



# HEALTH CARE OVERSIGHT AND COORDINATION PLAN 2020-2024 CFSP



WASHINGTON STATE  
**Department of  
Children, Youth, and Families**



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## Washington State

### Health Care Oversight and Coordination Plan

#### Coordination and Collaboration of Health Care Services Plan

The Department of Children, Youth, and Families' (DCYF) Health Care Oversight and Coordination Plan is developed, managed, and implemented in collaboration with state, public, and private health and child welfare experts and organizations. Partners with DCYF to provide oversight and coordination of the physical and behavioral health services for children and youth who receive services from DCYF include:

- Washington State Health Care Authority (HCA) – Washington's Medicaid state agency
  - Division of Behavioral Health and Recovery (DBHR)
- Coordinated Care of Washington – Medicaid Managed Care plan
- Department of Social and Health Services (DSHS)
  - Aging and Long-Term Support Administration (AL TSA)
  - Developmental Disabilities Administration (DDA)
- Washington State Department of Health (DOH)
- Community physicians
- Seattle Children's Hospital
- University of Washington (UW)
- Children's mental health specialists
- Passion 2 Action (P2A) – Foster youth and alumni advisory board to DCYF

These professionals, individuals, and organizations represent a mix of public and private partners. DCYF values the input and guidance from resources who have “lived experience” in the foster care/child welfare system.

Through workgroups and consultation with professional resources, the department continuously works to ensure that the well-being needs of children in care are met.

The State of Washington has four programs across multiple departments to provide coordination and oversight of physical and behavioral health care services for children and youth in out-of-home care. The four programs are integrated and are supported by agency leadership to prioritize the DCYF population.

#### Department of Children, Youth, and Families – Headquarters Well-Being Unit

The Well-Being Unit has three program managers with responsibility for implementation and maintenance of statewide policy and programs related to the physical and behavioral health of children and youth in DCYF placement and care authority. The program managers coordinate and consult with internal and external stakeholders and system partners to assure that DCYF policy and programs support and improve the well-being outcomes of children served by DCYF. A behavioral health professional supervises the unit and includes program managers who oversee:

- Screening and assessment
- Systems integration/behavioral health

- Physical health
- Substance use disorder (hired by fall 2019)

The Well-Being Unit also includes four On-going Mental Health (OMH) screeners. These staff are specially trained, non-case carrying staff that re-administer behavioral health screening tools for children that remain in out-of-home care longer than six months. OMH uses the same age-appropriate, validated screening tools used when children initially enter care.

### Health Care Authority – Foster Care Medical Team (FCMT)

The FCMT is a specialized unit of eligibility staff who initiate, monitor, and maintain Medicaid eligibility for children and youth in foster care, adoption support, and youth who are in foster care on their eighteenth birthday who maintain Medicaid eligibility until they turn twenty-six.

The FCMT receives electronic notification from FamLink (SACWIS) when a child enters placement, moves, or is adopted. This automatic process ensures assignment to the correct Medicaid program and supports continuity of care for access to established and needed services.

The FCMT requests medical records for children who remain in foster care for forty-five days based on Medicaid billing data. FCMT uploads any records they receive into FamLink so the records are available to the child's caseworker.

### Coordinated Care of Washington (CCW) - Apple Health Core Connections (AHCC)

AHCC is part of CCW's contract with HCA to provide a single, statewide, managed care plan for all eligible children and youth in foster care, adoption support, and extended foster care (including alumni of foster care until their twenty-sixth birthday). Overall, AHCC serves approximately 26,000 children, youth, and young adults in this program.

AHCC reviews all newly enrolled children and youth to determine their level of need for care management services. AHCC employs registered nurses and behavioral health professionals to provide this service. A child with physical and behavioral health needs will receive care coordination for both.

### DSHS – Aging and Long-Term Support Administration: Fostering Well-Being (FWB)

FWB unit was established in 2009 as part of DCYF's early efforts to implement the federal Fostering Connections Act of 2008. FWB is staffed with six part-time pediatricians, two registered nurses, one program manager, and one outcome improvement specialist. When AHCC was implemented in April 2016, FWB retained care coordination responsibilities for dependent children (ages 0 – 18) in the Apple Health fee for service program. The fee for service population of children and youth are either Tribal and must choose to enroll in managed care or undocumented children who are not eligible for federal Medicaid programs. Washington uses state funded dollars to support children who are not eligible for any federal Medicaid programs. Currently the fee for service population represents approximately 1500 children and youth in out-of-home care.

In addition to care coordination, FWB provides:

- Consultation to caseworkers and caregivers from the six part-time pediatricians as Regional Medical Consultants (RMC) who have a regional presence
- Clinical expertise for licensing and contracts monitoring of Behavior Rehabilitation Services (BRS) group homes and Medically Fragile group homes.

- Quality assurance review of Child Health and Education Tracking (CHET) screening reports for identification of medically fragile children
- Referral of CHET screening reports to AHCC for children enrolled in the plan
- Coordination of services not covered by AHCC, i.e. transportation and dental

HCA, AHCC, and FWB are key partners and contributors with DCYF in Washington's efforts to ensure children in out-of-home care receive appropriate physical and behavioral health care services and supports. All partners coordinate with each other and the child's caseworker and caregiver to identify and address gaps in eligibility and services.

## Oversight and Coordination of Health Care

### (1) Developing a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice

Children must have an initial health screen by a medical professional as soon as possible but no later than five days after they enter foster care. Initial health screens help identify and manage urgent medical problems not immediately identified in the transition from the child's home into foster care.

