have been supported in making the connection between the need for better assessment and treatment of trauma and the risk of over-prescription, as well the importance of understanding the worker's role in asking questions, empowering the birth parents to be involved in making decisions, and advocating for treatment that is conservative and considers side effects through enhancements to foster care guidance. The VDSS training unit has developed an eLearning course that serves as an orientation to the effects of trauma on children, as well as an in-person course that focuses on the provision of trauma-informed child welfare services. Additionally, foster care policy requires the screening of all children in foster care for trauma, utilizing the trauma module of the CANS tool.

VDSS implemented the Psychotropic Medication Oversight Protocol in July 2019. (**Strategic Plan Permanency 5.3**) Workers complete a consent protocol that requires information be obtained from the prescriber describing the medication being prescribed, its intended use, and potential side effects. The

information is then entered into a consent form that verifies decisions such as: information has been provided to the caregiver responsible for providing the medication to the child, that birth parent(s) were involved in decision-making, that youth are involved in decision-making, and under what circumstances the LDSS will monitor more closely and/or consider obtaining a second opinion. Foster care guidance and the psychotropic-medication oversight protocol can be found at http://dss.virginia.gov/family/fc/index.cgi.

The consent form is provided to a psychotropic medication consenter (PMC) at the LDSS. This person or persons will be selected by the LDSS director and annually certified. With the implementation of the protocol, each local department of social services was required to establish a Psychotropic Medication Consenter (PMC) by July 31, 2019. The person(s) designated as the psychotropic medication consenter are required to complete CWSE4050: Psychotropic Medications and the Child Welfare Systems and CWSE4051: Psychotropic Medication Consenter prior to being designated as the PMC for the agency. The PMC for each agency must review and approve, or deny, the prescription of psychotropic medication to children in foster care. VDSS anticipates that the protocol module will be periodically updated and PMC will be re-certified annually.

The VDSS training unit offers another course related to psychotropic medications. FSWEB1000 Psychotropic Medications and Issues in Foster Care teachers practical approaches to working with medical professionals on the monitoring of psychotropic medications, key questions to ask and critical information to bring to the attention of the physician or psychiatrist prescribing the medications, how to express professional disagreement in a helpful manner that is in the best interest of the child, suggest alternative treatments to medication, and how to support foster parents advocating for their child. This course is required for all foster care service workers, and also will be a pre-requisite for becoming a PMC.

Since the implementation of the protocol, all 120 local departments have confirmed that they have designated a PMC within their agency. As of December 31, 2019, 39 family services specialists have completed the e-learning.

According to Safemeasures®, as of December 2019 2,159 children (27%) in foster care are prescribed psychotropic medication. The average number and percent of children prescribed psychotropic medication has remained consistent over the past year.

	No Psychotropic Medication Found		**Psychotropic Medication Found**		**Total Children**
Measurement Period	#	%	#	%	#
CY2019 Unduplicated Children	5,749	73%	2,159	27%	7,908
CY2019 Monthly Average	3,892	70%	1,655	30%	5,547
Jan-19	3,739	70%	1,579	30%	5,318
Feb-19	3,780	70%	1,610	30%	5,390
Mar-19	3,852	70%	1,627	30%	5,479
Apr-19	3,850	70%	1,650	30%	5,500
May-19	3,894	70%	1,670	30%	5,564
Jun-19	3,900	70%	1,687	30%	5,587

Jul-19	3,911	70%	1,678	30%	5,589
Aug-19	3,885	70%	1,652	30%	5,537
Sep-19	3,923	70%	1,677	30%	5,600
Oct-19	3,969	70%	1,694	30%	5,663
Nov-19	4,000	70%	1,682	30%	5,682
Dec-19	3,997	71%	1,655	29%	5,652

Finally, the health screens in OASIS have been revised to include the ability to enter data regarding prescriptions and to indicate whether the prescribed medication is a psychotropic medication. This information is now available in a report in SafeMeasures®, which makes it possible for LDSS supervisors, regional permanency consultants, and home office staff to monitor the incidence of psychotropic medication use. It is anticipated that this data will eventually be available in a report that will permit monitoring of psychotropic medication prescribing at the agency level.

