1. 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 through the last CFSP period 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 represented 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, limitations in the child welfare database (OASIS) continue to 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 the health care services that are available to them and continue to pose a challenge to 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 concerns related to the health care of children in foster care, which were 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. For example, 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. To further reach the medical community, the position was posted to the American Public Services Health Association. By March 2020, there had been a total of three applicants that had applied for the position, none of which had been determined to meet the minimum qualifications. VDSS continued to advertise and recruit for this position until the COVID 19 pandemic. The budget crisis the state experienced as a result of the pandemic led to a hiring freeze which wasn't lifted until 2021. Due to the number of vacancies that were a result of the hiring freeze, it was

necessary for VDSS to recruit and hire incrementally. The position is currently being evaluated to post with revised criteria so that VDSS will be able to recruit more effectively for that position. VDSS is considering making the position part-time or PRN to make it more attractive to applicants. (**Strategic Plan Permanency 5.1**)

While there have been no formal meetings of the advisory committee for the health plan due to the demands and challenges during and post pandemic, VDSS has continued to use the CWAC to provide input into policy decisions related to the health care of children in foster care. Additionally, VDSS routinely partners with various stakeholders to ensure the health needs of children in foster care continue to be met. At the start of 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. This workgroup has continued to meet and has proved to be a valuable resource for identifying and addressing issues related to the health needs of children in foster care. Most recently, this group has focused on the children in foster care with high acuity behavioral health needs to identify placements for these children that will meet their treatment needs. The CWAC committee has resumed meeting in 2021 which has also provided an avenue to gain valuable feedback from stakeholders around this issue.

The foster care omnibus bill established two additional regional consultant positions in each regional 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 consultant positions and a resource family consultant position in all five regional offices. This additional capacity at the regional level permits 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 use of COMPASS|Mobile, will result in more accurate and timely data becoming available.

The working relationship between DMAS and VDSS is positive and collaborative. Virginia was one of 12 states selected to participate in the Improving Timely Health Care for Children and Youth in Foster Care Affinity Group. The selection was based on the partnership between DMAS and VDSS and the readiness to bring data, experiences, stakeholders, and creativity to bear to improve timely access to health care services for children and youth in foster care. DMAS and VDSS are co-leads on the group which also includes representatives from the various managed care organizations. The aim of the work by this group is to establish more effective workflows that will increase the percentage of children entering foster care who receive their initial medical exam within 30 days of entering foster care. The group has established two tests of change that are currently being implemented. One includes a “warm hand-off" from the LDSS to the MCO so that the MCO is aware of new members more promptly and can reach out within a couple of days of the child entering foster care to assist in scheduling appointments. A second test of change includes one of the MCO’s employing a care manager that will be housed in the LDSS. Again, this will aid in the MCO being made aware of new members more promptly enabling them to provide support in making appointments and ensuring medical needs are met. The group started in late summer 2021 and will receive targeted technical assistance for a period of 12 months with the option to continue for an additional 12 months.

In 2021, the DMAS/Foster Care Partnership bi-monthly meetings resumed, providing increased collaboration with various stakeholders to improve the overall access to health care for children in and aging out of foster care. The group includes representatives from DMAS, VDSS, LDSS, OCS, VCOY, and LCPA. There are two smaller focus groups that are working to provide targeted interventions to

improve outcomes for youth transitioning out of foster care and to improve overall service utilization. The partnership brings together various stakeholders to enhance cross-agency communication, overcome barriers to meeting the health needs of children in foster care, and to share resources and information.

As new technologies and processes are developed, the relationship between DMAS and VDSS 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 into foster care guidance 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 permits 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 provided to the LDSS is the AAP-compatible "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents."