DCYF policy 4517 requires children in out-of-home care to receive age appropriate EPSDT examinations upon initial entry into out of home care and based on the Medicaid periodicity schedule:

- Within 30 days of out-of-home placement;
- Five examinations during a child's first year;
- Three examinations for children between one and two years of age; and
- Annual examinations for children between three and 20 years of age.

DCYF policy 4517 also requires caseworkers to schedule an initial dental exam to occur no later than the child's sixtieth day in placement.

The Child Health and Education Tracking (CHET) is a legislated, statewide program with specially trained child welfare staff. CHET staff do not carry an on-going caseload; their primary responsibility is to create a baseline of information for children when they enter out-of-home placement. CHET screens are completed for all children who remain in care 30 days and longer. CHET identifies and organizes essential information in the following domains:

- Physical health – Child receives an EPSDT by the thirtieth day in out-of-home placement.
  - CHET staff document known physical, behavioral, and dental health information or scheduled appointments in the final screening report
- Developmental – Using the following age appropriate, validated screening tools for non-school age children:
  - Denver Developmental Screening Tool II (birth – 1 month)
  - Ages and Stages Questionnaires-third edition (ASQ-3) (1 month – 66 months)
- Education – Records for school-age children are summarized in the final CHET report. Summary of the records includes identification of needs and if the child has an Individual Education Plan (IEP) or other education interventions through the school district.
- Social/Emotional – Using the following age appropriate, validated screening tools:

- Ages and Stages Questionnaires: Social Emotional (ASQ:SE) (1 month – 65 months)
- Pediatric Symptom Checklist (PSC-17) – (66 months to 17-year olds)
- Plus 3 – trauma screening (3-7 years)
- Screen for Childhood Anxiety Related Emotional Disorders (SCARED) – trauma screening (7 to 17-year olds)
- Global Appraisal of Individual Needs, short screener (GAIN-SS) – Substance use and co-occurring disorders (includes suicide question) – (13 to 17-year olds)
- Connections – The CHET screener meets with the child face-to-face and caregivers (as appropriate and based on the child's age) to review age appropriate and positive connections for the child to organizations, comfort items, and community supports that should be maintained while the child is in out-of-home care. For infants, this could be a blanket or toy; for older children and youth, this could mean participation in a cultural group or sports activity.

CHET staff create a CHET Screening Report to summarize the results of the screening tools, medical and education records, and interviews with the child and caregiver. The CHET Screening Report is uploaded into FamLink and sent to the child's caregiver within five days of completion. The child's caseworker uses the CHET report in consultation with the child's bio-family, caregivers, and service providers to establish a plan to address the child's urgent and long-term needs. Caseworkers and caregivers are encouraged to share the CHET report with the child's physical and behavioral health care providers.

The CHET screening report is shared with FWB and AHCC as a tool that identifies the child's initial care coordination needs to address physical and behavioral health concerns.

- FWB nurses determines if a child meets the Medically Fragile definition per [DCYF policy 45171](#).
- FWB forwards CHET Screening Reports for all children enrolled in AHCC to the health plan for initial identification of the child's physical and behavioral health care coordination needs.
- FWB provides care coordination when appropriate to fee for service children.

CHET workers make referrals to the Early Support for Infants and Toddlers (ESIT) program when developmental concerns are identified on the Denver or ASQ-3 for children under 3-years of age.

Caseworkers are responsible to ensure that children in out-of-home care beyond 30 days receive ongoing, age appropriate EPSDT examinations and any follow-up services identified in the EPSDT examination.

The FWB develops written recommendations when they provide care coordination to foster children in the Apple Health Fee for Service population including children who are medically fragile or complex. These recommendations assist the caregiver and DCYF caseworker to identify appropriate placements and accomplish any prescribed follow-up referrals and services related to the child's physical and behavioral health care.

## (2) Health Needs Monitored and Treated

The first Shared Planning Meeting (SPM) is held within 60 days of the child entering out-of-home placement to discuss and address the results of the CHET screening and the EPSDT.

SPMs occur throughout the life of the case and include bio-family, caregivers, service providers, and others important to the child and their case. SPMs also consider whether the child is in the most appropriate placement to meet their physical and behavioral health needs, and what services will best meet the child's needs based on the CHET screening results.

DCYF screens children ages 7 to 17-years old for trauma related concerns in the CHET screening process so that caseworkers can link children and youth to appropriate behavioral health services.

- In 2019, DCYF will implement a newly validated screening tool that allows the screener to identify trauma concerns in children ages 3 to 6-years old.

The DCYF HQ Well-Being Unit has four Ongoing Mental Health (OMH) screeners. The OMH program began under a federal grant and in partnership with the University of Washington. The grant ended in 2018 and DCYF established OMH as a sustained program to identify and monitor behavioral health concerns of children and youth in out-of-home placement.

OMH re-screens children and youth ages 3 to 17-years old who have been in care over six months. OMH uses the same emotional/behavioral health screening tools that are used in the CHET process:

- Ages and Stages Questionnaires: Social Emotional (ASQ:SE)
- Pediatric Symptoms Checklist-17 (PSC-17)
- Screen for Child Anxiety and Related Emotional Disorders (SCARED) trauma tool.

These screeners assist caseworkers and caregivers by identifying new behavioral health concerns and making recommendations for referrals to services and evidence-based treatments.

OMH summarizes the screening results and items needing follow-up into a report that is shared with the caregiver and caseworker.