In regards to DMAS, MCO health plans provide pharmacological management, including prescription and review of medication, when performed with psychotherapy services. Health plans have established drug utilization review (DUR) boards that comply with the DUR program standards as described in section 1927(g) of the Social Security Act and 42 CFR 456, subpart K, including prospective DUR, retrospective DUR, educational program, and the DUR board. Health plans, as well as the fee-for-service delivery system, require service authorization for atypical and typical antipsychotics prescribed to all members under the age of eighteen.

DMAS contracts with an EQRO, which conducts (as an optional external quality review (EQR) task under the Centers for Medicare & Medicaid Services (CMS) Medicaid guidelines) an annual focused study that provides quantitative information about children and adolescents placed in foster care and receiving medical services through Medicaid managed-care service delivery. The study includes specific indicators addressing utilization of antipsychotic medications, children's receipt of follow-up care following hospitalization for mental illness, and the prevalence of children prescribed antidepressant medications or medications for ADHD.

Specifically in regards to the guidance included in ACYF-CB-PI-12-05, Virginia's psychotropic medication protocols includes the following:

- **Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication.**

  Health plans have established policies and procedures in place to ensure foster care children receive assessments and medical, dental, and behavioral health visits. A fully completed assessment addresses health care needs, including mental health, interventions received, and any additional services required, including referrals to other resources and programs. EPSDT-required medical screenings include a comprehensive health and developmental history, including assessments of both physical and mental health development. Pharmacy services for children are reviewed in accordance with EPSDT requirements to cover drugs when medically necessary, based on a case-by-case review of the individual child's needs, such as for off-label use.

- **Informed and shared decision-making (consent and assent) and methods for ongoing communication between the prescriber, the child, the child's caregivers, other healthcare providers, the child welfare worker, and other key stakeholders.**

  The psychotropic medication oversight protocol includes a comprehensive consent document to be completed by the service worker that addresses how consent/assent is to be obtained with the youth/child how birth parents are to be involved in the decision-making, how caregivers are to receive information about prescriptions and provide information to the prescriber regarding changes in behavior or mood and any potential side effects and that information about medical conditions and medications are to be shared with prescribers of psychotropic medication and information about psychotropic medication is to be shared with healthcare providers addressing other issues.

- **Effective medication monitoring at both the client and agency level.**

  At the client level, the psychotropic medication oversight protocol creates a process through which the service worker and director-designated PMC are aware of all psychotropic medications prescribed, and monitor their use with all children in the custody of the agency. Although OASIS has been modified to permit the entry of psychotropic medication information, there is no mechanism to require that the fields are filled out or updated each time a prescription changes. Currently the data available from OASIS is not particularly helpful for monitoring psychotropic medication prescription at the agency level.

  Additional regional office capacity for technical assistance and case reviews will facilitate increased agency oversight in time. The new director of health and safety will be tasked with developing a plan for identifying when agency practice is failing to meet the health and safety needs of children in foster care and/or when the rate of psychotropic medication prescription differs significantly from other LDSS.

- **Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible child and adolescent psychiatrist at both the agency and individual case level.**

  The psychotropic medication oversight protocol identifies situations when the LDSS should consider seeking a second opinion or accessing a consultation with a child and adolescent psychiatrist over a primary-care physician. The mechanism for accessing this level of mental health expertise is to contact the foster care coordinator through the child's MCO. Contact information for the MCO care coordinators is available on the VDSS intranet site.

  The health plan's community-based mental health providers (public and private) shall meet any applicable DBHDS certification and licensing standards. Behavioral health providers shall meet the department's qualifications as outlined in 12 VAC 30-130-5000, et. al. and the department's

most current behavioral health provider manuals, including the manuals for community mental health rehabilitative services, mental health clinics, and psychiatric services providers.

On the agency level, the new director of health and safety will be responsible for identifying and intervening with LDSS that are in need of mental health expertise and consultation regarding consent and monitoring issues.