MCOs 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 also educate and inform members who are not complying with the EPSDT periodicity and immunization schedule. As noted above, this is the focus of the Foster Care Affinity Group. 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 2021-2022 Child Welfare Focused Study demonstrated that children in foster care have **higher** rates of appropriate health care utilization than a comparable population for most study indicators in measurement year (MY) 2019, MY 2020, and MY 2021. Study findings show that MY 2021 differences in rate between children in foster care and controls were greatest among the dental study indicators (Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services; and Topical Fluoride for Children—Dental or Oral Health Services by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively), the Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics measure (by 20.4 percentage points), and the Behavioral Health Encounters—CMH Services indicator (by 17.1 percentage points). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics

Healthcare Utilization Study Indicator Results for Children in Foster Care and Controls

Measure	Children in Foster Care Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	64.8%	54.7%	<0.001*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	63.8%	60.0%	0.46
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	79.7%	75.8%	0.31
Oral Health			
Annual Dental Visit	70.6%	52.4%	<0.001*
Preventive Dental Services	64.6%	45.6%	<0.001*
Oral Evaluation, Dental Services	63.5%	44.5%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	35.0%	20.8%	<0.001*
Topical Fluoride for Children—Dental Services	28.3%	16.0%	<0.001*
Topical Fluoride for Children—Oral Health Services	2.4%	2.1%	0.43
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	64.2%	59.7%	0.56
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	92.9%	81.5%	0.25
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.0%	35.7%	0.67
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	89.2%	68.4%	0.01*
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	78.1%	66.4%	0.04*
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	88.6%	81.8%	0.13

Measure	Children in Foster Care Rate	Controls Rate	*p*
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	93.0%	90.2%	0.43
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	96.5%	96.5%	1.00
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	98.2%	97.2%	0.70
Substance Abuse			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	0.0%	0.0%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment	40.8%	48.1%	0.51
Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment	25.4%	18.5%	0.48
Respiratory Health			
Asthma Medication Ratio	85.7%	80.2%	0.48
Service Utilization			
Ambulatory Care Visits	88.9%	89.7%	0.33
ED Visits	24.8%	31.5%	<0.001*
Inpatient Visits	4.5%	4.4%	0.82
Behavioral Health Encounters—ARTS	1.9%	0.7%	<0.001*
Behavioral Health Encounters—CMH Services	38.8%	21.7%	<0.001*
Behavioral Health Encounters—RTC Services	4.4%	2.6%	<0.001*
Behavioral Health Encounters—Therapeutic Services	10.4%	5.9%	<0.001*
Behavioral Health Encounters—Traditional Services	67.8%	53.8%	<0.001*
Behavioral Health Encounters—Total	71.0%	57.5%	<0.001*
Overall Service Utilization	92.1%	93.0%	0.18

** Indicates that the rates are statistically different between the children in foster care and controls.*
NC indicates that the p-value could not be calculated since both numerators were zero.
P-values were calculated using Chi-square tests and Fisher's exact tests to quantify the relationship between foster care status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to Appendix A for indicator-specific technical specifications.

Measure	Children in Foster Care Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	68.0%	48.5%	<0.001*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	65.1%	56.1%	0.09
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	77.6%	74.5%	0.48
Oral Health			
Annual Dental Visit	79.1%	50.0%	<0.001*
Preventive Dental Services	72.0%	42.8%	<0.001*
Behavioral Health			
Seven-Day Follow-Up After Hospitalization for Mental Illness	65.6%	59.2%	0.45
Thirty-Day Follow-Up After Emergency Department (ED) Visit for Mental Illness	87.8%	78.9%	0.45
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.3%	27.8%	0.05
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	92.4%	78.9%	0.04*
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication within 1 Month	86.8%	74.8%	0.02*
Follow-Up Care for Children Prescribed ADHD Medication within 2 Months	92.5%	85.4%	0.09
Follow-Up Care for Children Prescribed ADHD Medication within 3 Months	95.3%	87.8%	0.05*
Follow-Up Care for Children Prescribed ADHD Medication within 6 Months	99.1%	95.9%	0.22
Follow-Up Care for Children Prescribed ADHD Medication within 9 Months	99.1%	96.7%	0.38
Substance Abuse			
Thirty-Day Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence	S	S	NC
Initiation of AOD Abuse or Dependence Treatment	29.1%	45.8%	0.15
Engagement in AOD Abuse or Dependence Treatment	S	S	0.26
Reproductive Health			
Contraceptive Care (Most Effective or Moderately Effective Method)	46.0%	31.9%	<0.001*
Contraceptive Care (Long-Acting Reversible Method)	8.6%	5.6%	0.09
Respiratory Health			
Asthma Medication Ratio	89.8%	75.9%	0.05*