When health and mental health concerns are identified in the CHET screen, the annual EPSDT examination, or the OMH screen the assigned DCYF worker makes referrals to community or local mental health providers for a comprehensive mental health evaluation.

CHET workers make referrals to the Early Support for Infants and Toddlers (ESIT) program when developmental concerns are identified on the Denver or ASQ-3 for children under 3-years of age.

Caseworkers make referrals to the FWB program for Tribal and undocumented children who are not enrolled in AHCC. Concerns and referrals are documented in FamLink and in the child's Court Report which is updated at least every six months and shared with the child's caregivers.

Training is provided to caseworkers and caregivers regarding their roles in linking children and youth to appropriate services to address specific physical and behavioral issues and how they can support children, youth, and families. Trainings include:

- Dynamics of Abuse and Neglect, Resilience and Evidence Based Practices - the identification of trauma symptoms
- Dynamics of Sexual Abuse (outside trainer Jordan Royal from the Harborview Center for Sexual Assault and Traumatic Stress) – significant discussion related to trauma, Trauma focused Cognitive Behavioral Therapy, working with non-offending parents

- Reunification Decisions & Transition Planning – how trauma impacts children’s behavior in care and during transitions home, impact of grief and loss, impact of transition on minimizing disruption/trauma to child
- Adolescent Issues – issues in adolescence including suicide and self-harm, internalizing and externalizing behaviors, and how to support youth with a variety of these concerns
- Supporting Children and Youth in Care – activity about essential connections explores the grief and loss/trauma of initial placement and subsequent moves. Trainees brainstorm on avoiding/minimizing these issues and supporting children and youth through the unavoidable ones.

The RMCs are available statewide and are available to answer questions from caseworkers and caregivers regarding trauma related issues.

Caseworkers utilize monthly visits with caregivers and children to:

- Discuss and monitor physical and dental health care needs and treatment plans.
- Support the caregiver and identify services that will meet the child’s well-being needs.
- Ensure the child’s behavioral health care needs are met.
- Ensure the child is in the most appropriate level of care to meet their needs.

Caseworkers are required to update the child’s health, mental health, and education status in the Court Report every six months.

CHET Screeners and caseworkers make referrals to the FWB Program when fee for service children with unaddressed or uncoordinated health and mental health concerns are identified. The referrals are reviewed to determine which children need follow-up or care coordination services to ensure their health and mental health treatment needs are met.

The FWB program staff provide consultation and care coordination services for children in out-of-home placement. The care coordination information is shared with medical providers, caregivers, and caseworkers. Care coordination services are not time limited. Once a plan of care is established, FWB staff monitor and update the plan as needed.

FWB nurses and specially trained program staff document important health and mental health information in FamLink to assist the assigned DCYF worker with continued monitoring and follow-up for children/youth in foster care.

DCYF has a contract with the Harborview Center for Sexual Assault and Traumatic Stress to provide the Foster Care Assessment Program (FCAP). FCAP is a multi-disciplinary evaluation that assesses the needs of children who are in out-of-home care for more than ninety days. Assessment services include a six-month follow-up period to assist the DCYF caseworker in implementing a placement plan and to help meet the needs of the child and family. Contracted services include:

- Permanency and Planning Consult - this service focuses on permanency and linking children and families with the most appropriate services. The consultation service provider structured case staffing, service identification, system navigation and care coordination. Permanency consultation also include identification of barriers achieving permanency, potential solutions, and action steps need to be taken to overcome identified barriers. Approximately forty-five-minute detailed consultation in person or via tele or video conference will produce a one-page summary of recommendations with timeline, referrals to evidence-based treatment as needed.



- Standard and comprehensive assessments - these services consist of structured clinical interviews and the administration of standardized measures. A multi-disciplinary team representing pediatrics, psychiatry, psychology, social work, DCYF, and other consultants (e. g., ethnic/cultural and foster/adoptive parent) will review the preliminary results of the assessment. A written report is provided to the caseworker regarding the child and parents/caregiver's functioning with specific recommendations for services and permanency including timelines.

Training to DCYF staff regarding trauma symptoms, mental health diagnoses, evidence based treatments, and psychotropic medications has been fully implemented. Trainings are in person and provided by the Alliance for Child Welfare Excellence (Alliance) via In-Service and Regional Core Training (RCT).

FWB staff attend the DCYF Tribal Policy Advisory Committee (TPAC) meetings. Feedback from these meetings is used to ensure Tribes are aware of any changes to programs or policies that impact health and mental health care for Tribal children served by DCYF and Tribes.

Coordinated Care of Washington (CCW) in consultation with DCYF provided trainings on Adverse Childhood Experiences, Resilience, and Trauma Informed Care for community providers, caregivers, and system partners.

AHCC calls caregivers of all children newly placed into foster care to discuss caregiver questions and concerns about the child's physical and behavioral health and identify any urgent needs that need to be addressed before or at the initial EPSDT examination. During this phone call, AHCC also informs the caregiver about the child's identified primary health care provider.

(3) How medical information for children in care will be updated and appropriately shared which may include the development and implementation of an electronic health record

DCYF policy 43092 requires CHET screeners to share the screening Report within five days of completion.

Assigned caseworkers must:

- Review and update the child's health records at the time of each placement using FamLink and provide the caregiver with a copy of this information (e.g. Child Information/Placement Referral (CIPR) form and Health/Mental Health and Education Summary). See [DCYF Placement Policy](#).
- Provide the caregiver with all completed assessments within five days of receipt.
- Update the child's health, mental health, and education status in the Court Report every six months.