- **Mechanisms for sharing accurate and up-to-date information related to psychotropic medications to clinicians, child welfare staff, and consumers, including both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials.**

  VDSS is significantly enhancing a dedicated intranet webpage where information about the MCO foster care points of contact and links to verified web sources where information about usual doses, purposes, and potential side effects, as well as other resources, are available. The enhancement will permit service workers, supervisors, and PMCs to more readily access information necessary to monitor the utility of any psychotropic medications prescribed and identify any potential side effects.

VDSS will continue to work at making improvements in the area of psychotropic medication oversight. The new director of health and safety for foster care will oversee the development of additional enhancements to the psychotropic medication oversight protocol, full implementation of the protocol, and a case review process for youth congregate care placements and/or prescribed psychotropic medication. Per ACYF-CB-PI-12-05, an agency-level review process utilizing existing data, case review data, and CFSR data will also be formalized.

Additionally, VDSS will work with the CWAC permanency sub-committee in developing strategies for communicating the protocol to target audiences, including:

- Front-line workers (VDSS service worker, FAPT and CSB case managers, clinicians, managed care managers);
- Caregivers/providers where child lives (foster care parents, treatment foster care and residential treatment providers, etc.);
- Prescribers of psychotropic medications (child and adolescent psychiatrists, nurse practitioners, primary care providers in public and private sectors);
- Youth; and
- Birth parents.

How the state actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

Foster care guidance directs LDSS to ensure that children in care receive regular preventive healthcare. When a child requires care for an illness, caregivers access primary care providers through the child's assigned MCO. Complex medical or behavioral needs that require the involvement of or consultation with a specialist are addressed through referrals and care coordination provided by the MCO.

Health plans conduct health assessments for each child within 60 days of enrollment in the health plan. Health plans also provide care coordination for CYSHCN among the multiple providers, agencies, advocates, and funding sources serving CYSHCN.

The procedures and protocols the state has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.

In accordance with the requirements of the FFPSA, Virginia enhanced procedures established in guidance to ensure that children in foster care are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses. Although the work to address monitoring and prevention of over-prescription of psychotropic medication had not previously included a focus on the prevention of inappropriate diagnoses, the psychotropic medication oversight protocol and the eLearning include information addressing the risks of inappropriate diagnoses and guidance around the worker's responsibility to intervene, as well as strategies to do so.

As VDSS's capacity to conduct case reviews is expanded in the next year, additional technical assistance and targeted review of diagnoses, the related use of congregate care placements, and use of psychotropic medications will also be expanded.

Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.

Youth in foster care who were receiving Virginia Medicaid at the age of 18 are eligible for Medicaid up to age 26. VDSS continues to coordinate with DMAS and LDSS to implement provisions of the ACA. At age 18, these youth are automatically evaluated for Medicaid in one of two eligibility categories and automatically enrolled into the up-to-age-26 category should they exit care. They then maintain their eligibility to age 26.

Beginning at age 14, youth in foster care participate in the development of a transition plan that, among other things, addresses the health and well-being needs of the youth. As they get closer to their 18th birthday, focus is placed on ensuring their continued eligibility for Medicaid, maintaining needed healthcare services, and providing them education about designating a health care power of attorney. The foster care chapter directs LDSS to encourage and assist the youth in seeking guidance from an attorney to address any questions. The current 90-day transition plan, which is completed with the youth approximately 90 days before their eighteenth birthday, includes the following items for the youth:

- I understand that during the 90 days before I turn age 18, I will finalize my plans for successfully transitioning from foster care to adulthood. This plan for successful transition will include the names of adult(s) who have agreed to help me during this transition and in the future. It will also address my specific needs, including housing, health insurance, education, local opportunities for mentors and continuing support services, workforce supports, employment services, and any other needs I identify.