** Indicates that the rates are statistically different between the children in foster care and controls.*
† This indicator has denominators of 2 and 1 for children in foster care and controls, respectively, so rates may be unreliable.
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
NC indicates that the p-value could not be calculated since there was no variation in numerator compliance for children in foster care and controls.
P-values were calculated using chi-square tests and Fisher exact tests to quantify the relationship between foster care status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to Appendix A for indicator-specific technical specifications.

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."

Although the DMAS Child Welfare Focus Study continues to find that children in foster care are receiving many services at a higher rate than a comparable population, there are areas where improvement is needed. 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 is addressed in 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. This service is also frequently recommended in Safe and Sound Go Team meetings when youth at risk of displacement are staffed.

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. In 2019, 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. In 2022, VDSS established the Office of Trauma and Resilience Policy (OTRP) to better support the implementation of trauma-informed practice and services in social service agencies across Virginia. Virginia HEALS is a model of service delivery that has been developed to assist service providers in better linking systems of care and providing support and care to children, youth, and families impacted by trauma and/or victimization. The ORTP support the Virginia HEALS project which includes checklists for agencies to assess the degree to which they are trauma-informed and a brief screening tool, the Screening for Experiences and Strengths (SEAS.) This tool is widely available for use by LDSS after completing a short training course. Additionally, training on trauma-informed care is 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 in foster care and/or who receive services funded by the CSA (§ 2.2-5209 Code of Virginia). The local FAPT uses 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;
- 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 includes items related to trauma and child welfare. The child welfare 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. The CANS online system provides 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 children in foster care 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 continues the implementation of FFPSA, issues previously identified relative to inconsistent availability, accessibility, and quality service across all communities in Virginia continue to 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 can 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.

As a result of an increase in youth in foster care who are experiencing behavioral health crises boarding in emergency rooms for extended periods of time while an appropriate acute bed is being located, a small work group is looking at how to 'flag' Medicaid recipients who are in foster care experiencing extended stays in an emergency room related to a behavioral health crisis. While LDSS have been encouraged to elevate these situations to the Safe and Sound Taskforce, these situations occur infrequently for many the

LDSS and the notification is often overlooked. This prevents the taskforce from beginning work on identifying and supporting the child's next foster care placement, in the event they cannot return to their pre-emergency room placement. The workgroup is negotiating concerns about confidentiality and data sharing between the many hospitals in Virginia, DMAS, the LDSS, and VDSS.

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 MCOs 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 MCOs' 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. Health 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.

In late 2020, further collaboration between DMAS and other state partners was initiated in an effort to improve care coordination for youth impacted by the child welfare system. Representatives from VDSS, DMAS, LDSS, LCPAs, CSA, and DMAS MCOs began meeting regularly to address any gaps in care coordination, identify opportunities for training or technical assistance, identify ways to work together to support youth transitioning out of foster care, and determining ways in which the Medicaid managed care benefits can best be utilized to support youth in foster care. The group quickly identified a disconnect between the LDSS and DMAS MCOs in that LDSS were unaware of the additional supports which are available to children in foster care through the MCOs. The group began to develop strategies to ensure the LDSS have a better understanding of the role of the MCOs. After a brief hiatus due to the pandemic, this group resumed meeting in mid 2021. In 2022, this group developed information flyers to share with LDSS as well as children and families impacted by the foster care system. The flyers outline the many ways in which the MCO can support children and families. The flyers have been distributed to LDSS as well as being posted to the Foster My Future website which targets youth formerly in foster care. The group has also developed webinars to share vital information about MCOs that will be made available to LDSS, foster parents, adoptive parents, LCPAs and congregate care providers.