Caseworkers and CHET screeners document known medical information into Health/Mental Health page in FamLink. This information is included in the Health/Mental Health and Education Summary that is updated every six months or when there is a placement change.

The FCMT staff at HCA request the previous two years of medical records for a child who was eligible for Apple Health prior to entering out-of-home placement and is in care longer than 45 days. All records received are uploaded into FamLink for the assigned caseworker to review and use in case planning.

The FWB unit is available to provide care coordination services to fee for service children in out-of-home care including those who are medically fragile or complex. The care coordination information is shared with medical providers, caregivers, and caseworkers. Care coordination

services are not time limited. However, once a plan of care is established services may be on an as-needed basis.

FWB nurses and specially trained program staff document medical and mental health information into FamLink about fee for service children who receive care coordination services. HCA developed an access for physical and behavioral health care providers to view paid claims data in ProviderOne. Providers can see the most recent two years of claims including prescriptions, hospitalizations, dental, and immunizations.

All AHCC contracted providers have access to a secure provider portal that reflects billing data and information vital to the coordination of health and behavioral health care services. This helps to avoid over and under immunization, re-trying of medications already attempted, and continuation of treatment protocols to maintain progress of established health goals for the child.

FWB nurses enter immunizations into the Washington State Immunization Information System (WSIIS) when there is new or different information than what is reflected in the registry. Once entered, any medical provider who subscribes to WSIIS can see the child's immunization history.

The FCMT created a form to help tribes identify prior foster youth who may be eligible for Apple Health until their 26<sup>th</sup> birthday. The form also streamlines the process for Tribes and the FCMT to reinstate Apple Health eligibility.

Completed CHET reports are shared via a secure file transfer site with AHCC. AHCC uses the CHET report to assess the child for care coordination needs.

The OMH screeners upload the results of the mental health screening tools into FamLink, and the caseworker is notified by email that the report is uploaded. A copy of the OMH report is mailed to the child's caregiver.

DCYF and HCA executed a data share agreement that allows the two agencies to establish data and information sharing protocols. This information sharing is necessary to ensure children served through the AHCC plan receive timely, appropriate, and coordinated physical and behavioral health care services.

Families of adopted children and youth ages 18 to 26-years old who choose to remain enrolled in AHCC are able to access their health information through the CCW secure client portal.

#### (4) Steps to ensure continuity of health care services (which may include the establishment of a medical home for every child in care)

AHCC is primary mechanism to provide a "medical home" for children and youth in out-of-home placement. AHCC assures that newly enrolled children are assigned to a primary health care provider or retain the same provider(s) the child saw prior to entering care. AHCC has a "Continuity of Care" benefit that allows the child to continue to see non-AHCC contracted providers while AHCC works to establish a contract.

When the child has an identified primary care provider or medical home, caregivers are encouraged to maintain that relationship and ensure continuity of care.

DCYF caseworkers are required to generate the Child Information and Placement Referral (CIPR) form in FamLink. Caregivers receive the CIPR no later than 72 hours after an initial placement or a placement change and includes the physical, behavioral, and education information known about the child at the time of initial placement or a placement move.

CHET screeners document available information about medical, dental, and mental health providers in FamLink in the health/mental health pages for each child. The CHET report is then uploaded into FamLink.

Caseworkers and caregivers jointly develop a Caregiver Support Plan for medically fragile children. The Caregiver Support Plan addresses the training and support needs of the caregiver and outlines a plan for planned and emergency respite care for the medically fragile child.

FCMT mails reports that contains Medicaid billing data to caregivers of children ages twelve and younger when a child first enters out-of-home placement. These reports include immunization information from the DOH Washington State Immunization Information System. This supports continuity of care by helping caregivers identify possible primary care providers or medical home.

Youth who are not residing in their approved placement or who are in a temporary situation remain eligible for AHCC; their eligibility is not closed or suspended. Continued eligibility allows the youth to seek medical treatment or obtain needed prescriptions such as insulin when they are “on the run.”

In January 2019, a fully integrated behavioral health system through CCW, AHCC program was implemented. AHCC program covers foster care, adoption support, and alumni of foster care population and covers full array of behavioral health services in addition to their physical health, in all 39 counties in the state.

Referrals packets to Behavior Rehabilitation Service (BRS) providers include physical and behavioral health care information so that potential providers understand the level of care the child or youth requires.

#### (5) Oversight of prescription medications

DCYFs [Psychotropic Medication Policy 4541](#) outlines expectations regarding the role of the DCYF caseworker and obtaining consent from a youth (13 years and older) or bio-parent (for a child 12 years and younger) when psychotropic medications are prescribed. The policy also addresses obtaining authorization from the court, when necessary.

Information about the youth’s rights to informed consent for psychotropic medications is included in the “Your Rights, Your Life” booklet for youth.

The Alliance and DCYF developed the “Mental Health: A Critical Aspect to Permanency and Well-Being” curriculum for caseworkers which addresses screening for trauma, mental health needs, psychotropic medications, and evidence based treatments. This training is currently provided in a train the trainer format and is part of RCT for new caseworkers.

The FWB program provides care coordination services for fee for service children and youth which includes the identification of medications that require oversight. Children and youth who have a mental health diagnosis and are prescribed a psychotropic medication are eligible to receive care coordination.

- FWB receives a monthly list from the HCA of fee-for-service children ages 0 – 5 years old who are prescribed a psychotropic medication. FWB monitors and provides care coordination until the child turns six years of age. FWB communicates with the child’s caseworker and caregiver regarding concerns and medication monitoring.