- I understand the importance of identifying someone to make health care treatment decisions on my behalf, if I become unable to make them and if I do not have or want a relative to make these decisions. I can identify a health care power of attorney using the form on the Virginia Department of Health's website, titled "Virginia Advance Medical Directive." http://www.vdh.virginia.gov/OLC/documents/2008/pdfs/2005%20advanced%20directive%20form.pdf

Additionally, in the plan for successful transition section of the 90-day transition plan, the following information is reviewed and collected:

Health Care and Insurance (e.g., contact information, policy numbers)			
I have health insurance:		Yes No	
Name of insurance company:			
Policy ID #:			
Phone number of insurance provider:			
Date of last medical exam:		Date of next medical exam:	
Date of last dental exam:		Date of next dental exam:	
I have identified someone to make health care treatment decisions on my behalf if I become unable to make them (a health proxy/ healthcare power of attorney) using the form on the Virginia Department of Health's website, titled "Virginia Advance Medical Directive.",. Yes No (circle one)			

The foster care guidance includes directions for the LDSS to provide additional information to youth who request it during the transition-planning process.

Health plans are required to establish a process to notify youth in foster care who are approaching age 17 of the Medicaid programs that provide continued health care coverage, specifically former foster care and Fostering Futures. The health plans assist in care coordination during this transitional period. The transition plan includes provisions for convening a comprehensive treatment team meeting to discuss the services and supports the enrollee will need post-separation. If the services are not covered by Medicaid, the plan provides information for the enrollee, or their authorized representative, about any community programs that may be able to meet their needs. It makes the necessary referrals, as needed.

<u>Ensuring the Health and Safety of Children in Foster Care during the COVID-19 Pandemic</u>

The Governor declared a state of emergency on March 12, 2020 and issued a Stay at Home order on March 30, 2020. The state of emergency which was set to expire June 10, 2020 has been extended indefinitely in response to the COVID – 19 pandemic. VDSS and local departments moved quickly to ensure the continued health and safety of children in foster care. Several workgroups were formed to address various needs that were anticipated due to the pandemic. VDSS immediately collaborated with numerous state agencies in an effort to be proactive in brainstorming solutions and developing plans to address anticipated issues specifically related to health and safety.

VDSS worked closely with DFS licensing and LDSS to identify foster families that were equipped to care for children and youth who tested positive for COVID or had been exposed to COVID and may have been required to quarantine. This provided the regional consultants with the necessary resources to assist LDSS in locating placement for children. In an effort to further support placements, additional enhanced maintenance was made available for any family caring for a sick/exposed child in the event that foster parents lost time at work to care for children who needed to be quarantined or were unable to use daycare due to the pandemic.

VDSS collaborated with other state agencies including DBHDS, OCS, DMAS, DJJ, and DFS licensing to ensure that congregate care providers across the state were prepared to properly care for children placed in their facilities as well as being prepared to take new admissions when necessary. As a result of this work, a joint letter was sent to congregate care providers and shared with LDSS to ensure consistent messaging regarding congregate care admissions and care of the children placed. Additionally, VDSS advocated to VDH that children in foster care, particularly in congregate care settings be prioritized for COVID testing. VDSS worked closely with the Virginia Home for Boys and Girls to explore their willingness and ability to devote one of their cottages to providing care for children who were sick/exposed and requiring quarantine before being placed in a family. After much discussion and consideration, it was determined that this was not a feasible solution and VDSS continued to focus on securing family based placements. One children's residential facility experienced an outbreak of COVID among both staff and children and VDSS remained in constant communication with the facility to ensure the health and safety of the children placed there. There were a total of 21 children that tested positive, 11 of which were asymptomatic while the other 10 had only very mild symptoms. VDSS worked closely with the facility to provide support and troubleshoot any staffing issues that arose.

As LDSS moved to conducting monthly worker visits virtually, VDSS worked quickly to secure a virtual platform that was HiPAA compliant and readily available to service workers. In addition, guidance and job aids were created to provide LDSS with the support necessary to ensure that virtual worker visits continued to address the child's health and safety even though most children were not being seen in person. VDSS stressed the importance of continuing to see children in person while taking the proper safety precautions (including PPE) if the LDSS believed that child was at risk.