Also in late 2020, VDSS partnered with Virginia Health Catalyst regarding adult dental benefits. Beginning July 1, 2021, adults in Virginia who are covered by Medicaid will now be able to access dental benefits, something that was previously unavailable. The Virginia Health Catalyst developed marketing materials to share with older youth in foster care and attended meetings in each region with supervisors from LDSS to ensure LDSS were aware of this new benefit. The marketing material was added to the Foster My Future website in an effort to share this information with youth formerly in foster care.

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 to 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 required activities 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 certified through the completion of the required VDSS training course. With the implementation of the protocol, each local department of social services was required to establish at least one Psychotropic Medication Consenter (PMC.) The person(s) designated as the PMC are required to complete CWSE4050: Psychotropic Medications and the Child Welfare Systems and CWSE4051: Psychotropic Medication Consenter. 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. The regional practice consultants maintain a list of the PMCs designated for each agency to ensure that each agency has a trained consenter at all times.

The VDSS training unit also offers another course related to psychotropic medications. CWSE4050: Psychotropic Medications and Child Welfare System teaches 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 the child in their care. This course is required for all foster care service workers and is a prerequisite 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. In 2021, 71 family services specialists, supervisors, or directors completed the e-learning: CWSE4051: Psychotropic Medication Consenter, resulting in a total of 553 completions since May 2019. There have been 324 completions of the e-learning: CWSE 4050: Psychotropic Medications and the Child Welfare System and 37 completions of FSWEB 1000:

Psychotropic Medications and Issues in Foster care in 2021. CWSE4050: Psychotropic Medications and the Child Welfare System was added to the mandatory training for new foster care workers in July 2019. In 2022, 298 family services specialist, supervisors or directors completed the course VDSS- CWSE4050: Psychotropic Medications and the Child Welfare System and 72 completed VDSS- CWSE-4051: Psychotropic Medication Consenter. Regional permanency practice consultants are provided a list of individuals who have completed the CWSE4051 course quarterly to help support monitoring of the LDSS's compliance for this requirement.

According to Safemeasures®, as of December 2022, 1,578 children (31%) in foster care, including those 18 to 21, are prescribed psychotropic medication. The average percentage of children prescribed psychotropic medication has decreased slightly over this past year.

Measurement Period	No Psychotropic Medication Found		Psychotropic Medication Found		Total Children
	#	%	#	%	#
Jan- 22	3,256	67.8%	1,540	32.1%	4,796
Feb- 22	3,309	68.0%	1,697	33%	5,006
Mar- 22	3,346	68.1%	1,565	31.9%	4,911
Apr- 22	3,372	68.5%	1,548	31.5%	4,920
May-22	3,390	68.7%	1,548	31.3%	4,938
Jun-22	3,409	68.6%	1,558	31.4%	4,967
Jul- 22	3,404	68.7%	1,551	31.3%	4,955
Aug- 22	3,401	68.5%	1,567	31.5%	4,968
Sep-22	3,495	69.1%	1,562	30.9%	5,057
Oct- 22	3,538	69.3%	1,571	30.7%	5,109
Nov-22	3,537	69.3%	1,569	30.7%	5,106
Dec-22	3,506	69.0%	1,578	31.0%	5,084
2022 Monthly Average	3,437	69%	1,561	31%	4,998

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.

As it pertains 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.

As mentioned previously, 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. The "Healthcare Utilization Study Indicator Results for Children in Foster Care and Controls" chart above outlines the results of this study.

Specifically, the guidance included in ACYF-CB-PI-20-02, 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.**

  MCOs 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 how information about psychotropic medication is to be shared with health care 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.

Regional permanency practice consultants conduct congregate care reviews of children in foster care as a requirement of SB 1339 (2019). As part of the review, consultants evaluate what assessments have been completed on the youth and what necessary services have been or need to be implemented as a result of those assessments, including medication management. Consultants reference the youth's medications and medication management in their congregate care reviews and continue to provide ongoing technical assistance regarding the completion of these fields in OASIS.