HCA sponsors the Pediatric Mental Health Stakeholder workgroup to establish and review Washington’s community thresholds for reasonable prescribing limitations that are applied to the Medicaid population including children and youth in foster care. The workgroup meets “as

needed” and is comprised of child psychiatrists, pediatricians, community mental health professionals, client advocates, and other community stakeholders.

The primary intervention used by HCA for psychotropic medication oversight is a mandatory review from the contracted Second Opinion Network (SON) when community established thresholds are exceeded. The SON is comprised of pediatric psychiatrists on staff at Seattle Children’s Hospital.

A second opinion is triggered by algorithms within the ProviderOne payment system that look at whether there are multiple mental health medications prescribed for a child, the dosage prescribed, and the age of the child, (too much, too many, too young).

SON reviews are triggered for:

- Children receiving two or more atypical antipsychotics (AAPs)
- Children age five or younger receiving psychotropic medications
- Children receiving five or more psychotropic medications
- High doses of ADHD, AAPs, or antipsychotics. Prescribing of antipsychotics (both atypical and conventional) in doses that exceed the thresholds recommended by the HCA’s Pediatric Mental Health Stakeholder Workgroup

In addition to the SON, HCA (through contract with Seattle Children’s Hospital) maintains the Partnership Access Line (PAL). PAL is a telephone based pediatric mental health consultation system. PAL employs child psychiatrists and caseworkers affiliated with Seattle Children’s Hospital to deliver these consultation services. The PAL team is available statewide to any primary care provider. Primary care providers are encouraged to call the PAL toll free number as often as they would like to answer questions regarding diagnostic clarification, medication adjustment, or treatment planning.

FWB RMC provide consultation to the FWB nurses and caseworkers regarding medications and their side effects.

AHCC embeds a formal psychotropic medication utilization review (PMUR) into their practice. AHCC updated the way their database collects information resulting in limited data availability for calendar year 2018. Between August 1, 2018, and December 31, 2018 the PMUR process fully reviewed 98 children and youth. The review showed us that:

- 36 children and youth were outside of typical/recommended prescribing parameters.
- 45 children and youth were identified with a regimen outside of parameters but within the standard of care.
- 17 of the members were within parameters for standards of care.

PMUR utilizes a peer-to-peer process to address medication concerns with prescribers.

The AHCC PMUR process uses specific criteria to indicate where there is a need for further review of a child’s clinical status.

For a child who is prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient’s clinical status:

1. Absence of a thorough assessment for a DSM-5 diagnosis(es)
2. Four (4) or more psychotropic medications prescribed concomitantly
3. Prescribing of:
  - a. Two (2) or more concomitant stimulants

- b. Two (2) or more concomitant alpha agonists
  - c. Two (2) or more concomitant antidepressants
  - d. Two (2) or more concomitant antipsychotics
  - e. Three (3) or more concomitant mood stabilizers
4. The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.
  5. Psychotropic polypharmacy (2 or more medications) for a given mental disorder is prescribed before utilizing psychotropic monotherapy.
  6. The psychotropic medication dose exceeds usual recommended doses.
  7. Prescribing of:
    - Stimulants: Under age 3-years old
    - Alpha Agonists Under age 4-years old
    - Antidepressants: Under age 4-years old
    - Mood Stabilizers: Under age 4-years old
    - Antipsychotics: Under age 5-years old
  8. Prescribing by a primary care provider who has not documented previous specialty training for a diagnosis other than the following (unless recommended by a psychiatrist consultant):
    - Attention Deficit Hyperactive Disorder (ADHD)
    - Uncomplicated anxiety disorders
    - Uncomplicated depression
  9. Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose- and lipids at least every 5 months.

DCYF Licensing Division (LD) requires that all regional licensors and BRS group care providers receive training about medication documentation and safe storage. The training is also available for other DCYF staff and non-BRS group care staff. Regional licensors review medication storage and logs as part of their bi-annual health and safety review of BRS group care programs. For a child who is prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient's clinical status:

1. Absence of a thorough assessment for a DSM-5 diagnosis(es)
2. Four (4) or more psychotropic medications prescribed concomitantly
3. Prescribing of:
  - a. Two (2) or more concomitant stimulants
  - b. Two (2) or more concomitant alpha agonists
  - c. Two (2) or more concomitant antidepressants
  - d. Two (2) or more concomitant antipsychotics
  - e. Three (3) or more concomitant mood stabilizers
4. The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.

5. Psychotropic polypharmacy (2 or more medications) for a given mental disorder is prescribed before utilizing psychotropic monotherapy.
6. The psychotropic medication dose exceeds usual recommended doses.
7. Prescribing of:
  - Stimulants: Under 3-years old
  - Alpha Agonists Under age 4-years old
  - Antidepressants: Under age 4-years old
  - Mood Stabilizers: Under age 4-years old
  - Antipsychotics: Under age 5-years old
8. Prescribing by a primary care provider who has not documented previous specialty training for a diagnosis other than the following (unless recommended by a psychiatrist consultant):
  - Attention Deficit Hyperactive Disorder (ADHD)
    - Uncomplicated anxiety disorders
    - Uncomplicated depression
9. Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose- and lipids at least every 5 months.

RCT and In-service (IST) Mental Health training from the Alliance includes understanding use and oversight of psychotropic medications and matching behavioral symptoms based on screening results to appropriate evidence based practices.

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

DSHS employs physicians as part-time medical consultants in each region to provide consultation to caseworkers and caregivers. These physicians also provide medical oversight to the FWB Program.

The Deputy Chief Medicaid Officer (DCMO) at HCA is assigned to provide consultation for DCYF to ensure child welfare policy is consistent with Medicaid rules and standards of care. This includes input regarding evidence and research based clinical interventions. The DCMO also provides assistance to resolve child specific issues related to Medicaid covered benefits. DCYF contracts with Harborview Center for Sexual Assault and Traumatic Stress to complete a Foster Care Assessment on children with placement stability issues or concerns about reunification. A comprehensive report is completed which includes recommendations from a team that consists of community medical and mental health providers.

In compliance with [RCW 74.14B.030](#), each DCYF Region is required to conduct a Child Protection Team (CPT) staffing. The CPT includes medical, law enforcement, mental health, substance abuse, and other appropriate community professionals. This cross-system review team meets to assist DCYF when making decisions regarding placement and filing of dependencies.

DCYF Regions convene meetings with Developmental Disabilities Administration (DDA) regional staff to coordinate regarding mutually served children to ensure they receive appropriate services.

DCYF partners with HCA and the AL TSA through the FWB Program to ensure fee for service children receive appropriate physical and behavioral health services and treatment.

All caregivers of newly placed children receive a phone call from AHCC staff to determine if the child has any urgent or unmet physical or behavioral health care needs, answer questions about the AHCC plan and managed care, and assign a primary care provider.

Completed CHET screens for AHCC enrolled children are shared with the managed care plan. AHCC reviews the CHET reports and assigns the child to the appropriate care coordination level. AHCC contacts caseworkers if a child requires more intensive levels of care coordination.

CHET screeners and FWB send requests for “expedited referrals” to AHCC for care coordination if there are concerns about medically complex or medically fragile children during the CHET screening process.

AHCC provides training opportunities for DCYF licensed and unlicensed caregivers. DCYF staff are also welcome to attend AHCC trainings. Trainings include:

- Trauma Informed Care (National Child Traumatic Stress Network (NCTSN) curriculum)
- Resiliency
- Hope for Healing (Association for Training on Trauma and Attachment (ATTACH) curriculum)
- Substance Use, Abuse & Addiction
- Suicide Prevention
- Whole Brained Parenting
- Coping with Holiday Stress
- Adverse Childhood Experiences
- Childhood Development
- Sexual Health in Foster Care- Skill Building for Caregivers

AHCC continually expands their training library and is responsive to requests from DCYF for development of new trainings.

(7) Steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the new requirement to include options for Health Care Insurance and Health Care Treatment Decisions

### *Transition Planning*

All youth exiting foster care in Washington State are eligible for Medicaid until their 26th birthday. As required by policy (Practices and Procedures Chapter 4000, section 43104), this information is discussed at the Transition Staffing, again 90-days prior to the youth exiting care and addressed during the monthly DCYF worker visits as needed.

During the National Youth in Transition Database (NYTD) survey calls, the survey team explains to youth that they have medical coverage to age 26. Additionally, the team supplies the contact information to AHCC.

DCYF has a pilot in Clark County where AHCC regional representatives are standing members of a youth's Shared Planning meeting prior to the youth exiting care. During the meeting, AHCC will provide the youth with resources and discuss services available to them until age 26.

### *Health Care Treatment Decisions*

To support youth in their transition out of care and ensure they are knowledgeable about a Durable Power of Attorney for Health Care, DCYF has incorporated the following language into its Transition Plan for Youth Exiting Care (DSHS 15-417):

*The importance of having a Durable Power of Attorney for Health Care, which would designate another person to make health care treatment decisions on my behalf in case I become incapacitated and unable to participate in such decisions and I do not have or want a relative who would otherwise be authorized to make such decisions, including where to find the document and how to execute it. <http://www.doh.wa.gov/livingwill/registerdocuments.htm>.*

This information is addressed at the Transition Staffing, again 90-days prior to the youth exiting care and addressed during the monthly DCYF caseworker visits as needed.

In addition, the Independent Living (IL) and Responsible Living Skills Program (RLSP) contracts include a requirement for providers to discuss the importance of having Durable Power of Attorney for Health Care with all youth exiting care.

(8) The procedures and protocols the state or tribe has established 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 (section 422(b)(15)(A)(vii) of the Act).

### *All Children*

Every child in out of home placement thirty days or longer receives a CHET screen which is completed by the thirtieth day of placement.

All CHET screens are reviewed by the FWB to identify children who meet the medically fragile criteria in DCYF policy 45171. When a child meets the medically fragile criteria:

- FWB sends an expedited referral to AHCC to request care coordination and notifies the DCYF caseworker about the referral.
- FWB provides care coordination for medically fragile children who are not enrolled in AHCC and remain fee for service (i.e. Tribal and undocumented children).
  - When health and mental health concerns are identified in the CHET screen or the EPSDT examination, the assigned DCYF caseworker and caregiver work with AHCC to identify appropriate physical and mental health providers to meet the child's identified needs.

### *Medically Intensive Children's Program*

The Medically Intensive Children's Program (MICP) provides skilled nursing services to children 17-years-old and younger. These children have complex medical needs that require a registered nurse to provide support. Nursing services may be provided in the family home, foster homes, and in contracted medically intensive children's group and staffed residential homes. This Medicaid program helps to keep families together. It also greatly reduces the cost of in-patient hospital care where these children would be cared for without this program.