- **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) must 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 has significantly enhanced 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 permits 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-12-02, an agency-level review process utilizing existing data, case review data, and CFSR data will also be formalized.

Additionally, VDSS will work with the DMAS Foster Care Collaboration group 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 expanded in the past year, additional technical assistance and targeted review of diagnoses, the related use of congregate care placements, and use of psychotropic medications was also 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 health care services and providing them education about designating a health care power of attorney. Foster care guidance directs LDSS to encourage and assist the youth in seeking counsel 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.

Ensuring the Health and Safety of Children in Foster Care during the COVID-19 Pandemic

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 was then 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 the health and safety of children in foster care.

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. To further support placements, additional enhanced maintenance was made available for any family caring for a sick/exposed child if 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 21 children who 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 continued to stress the importance of seeing children in person while taking the proper safety precautions (including PPE) and documenting a clear safety risk if the visit is done virtually.

During the pandemic, especially in the initial months, many health practitioners were postponing routine well-child checks to minimize exposure risk to the virus. VDSS provided the following guidance to agencies in these situations:

> "Agencies should follow the recommendations from the child's medical provider during this time. If the child's medical provider does not recommend that they come in for their wellness medical or dental exam at this time, the agency should document clearly the recommendation from the medical professional in the child welfare information system. This includes all medical and dental requirements, including those when the child enters foster care. For the 72-hour requirement for children with urgent health, mental health, or substance use disorder needs upon entering foster care, the worker should contact the appropriate medical professional, describe the child's needs, and follow the recommendation of the provider. The child's needs may be able to be met through a telehealth appointment. However, if the child requires emergency care, the worker needs to locate a provider who can fulfill that child's needs."

Virginia's COVID 19 State of Emergency came to an end on June 30, 2021.

In September 2021, VDSS issued a broadcast to all local departments encouraging them to ensure equitable access to COVID-19 vaccines for children and youth in foster care and included a list of resources to support them in their ongoing efforts. The broadcast is included below.

Broadcast:

Ensuring Equitable Access to Vaccines for Children and Youth in Foster Care

Categories: Family Services

This broadcast is to support local departments of social services (LDSS) in providing equitable access to COVID-19 vaccinations to children and youth in foster care.

Ensuring access to vaccines means that individuals have:

- **information to make informed decisions;**
- **access to technology to locate and make appointments for vaccinations,**
- **transportation referral, transportation funds or reimbursement, or the direct provision of transportation to travel to a vaccination site;**
- **child care arrangements;**
- **accommodations for individuals including those with disabilities; and**
- **language assistance services for individuals with limited English proficiency**

(Children's Bureau, ACF, Letter to Child Welfare Directors About Equitable Access to COVID-19 Vaccine)

The decision to vaccinate a youth in foster care against COVID-19 needs to be part of the informed decision-making process that includes the wishes of the youth and family as well as input from their health and other service providers. Youth and their families should be provided with the information and resources necessary for them to make an informed decision regarding the vaccine and for parents to provide consent.

As schools resume their in-person instruction and surges in COVID-19 (and any variants) occur, it is more critical than ever to ensure that local agencies are taking all measures possible to be proactive in prioritizing youth in

foster care's health and safety. Additionally, youth may need assistance from their local agency as they begin to enter the workforce or attend college where vaccine requirements may be mandatory.

LDSS should have ongoing discussions with children/youth and their families regarding vaccination and ensuring equitable access to vaccines and document these conversations in OASIS. These discussions should also incorporate recommendations of the child's medical professionals and ensuring the child and family have access to the child's medical professionals for questions or more information.

Resources:

HHS "How to Talk about Covid-19 Vaccines with Parents and Teens"
CDC "COVID-19 Vaccines for Children and Teens"
CDC "Families and COVID-19"
FDA "5 Things You Need to Know about Covid-19 Vaccine Adolescents 12-17"
UNICEF "How to talk to your children about COVID-19 vaccines"