## MICP Eligibility Requirements:

- 17-years old or younger;
- Have complex medical needs (example, ventilator dependent, tracheostomy care);
- Enrolled in Washington Apple Health (Medicaid); and
- Require at least four hours of continuous skilled nursing care per day.

*Wraparound with Intensive Services (WISe) and Behavior Rehabilitation Services (BRS)*

In October 2017, DCYF implemented a Wraparound with Intensive Services (WISe) policy 4542. The policy requires DCYF caseworkers to refer or verify that a referral for WISe screen is made to a designated mental health provider for children and youth with complex behavioral health issues whose needs can be met in the community. WISe is designed to provide comprehensive, behavioral health services and supports to Medicaid eligible individuals, up to 21-years-old with complex behavioral health needs and their families. Once a WISe referral is made, information is gathered from the referent, and the Child Adolescent Needs and Strengths (CANS) screen is completed by the CANS-certified screener. The CANS algorithm combined with clinical decision determines whether the youth would benefit from WISe. A WISe screen is also required for all youth prior to consideration of any level of the DCYF Behavioral Rehabilitation Services (BRS). If WISe is unavailable or unable to meet the needs of a youth, DCYF may utilize BRS to support the youth who require intensive services and placement supports. BRS is a temporary (no longer than 12-months) intensive wraparound support and treatment program for children and youth with high-level complex service needs. BRS can be provided in a child's home prior to placement, a foster home, or group home setting. BRS is intended to stabilize children and youth (in-home or out-of-home) and assist them in achieving their permanent plan.

- To be considered for BRS level of services, in addition to the WISe screening, a child or youth must be recommended for BRS level of service in an SPM or Family Team Decision Making (FTDM) meeting.
- The DCYF caseworker staffs the case with their supervisor and completes a BRS referral packet. This referral is reviewed by the supervisor and the area administrator (AA) for appropriateness. If appropriate, the supervisor and AA sign the referral and the packet is submitted to the regional BRS program manager for review and final approval. The regional BRS program manager will make sure that all less restrictive levels of care were tried and unsuccessful and that they youth needs BRS level of services.
- The BRS program manager works to keep the youth in the lowest level of BRS environments as the child or youth's behaviors and treatment needs allows.
- The DCYF caseworker tracks the progress of each youth and reviews the treatment plan with the Child and Family Team at least a quarterly basis to ensure that the currently level of care is still necessary. A new WISe screen is done every 6-months and at discharge while a youth is in BRS.
- The regional BRS program manager reviews the child or youth's status every six months with the caseworker and service provider. These reviews include the child or youth's service needs, level of care, expected exit date, and transition plan to a lower level of care or home.
- All youth who receive any BRS level of services are re-screened every six months by a DCYF contracted Registered Nurse to ensure the youth meets medical necessity.

### *Children's Long-term In-patient Program (CLIP)*

CLIP is the most intensive inpatient psychiatric treatment available to WA State residents, ages 5 to 18-years-old. CLIP is psychiatric treatment provided in a secure and highly structured setting that are designed to assess, treat and stabilize youth diagnosed with psychiatric and behavioral disorders meet Medical Necessity.

CLIP consists of only 82 beds in five facilities across the State of Washington. The facilities are located in King, Pierce (two), Spokane, and Yakima county.

Individualized treatment is provided through the use of evidenced based practices designed to increase the youth's skills and adaptive functioning with a focus on reintegration back into a community setting, as quickly as possible.

Children and youth in the placement and care authority of DCYF and who require inpatient mental health treatment are eligible for this service.

CLIP admission process can be divided into two ways, voluntary and involuntary processes:

#### *Voluntary Process*

- A Voluntary CLIP application is submitted to the youth's local Behavioral Health Organization (BHO) or Managed Care Organization (MCO) to determine whether medical necessity criteria is met, and if CLIP level treatment is appropriate.
- Applicants 13-years-old and older must agree to enter CLIP, unless they are on a 180-day Involuntary Treatment Act (ITA) Court Order.

#### *Involuntary Process*

- Under [WA State's RCW 71.34](#), adolescents aged 13 to 17-years old may be committed for up to 180-days of involuntary inpatient psychiatric treatment, at which time the youth becomes eligible for admission to CLIP.
- Youth are assessed by a Designated Crisis Responder (DCR) who determines that Involuntary Treatment Act (ITA) criteria is met.
- When a less restrictive alternative is not possible, the youth is placed on an ITA order.
- The adolescent's name is placed on the statewide waiting list as of the day of the 180-day restrictive ITA order.

Admission to a psychiatric inpatient treatment occurs only if the child meets medical necessity guidelines as determined by the local Behavioral Health – Administrative Services Organization (BH-ASO) authorized mental health professional(s) and with the concurrence of the professional person in charge of the facility.

#### *Training for DCYF Staff*

The Alliance addresses identification of trauma symptoms throughout RCT and IST. These trainings help caseworkers understand the impact of trauma on the child to be considered when making placement decisions.

RCT and IST training modules include information about:

- Dynamics of Abuse and Neglect - resilience and evidence based practices
- Dynamics of Sexual Abuse– including significant discussion related to trauma, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and working with non-offending parents

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- Reunification Decisions & Transition Planning – how trauma impacts children’s behavior in care and during transitions home, impact of grief and loss, and impact of transition on minimizing disruption/trauma to child
- Adolescent Issues – issues in adolescence including suicide and self-harm, internalizing and externalizing behaviors, and how to support youth with a variety of these concerns
- Understanding Use and Oversight of Psychotropic Medications and Matching Behavioral Symptoms Based on Screening Results to Appropriate Evidence Based Practices.
- Supporting Children and Youth in Care –explores the trauma impact including grief and loss of initial placement and subsequent moves. Trainees brainstorm ideas to avoid or minimize these issues and support children when moves are unavoidable.
- Mental Health – In-depth Applications for Child Welfare – focuses on using the results of the CHET and OMH screenings to match children and youth to Evidence Based Practices (EBPs) that are targeted to meet the identified needs.

### Lessons Learned from 2015 - 2019

Children and youth in out-of-home placement do not consistently receive preventive dental examinations every six months. Caregivers and caseworkers need additional training and information regarding preventive dental care.

DCYF needs current data to assure that the existing processes for oversight of psychotropic medications prescribed to children and youth in out-of-home care:

- Continues to demonstrate a reduction in the prescribing of psychotropic medications.
- Reflects an increase in the use of evidence based services when psychotropic medications are prescribed.

Sharing the CHET report with AHCC and FWB resulted in increased linkage of identified behavioral and physical health to appropriate services.

DCYF has additional information about a child’s behavioral health needs through the OMH screening process that should be shared with AHCC to ensure coordination and access to appropriate services and providers.

CFSR data showed that children and youth do not consistently access follow-up care to address identified physical and behavioral health concerns.

Washington’s mental health system does not have a “step-down” or respite option for children and youths who transition to and from intensive in-patient behavioral health services. This lack of resources affects family and placement stability, and retention of out of home caregivers.

### New Activities for 2020-2024

PLAN ELEMENT	PLANNED ACTIVITIES
1. Schedule for initial and follow-up health screenings	<ul style="list-style-type: none"> <li>• DCYF child welfare programs will coordinate with the CQI team to communicate with regional staff about the periodicity schedules for EPSDT and dental examinations.</li> <li>• In 2019, DCYF will implement a newly validated screening tool that allows the screener to identify trauma concerns in children ages 3 – 6.</li> <li>• In 2019, AHCC will begin calling caregivers of children and youth</li> </ul>

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PLAN ELEMENT	PLANNED ACTIVITIES
2. How health needs are monitored and treated	<ul style="list-style-type: none"> <li>• Work with data from HCA and CRT regarding dental care provided to children and youth in out-of-home placement to identify barriers to receiving preventive dental care every six months.</li> <li>• In 2019, DCYF will explore the ability to share the OMH report with AHCC and FWB as appropriate.</li> </ul>
3. Updating and sharing medical information	<ul style="list-style-type: none"> <li>• In 2019, DCYF will continue to work with AHCC for access to the AHCC secure portal. Access to the portal will allow appropriate DCYF staff to see health related information such as immunizations and medications. Barriers to current access include assurance of HIPAA protections for certain types of information such as behavioral and reproductive health information.</li> <li>• In 2019, DCYF will explore the ability to share the OMH report with AHCC and FWB as appropriate.</li> </ul>
4. Continuity of health care services	<ul style="list-style-type: none"> <li>• In 2019 DCYF will participate in HCA's legislatively mandated workgroup to review options for Washington's Medicaid dental benefit. The workgroup will assess whether the state should move to a managed care dental benefit, remain fee for service, or a combination</li> <li>• DCYF will work with HCA and AHCC to assist caregivers and caseworkers to connect children and youth with appropriate level of behavioral health services after utilizing high-level interventions such as, emergency department, inpatient psychiatric hospital, crisis services, and long-term inpatient treatment.</li> <li>• DCYF will work with HCA and AHCC to improve rates of follow-up care provided to children with identified needs.</li> <li>• DCYF will work with SAMHSA, HCA, and AHCC to expand therapeutic foster care bed capacity and create a "step-down" for children and youths who exit and enter intensive behavioral services. The newly developed therapeutic foster care beds will provide access to clinical intervention with specifically trained foster parent homes, for children and youth in DCYF care and custody with complex and intensive mental health and behavioral health needs.</li> </ul>
5. Oversight of prescription medications	<ul style="list-style-type: none"> <li>• By spring 2020, DCYF will work with HCA and AHCC to develop a youth-driven communication regarding psychotropic medications and consent.</li> <li>• In 2019, DCYF will request the development of a youth-specific on-line training regarding psychotropic medications and consent.</li> <li>• DCYF will partner with HCA and AHCC to obtain current data regarding the effectiveness of existing processes that provide oversight of psychotropic medications prescribed to children and youth in out of home care.</li> </ul>
6. Consultation with medical and non-medical stakeholders and child welfare experts	<ul style="list-style-type: none"> <li>• New Substance Use Disorder (SUD) program manager will collaborate with other state agencies, community stakeholders, and treatment providers to ensure programs that allow parents to have their children present in residential treatment facilities are sensitive to the issues surrounding families who receive services from DCYF.</li> </ul>
7. Transition planning for youth	<ul style="list-style-type: none"> <li>• Include AHCC as a standing member at the statewide IL meetings.</li> <li>• Explore expansion of Clark County pilot to include AHCC regional representatives as standing members of a youth's transition planning meeting prior to the youth exiting care</li> </ul>

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PLAN ELEMENT	PLANNED ACTIVITIES
8. FFPSA requirements and assuring appropriate placement related to diagnoses	<ul style="list-style-type: none"><li>• Revise <a href="#">BRS policy 4533</a> to reflect the requirements stipulated in the Family First Prevention Services Act.</li></ul>